TOWARD AN
ORGANIZED, IDEAL SYSTEM OF CARE
FOR
RHODE ISLAND'S CHILDREN, YOUTH AND FAMILIES

The Report of the Ideal System of Care Committee
of the
Rhode Island System of Care Task Force

April 8, 2002

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Honorable Thomas J. Izzo
Honorable Steven M. Costantino
Robert L. Carl, Jr., Ph.D., Director
State House
Providence RI 02903

Dear Ideal System of Care Task Force Chairmen:

Rhode Island policymakers from all three branches of government - Executive, Legislative and Judicial- as well as the private sector are committed to conceptualize and realize an "Ideal System of Care" for Rhode Island's children, youth and families. This report reflects the consensus of the members of the Ideal System of Care Committee, a broad-based, self-selected committee that was established as a workgroup of the RI System of Care Task Force.

I am pleased to forward this report and its recommendations for your consideration. The recommendations are informed by presentations, written submissions, and debate from numerous sources including individual committee members. They reflect input provided by the other two Task Force workgroups, Current Reality and Foster Care. The organized, ideal system is defined by four major themes – family centeredness, educational success, community based service delivery, and system accountability - which emerged during the course of the committee's discussions and flow from a shared vision of a service system that supports children in families. The committee recognized the need for short-term program initiatives to transition from the current reality to an ideal system. However, all participants recognize that real progress can be made only through the implementation of long-term, systemic change. This report recognizes that while the implementation of the recommendations requires the commitment of the citizens of the State, the appropriate lead state agency for implementing and administering the key recommendations of this report is the Department of Children, Youth and Families (DCYF).

This report is a blueprint for action. The committee is cognizant that the current reality within the State will impact the implementation of the blueprint as we move forward within the context of an uncertain economic forecast, a change in the leadership in the Executive Branch, and a change in the size and alignment of the Legislature. Rhode Island has continually demonstrated a commitment to providing adequate, competent and timely services to its children and youth. This report proposes a strategy for the location, level and funding for the provision of those services.

I look forward to working with you and the other members of Rhode Island's system of care toward implementing the actions in this plan.

Thank you for the opportunity to be a part of this significant effort.

Sincerely,

A. Kathryn Power
Director, Department of Mental Health, Retardation and Hospitals
Chairwoman, Committee on the Design of the Ideal System of Care

TABLE OF CONTENTS

APPENDICES

PREFACE

The Ideal System of Care Committee was created by the Rhode Island System of Care Task Force and charged to design a full system of services that will provide effective supports and services to children and their families. Looking beyond the current configuration of services, departments and providers, the committee worked to design a system that builds on the strengths of families through the most effective use of finite state resources.

This Ideal System of Care for our state's children and youth is a vision. It is a proclamation of shared goals and a design for better outcomes. The importance of this vision to our state and its future served to induce all three branches of government into its preparation. Critical to the lives of our most vulnerable citizens, Rhode Island's Legislative, Executive, and Judicial bodies are each charged with distinct governmental functions relative to our children and youth. By participating in this planning process, no branch of government has sacrificed any of its authority, power or obligation. Constitutional checks and balances set the context for this vision and comprise the legal foundation of governmental responsibility which may not unilaterally be abdicated. In an Ideal System of Care, if each and every child is to succeed, all three branches of government must be vigilant in fulfilling their distinct roles in the lives of children.

Integral to any effort on behalf of children and their families is understanding the role and authority of distinct government bodies.

The Family Court has the statutory authority to oversee and implement all the duties as enumerated within Chapter 1 of Title 14, Chapter 11 of Title 40 and any other statutory charge as outlined within Section 8-10-3 of the Rhode Island General Laws.

The Department of Children, Youth and Families has the statutory authority and responsibility to mobilize the human, physical, and financial resources available to plan, develop, and evaluate a comprehensive and integrated statewide program of services designed to ensure the opportunity for children to reach their full potential, including prevention, early intervention, outreach, placement, care and treatment, and aftercare programs. The Department is the single authority to establish and provide a diversified and comprehensive program of services for the social well-being and development of children and their families. In furtherance of its purpose, the Department of Children, Youth and Families cooperates and collaborates with the Family Court, other public and private agencies, and the federal government in the development and implementation of comprehensive programs to support children and families.

While the committee made very effort to design an Ideal System of Care, the committee recognizes the challenges inherent in the implementation of any systemic change. Further, the committee recognizes that a body of law exists, both state and federal, which comprises the underpinnings of child welfare, juvenile justice, and children's behavioral health services. This report, its recommendations, and implementation plan must be viewed within that framework.

CHAPTER 1: EXECUTIVE SUMMARY

Rhode Island's organized Ideal System of Care for Children, Youth and Families is built on the strengths of families and communities, the successes of past initiatives, and is responsive to the challenges of the past. It is a system that is operationally feasible, financially realistic and supported by broad consensus. This system is a strategic instrument for moving the State closer to the four outcomes embraced by the Rhode Island Children's Cabinet and other key state and community leaders:

- All Children Entering School Ready To Learn
- All Youth Leaving School Ready To Lead Productive Lives
- All Children And Youth Safe In Their Homes, Neighborhoods And Schools
- All Children Living In Families That Are Self-Sufficient, yet Interdependent

The organized, ideal system is defined by the themes that follow and implemented through the identified strategies and processes which support these themes.

THEME: FAMILY CENTERED PRACTICE – A FUNDAMENTAL SHIFT IN SERVICE DELIVERY

The Ideal System supports the role of the family as the primary caregiver for children and recognizes that the optimum interventions for any individual child and their family are the interventions most proximate to home with the full resources of the community made available to that child and family *(see Chapter 3 and Appendices B and D)*. It is critical to note that "families" include biological parents, adoptive families, extended kinship networks, legal guardians and temporary foster families. The broad vision is one in which a substantially greater portion of state resources are allocated to universal and selected prevention or early intervention services. However, the Ideal System acknowledges that substantial portions of the state's limited resources must be focused to meet the immediate needs of identified priority populations.

THEME: PREVENTION AND EDUCATION

The system's foundation is coordinated by local community members and state staff to ensure that all neighborhoods where families live have strong prevention and educational services and supports for the complex and changing needs of today's children and families. It is a system which provides families and other caregivers ready access to the resources necessary to meet children's developmental needs. The system has mechanisms to redirect cost savings from reduced reliance on restrictive and expensive out-of-home placements to community-based prevention and intervention services. This is accomplished by shifting service delivery methods for these priority populations from a provider-driven, bed-based methodology to a **culturally competent, family centered, community-based methodology that is school-linked**, provides adequate state aid to achieve better outcomes, and integrates

state and local agency resources *(see Chapter 2).* Included among these resources are those that meet the basic physical, emotional, developmental and educational needs of all children, as well as special resources to meet the individual needs of children with disabilities and social, emotional, and behavioral disorders; children who have been abused and/or neglected; and youth involved with the juvenile justice system.

SYSTEM STRATEGY #1 - CHILDREN'S CABINET'S LEAD SYSTEM ROLE

In this Ideal System, the Children's Cabinet provides the state leadership necessary to assist each community in organizing new or strengthening existing collaborations *(see Chapter 2).* These *Community Prevention Partnerships (CPP*'s) are composed of all key stakeholders including, but not limited to, families, community based organizations, Local Coordinating Councils for Children's Behavioral Health (LCC's), schools, law enforcement, faith organizations, business leaders, and mental health and social service providers. These teams have **the responsibility, authority, and resources** to develop, implement, and measure the results of local strategic plans for enhancing prevention programming and identifying community, strengths, risks, and needs in relation to children and their families across the system of care. The Children's Cabinet state agencies support these entities in collaboration with local government and view these teams as the voice of the community in relation to funding decision-making (i.e., Comprehensive Children's Services pilot regulations)[1].

SYSTEM STRATEGY #2- COMMUNITY OWNERSHIP SUPPORTED BY STATE AID

In embracing these outcomes, the Ideal System is one which recognizes that communities bear the primary responsibility for helping children and families succeed, while ensuring that limited state resources are effectively mobilized to aid communities with this challenge *(see Chapter 2)*. Built on the concept of **family-centered practice** *(see Appendix B)* **and the principles of the Child and Adolescent Services System Program** *(CASSP; see Appendix D)*, this system recognizes and endorses the belief that the most effective path to success is for communities to take responsibility for - "to own" - all of their children and families, especially those viewed as the most challenging. All facets of the community, especially schools, accept their responsibility in supporting all children and families and ensuring that services are provided either in the community or as proximate to the community as possible. This support is particularly critical when an individual returns from placement outside of the community, including residential programs, psychiatric hospitals, the RI Training School and the Adult Correctional System.

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[1] These regulations were collaboratively developed by DCYF , RIDE and DHS as required by RIGL 42-72.7, and allow for a process which accomplishes two major goals: (a) to improve collaborative planning, comprehensive services and outcomes for children with complex special needs and their families; and (2) to establish a new system of service funding that utilizes current state level funding but establishes a funding system that provides for locally determined and family centered decision-making about the best utilization of that funding for locally-based residential treatment services and wraparound services as an alternative to out-of-region or out-of-state residential treatment services for children in the pilot service areas of Pawtucket/Central Falls and Washington County.

SYSTEM STRATEGY #3 – THE FAMILY COURT AND THE DCYF: A CRITICAL RELATIONSHIP

In the Ideal System, the DCYF is the lead agency with the statutory authority[2] and responsibility for developing and managing the system of care and services. The DCYF ensures that children, youth, and their families from the priority populations are provided the care necessary so that these children and youth either remain in their home or are provided a permanent home as quickly as possible within the parameters of effective clinical treatment and public and personal safety. At the same time, the RI Family Court[3] is the branch of government with statutory authority to make determinations regarding state custody of children and youth, permanency issues, and public safety. This system works on the premise that an effective relationship exists between DCYF and the Family Court that emphasizes appropriate health, safety and care issues for children, youth and families.

SYSTEM STRATEGY #4– PROMOTING BEST PRACTICES

The ideal system is geared at all levels to **research based prevention, early intervention, crisis intervention, and family stabilization** in order to provide children and their families the greatest levels of consistency and stability possible. Decisions regarding treatment and services are made on an individual basis according to the strengths, risks, and needs of the family and the best interest of the child with a recognition of available fiscal resources. Methods allow for the blending or collaborative use of various funding streams to benefit the child and family. Each child and family is provided with care that is supported by research and the highest professional standards. Providers are required and supported to deliver services according to nationally recognized standards with evaluation mechanisms in place to monitor outcomes *(see Chapter 8 and Appendix K).*

SYSTEM STRATEGY #5 – INCREASING THE POOL OF CHILD AND FAMILY SERVICE PRACTITIONERS

Mechanisms exist to ensure that there is an appropriate supply of paraprofessional caregivers and licensed professionals at all levels and across all disciplines *(see Chapters 4 and 5 and Appendix J).* The Children's Cabinet works with the Department of Human Services (DHS) as the Medicaid agency to ensure that Medicaid reimbursement rates across state agencies are adequate and consistent to encourage individuals to practice in Rhode Island. The Department of Health, the Department of Elementary and Secondary Education, and the Office of Higher Education lead the Cabinet's efforts to work with institutions of higher education to train and educate these professionals to work in Rhode Island. State agencies and private providers collaborate to develop and implement policies and practices, including career ladders, which enable the recruitment and retention of highly qualified professionals.

[2]Including RIGL 42-72-5, 42-72-16, 42-72-17, 42-72-18, 42-72-19 and 42-72.1-3.

[3]Including RIGL 8-10-3, 14-1-5, 14-1-11, and 15-7-7.

SYSTEM STRATEGY #6 – RESOURCE MAXIMIZATION

In the Ideal System, either private or public health insurance covers all children and their families *(see Chapter 4)*. Mental health screening for children is a requirement for both Medicaid (EPSDT/SCHIP) and private insurers. When problems are identified, children receive a comprehensive behavioral assessment, evidence-based family centered treatment and effective aftercare services.

DCYF works closely with both public and private insurance companies to develop clinical pathways and procedures for cost sharing when necessary. The Ideal System of Care builds on the success Rhode Island has achieved in maximizing access for children to healthcare. The Department of Human Services (DHS) continues to work with community partners and other state agencies to improve care and services for eligible children and maximize Medicaid reimbursement. Access to Medicaid-reimbursable services for children with special health care needs is enhanced through the expanded use of CEDARR Family Centers and the collaboration of CEDARR Family Centers with the DCYF's Care Networks and the LCC structure. The Department of Health (DOH), in collaboration with other state agencies, works with private health care insurers to extend benefits for children with special health care needs to assure access to quality screening, assessment, and all levels of medically necessary care for children.

DCYF STRATEGY #1 - LEAD ROLE WITH PRIORITY POPULATIONS

The Ideal System recognizes, embraces, and supports the statutorily defined lead role delegated to the Department of Children, Youth and Families "to plan, develop, and evaluate a comprehensive and integrated statewide program of services designed to ensure the opportunity for children to reach their full potential."[4] The DCYF, in collaboration with Children's Cabinet agencies, ensures that a full array of services is available to all children and their families. The DCYF focuses its resources on three priority populations, recognizing that a majority of the concentration of these populations are found in Rhode Island's five core cities[5]. These populations are:

- Abused and neglected children and youth **requiring state intervention to ensure safety;**
- Children and youth who meet clearly defined criteria for Serious Emotional Disturbance **and who require publicly supported care and services; and**
- Youth who are adjudicated as delinquent **and who require probationary supervision or incarceration.**

[4] RIGL 42-72-5(a)

[5] These are identified as Central Falls, Newport, Pawtucket, Providence and Woonsocket in the 2001 Rhode Island KIDS COUNT Factbook. Providence: Rhode Island KIDS COUNT, p. 3.

DCYF STRATEGY #2 – REGIONALLY ADMINISTERED AND INTEGRATED CARE AND CASE MANAGEMENT

DCYF integrates the day-to-day operation of juvenile corrections, children's behavioral health, and child welfare *(see Chapter 3).* Regional Offices coordinate all child welfare[6], behavioral health, and juvenile corrections services through the lens of **family-centered, culturally competent** *(see Appendices B and C)* practice that is **community-based and school-linked**. The DCYF strengthens the authority and responsibility of the four Regional Offices and the Rhode Island Training School for Youth (Training School), shifting to these locations day-to-day operational decisions with the requisite budgetary authority and responsibility. This shifts the focus of the Central Office to providing greater administrative support and oversight, technical assistance, and specialized resources to the Regional Directors and their staff. Child Protective Investigations and Intake also remain Central Office functions.[7]

DCYF STRATEGY #3 – COMMUNITY-BASED CARE NETWORKS

Working in partnership with the Community Prevention Partnerships from the communities in their region, Regional Directors lead the DCYF's efforts to create Lead Agency-directed Care Networks responsible for the provision and management of a continuum of *services (see Chapter 2 and Appendices G and H)* with the capacity to meet the needs of targeted populations within their respective region. The DCYF Central Office, through the Children's Services Research and Planning Center (CSRPC) and additional administrative support resources (i.e., program development, billing and reimbursement systems, utilization review), provides analytical, clinical and other technical support to the Regional Directors and the Community Prevention Partnerships to accomplish this task. These Care Networks are the DCYF's primary partner with DCYF social caseworkers and probation counselors for delivering direct care services within each region. The Care Networks are responsible for describing specific areas where they integrate with local schools and implement interagency agreements as described in the Rhode Island Student Investment Initiative.

DCYF STRATEGY #4 - CHILDREN'S SERVICES RESEARCH AND PLANNING CENTER (CSRPC)

The DCYF management and decision-making structure is supported by the Children's Services Research and Planning Center (CSRPC) *(see Chapter 2).* This Center reports to the DCYF Director and is composed of a small centralized group of DCYF staff and external researchers, focuses on management planning, research, and evaluation. This group supports the Director, Senior Executive Team, and Regional Directors by completing management, planning, and analysis tasks that continuously assess and improve the care and services within the Ideal System of Care delivered by and through the DCYF, including the development and implementation of performance measures and strategic plans. The Center

[6] Child Protective Services, including the child abuse hotline, investigative functions and intake remain Central Office functions

works in collaboration with other state and private agencies to ensure effective cross-disciplinary planning.

PUBLIC ACCOUNTABILITY PROCESS #1 - OUTCOMES, INDICATORS AND PERFORMANCE MEASURES

Key to the success of the Ideal System is the ability to effectively evaluate performance and outcomes and to use these evaluations to improve practices *(see Chapter 6 and Appendix K).* The system is accountable through context evaluations, implementation evaluations, and outcome evaluations. The Children's Cabinet establishes system-wide outcomes and key social indicators. The DCYF develops performance measures for the DCYF and its Care Networks. The indicators and measures are aligned with and logically linked to the four Children's Cabinet outcomes. The Ideal System places high value on the four Children's Cabinet outcomes and routinely measures and reports on key social indicators and individual program performance measures.

PUBLIC ACCOUNTABILITY PROCESS #2 - IMPLEMENTATION TIMELINE

The plan that follows is intended to be implemented over the next five years while ensuring stability for children and families and causing as few disruptions to services as possible *(see Chapter 7).* The success of the Ideal System is dependent on the ability of all key stakeholders to collaborate. Success is measured in terms of:

- positive changes in outcomes for children and families,
- customer satisfaction, and
- the ability of the system to complete identified tasks and meet prescribed milestones within predetermined time frames.

System stakeholders in the system commit to this collaborative process and identify clear timelines for progress, evaluation, reporting, and adaptation.

CHAPTER 2: COMMUNITY-STATE PREVENTION PARTNERSHIPS/ROLE OF THE CHILDREN'S CABINET

Community and State Leaders clearly recognize the important role prevention services play in the system of care and in supporting children, youth, and families for success. The promotion of emotional and physical health is a key responsibility of the Children's Cabinet in partnership with local communities. The system's foundation is the commitment of local communities and the State to ensuring that all neighborhoods have strong prevention and educational services to support the complex needs of their children and families. The Children's Cabinet provides leadership in regard to the development of a structure by which collaboration among state agencies is explicitly described and implemented, including dedicating personnel and other resources.

The principles of **family-centered** *(see Appendix B)* and **culturally competent** *(see Appendix C)* practice are embedded values in the Ideal System of Care's community-based prevention services. The system ensures that families and the multiple cultural, linguistic and religious groups that make up the community are viewed as valuable and equal partners at all levels of development, implementation and service delivery. Built upon CASSP principles *(see Appendix D),* this system ensures that decisions regarding treatment and care are made on an individual basis according to the strengths, risks, and needs of families and the best interest of the child with a recognition of available fiscal resources.

Rhode Island's Ideal System understands the role it plays in promoting the mental health of children as defined by the US Surgeon General[8]. It is a system geared at all levels to the earliest possible intervention, prevention, crisis intervention, and family stabilization in order to provide children with the greatest opportunities to achieve and maintain good mental health. It has the capacity to provide services to all children and families at the level[9, 10] of

[8] "Spanning roughly 20 years, childhood and adolescence are marked by dramatic changes in physical, cognitive, and social-emotional skills and capacities. Mental health in childhood and adolescence is defined by the achievement of expected developmental cognitive, social and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills (Surgeon General's Report, 2000, p.123)".

[9]The MECA study (Methodology for Epidemiology of Mental Disorders in Children and Adolescents) estimated that [nationwide] almost 21 percent of US children ages 9 to 17 had a diagnosable mental or addictive disorder associated with at least minimum impairment (Surgeon General's Report, 2000, p.123)". Eleven percent of youth have significant functional impairment. This estimate translates into a total of 4 million youth who suffer from a major mental illness that results in significant impairments at home, at school and with peers and five percent are classified with extreme functional impairment (Surgeon General's Report, 2000, p.124).

[10]The foremost finding in the Surgeon General's report is that [nationwide] most children in need of mental health services do not get them (p. 180). The conclusion that a high proportion of young people with a diagnosable mental disorder do not receive any mental health service at all (Burns, et al., 1995; Leaf et al., 1996) reinforces an earlier report by the US Office of Technology Assessment (1986) which indicated that approximately 70 percent of children and adolescents in need of treatment do not receive mental health services. Only one in five children with a serious emotional disturbance used mental health specialty services although twice as many such children received some form of mental health intervention (Burns et al, 1995). Thus, about 75 to 80 percent fail to receive specialty services, and the majority of these fail to receive any

prevention or intervention they need while focusing on supporting and maintaining children and youth in their home or as proximate to their home as possible.

Service needs are identified, developed, and implemented across all three levels of the prevention continuum:

- **Universal Prevention Services:** Evidence-based services designed to be accessible to all children and families regardless of their level of need with the intended outcome of reducing the number of children and families requiring higher levels of services. Examples include wellness educational campaigns, child abuse prevention media campaigns, emotional competency programs with children, out-of-school time programs, general recreational programs, mentoring programs, teen pregnancy prevention programs, drug and alcohol abuse education programs, and domestic violence prevention programs.

- **Selected Prevention Services:** Evidence-based services designed to address factors that hamper the abilities of families to appropriately foster their children's development and ensure that families have access to the resources that are necessary to meet their children's developmental needs. Examples of these include parent education programs, family resource and support programs, counseling, parent aide programs, home visiting programs, wraparound and non-traditional services, therapeutic recreation programs, mentoring programs, school-based health clinics and prevention education for youth, parents and professionals.

- **Indicated Prevention Services:** Evidence-based services designed to address the needs of families and children with special health care needs as well as those exhibiting indicators known to be high predictors for teen pregnancy, early drug and alcohol use and/or abuse, witnesses to or victims of domestic violence, child abuse or neglect, and juvenile delinquency. Examples of these include early intervention services for young children, counseling, parent education programs, parent aid programs, home visiting programs, therapeutic daycare, school-based mental health support teams, wraparound and non-traditional services, teen pregnancy prevention programs, drug and alcohol abuse education programs, in-home services for children with special health care needs, mentoring programs, domestic violence prevention programs, and juvenile hearing boards.

The reality of the current system is very different. Fragmentation of the service delivery system frequently leads to prevention planning and programming being developed and conducted within silos. Multiple funding streams with unaligned priorities from multiple agencies lead to overlap, redundancy, and sometimes competing goals. There is little coordination at the local or state levels in regard to prevention planning and service delivery. The Ideal System remedies this by ensuring that indicated prevention services are targeted and funded locally by the DCYF and other state agencies through Care *Networks (see Chapter 3)*. Universal and selected prevention services are coordinated by the Children's Cabinet and local communities with funding from federal, state, and local sources.

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services at all, as reported by their families (Surgeon General's Report, 2000, p180)"

COMMUNITY/STATE PREVENTION PARTNERSHIP RECOMMENDATIONS

In the Ideal System, the Executive, Legislative, and Judicial branches of government collaborate to eliminate this fragmentation, shift responsibility for children and families to the community level, and ensure that communities are given the requisite fiscal and technical resources to be able to "take ownership" of their children and families.

In order to move the State and local communities to the prevention planning and service delivery paradigm described above, the following recommendations are made:

1. $ **The Children's Cabinet must take the lead role in organizing new or strengthening existing collaborative entities in Rhode Island's communities. These entities, to be known as *Community Prevention Partnerships (CPP's)*, will at a minimum be required to be composed of all key stakeholders including, but not limited to, families, community based organizations, schools, law enforcement, faith organizations, business leaders, and mental health and social service providers. These entities will be formally recognized by the State as the voice of their respective community(ies) in relation to universal and selected prevention planning, service delivery, and funding decision-making. With school districts as key members, these partnerships will be required to develop, implement, and measure the results of strategic plans for enhancing prevention programming and identifying the needs of the their community in relation to children and families across the system of care** *(see Appendix E).*

   Significant progress has been made in the area of developing and supporting collaborative entities in the five core communities through the DCYF-administered *Comprehensive Strategy Initiative for Serious, Violent and Chronic Juvenile Offender*. Community planning teams exist in each of the five core cities. These teams are representative of the stakeholders identified above and have successfully completed five-year strategic plans aimed at reducing juvenile violence and delinquency by supporting strong prevention and intervention programming from birth to young adulthood. Each of the *Comprehensive Strategy Planning Teams* are supported by the mayor of their respective city or town.

   With limited financial support from the state for coordination, they have used their coalitions to garner significant federal and state funds to operate youth employment programs, reading readiness programs for school-age children, mentoring programs, domestic violence awareness programs, and other services. The coordinators of these teams have played an integral role in the work of the *Youth Success Cluster* of the Children's Cabinet, a state level collaboration focused on infusing a youth development philosophy within state and local initiatives and programs.

   These teams are examples of viable options for the Cabinet to build on when developing *CPP's*. These groups have been highly effective in breaking down the barriers among local agencies and finding ways to cooperatively identify resources to be used to benefit the community as a whole, rather than to build the programs and

services of a particular agency. *However, additional resources will need to be identified to provide support to the CPP's for minimal but necessary infrastructure development and maintenance. An analysis of this support need will need to be conducted by the Children's Cabinet.*

2.  **The Children's Cabinet must submit enabling legislation, similar to that used for the creation of Juvenile Hearing Boards, which will grant cities and towns, either individually or in collaboration with adjoining communities, the authority to create Community Prevention Partnerships.**

This enabling legislation will outline the parameters under which CPP's will operate, including their relationship to existing agencies and programs. It will delineate the local authority under which the CPP will operate as well as oversight and reporting relationships to the Children's Cabinet and other state agencies.

3. **State leaders, in collaboration with local government, should fully support the *CPP's*.**

Much of the fragmentation that occurs at the community level has been driven by seemingly competing and often duplicative federal and state funding streams, statutes, and regulations. Many funding sources require the local provider receiving funds to develop community collaboratives with many if not all of the same partners previously identified. As the "pilot" phases of these individual initiatives end, the collaboratives compete against one another to obtain funding for their continued operation.

By formally identifying the *CPP's* as the local vehicles for comprehensive community-level analysis, planning, and service decision-making, the State is taking a major step forward in reducing this fragmentation. To further enhance the *CPP's*, state agencies, the Legislature, and the Family Court will view the *CPP's* as the principal vehicle from which to seek advice and to use to determine funding priorities when reaching out to communities with new state initiatives. State leaders will also focus on reviewing current state "mandates" for community collaboratives and every effort will be made to merge these into the local *CPP*.

4. $ **The Children's Cabinet must develop a permanent state staff level subcommittee to develop and coordinate prevention planning among state agencies and ensure that this subcommittee is provided the resources necessary to succeed. This subcommittee will be viewed as the state's key link to the CPP's and will be required to ensure community participation in their deliberations and decision-making process. It will be responsible for assisting communities with identifying research-based programs and services, coordinating funding streams, developing program outcomes and measurements, and evaluating the success of state and community efforts in the area of prevention.**

Many stakeholders have advocated for a formal mechanism by which families, providers, and advocates can present regular feedback on how the system as a whole and the various sub-components are operating and to gather feedback on ideas to increase the system's effectiveness. The Prevention Planning Subcommittee will serve this purpose. It will also serve as the principal forum for planning and implementing statewide universal and selected prevention initiatives.

In order to implement this recommendation, the Children's Cabinet must review its current committee structure with a focus on merging committees which have similar missions and responsibilities. For example, the Youth Success Cluster, in existence for four years, has been successful at moving forward on issues such as youth employment, reducing juvenile delinquency, and out-of school time programming with a youth development focus. The Children's Cabinet also recently endorsed a new subcommittee, the Statewide Prevention Planning Committee, in response to the State applying for and receiving the State Incentive Grant Award from the Center for Substance Abuse Programs (CSAP) of the US Department of Health and Human Services (DHHS). Rather than attempt to support the work of multiple subcommittees which may often be duplicative, the Cabinet must review them and determine the most effective subcommittee structure for the future.

Given the DCYF's designation as the state agency principally responsible for the implementation of the recommendations of this report, it is reasonable that the DCYF be called upon to administer prevention planning and implementation for the Children's Cabinet in collaboration with its sister state agencies.

5. $ **The Children's Cabinet agencies, through the Prevention Planning Subcommittee, must review the State's prevention funding streams with the goal of blending funding as permissible under state and federal guidelines and increasing the level of collaboration in regard to funding decision-making.**

There currently exists numerous funding streams managed within multiple departments that are principally and sometimes solely focused on prevention activities. Examples include the Safe and Drug Free Schools Program and the Healthy Kids, Healthy School Program administered by the RI Department of

Education (RIDE); child abuse prevention funding administered by the DCYF's Children's Trust Fund; underage drinking prevention and the new State Incentive Grant Program administered by the RI Department of Mental Health, Retardation and Hospitals (MHRH); teen pregnancy prevention administered by the RI Department of Health (DOH); and juvenile delinquency prevention administered by the RI Department of Administration's (DOA) RI Justice Commission (RIJC).

Although efforts have been made to increase the level of blending of these funds as permitted by state and federal laws and regulations or to increase the level of collaboration in decision-making processes, much more progress must be made in this area. The Prevention Planning Subcommittee of the Children's Cabinet is an ideal venue for further analysis and the development of a collaborative plan.

6. $  **The Children's Cabinet must develop and implement a plan which provides for greater information sharing and collaborative decision-making among agencies, especially the DCYF, DHS, RIDE, MHRH, DOH, the Judicial Branch, DOC, the Attorney General, the Public Defender, and Law Enforcement.**

The Children's Cabinet recognizes the value of increasing the capacity for information to be shared across agencies in accordance with state and federal laws. The lack of this capacity hampers the State's ability to identify and track service use patterns, arrest and recidivism patterns, service gaps, and other key indicators. The Cabinet has created an interagency workgroup, the KIDSLink Project, to begin to develop such an information sharing plan. This effort must be fully supported by key stakeholders at all levels. This capacity will permit agencies to more effectively communicate with one another, see where services overlap, track recidivism, identify existing gaps, and analyze some of the global budget implications for the children and families served. For example, this interface would allow the State to identify which families are receiving the most services from all public agencies in order to determine the feasibility of cost-saving interventions such as targeted case management and support services. In developing such an interface, the State must make every effort to protect and ensure the confidentiality of individuals by building in appropriate safeguards.

7. $ **The Children's Cabinet supports a statewide Information and Referral System that is consistent across departments and may be accessed by youth, parents, other supportive adults, and children's services professionals. This system will have up-to-date computerized information on access to and performance of children's prevention and treatment services, related state and federal laws, entitlements, regulations, eligibility, and admissions' processes. Information will be available in several languages and be accessible by phone, Internet, and fax.**

Prevention and treatment programming cannot be utilized effectively if the individuals who need the services do not know about them. This information and referral service will provide children, youth, families, and professionals with the access they need to obtain current information on services, legal rights, and other information.

8. $ DCYF, RIDE and DHS must immediately implement the agreed upon "Coordinated Children's Services System Regulations" (the "pilot" regulations).

These regulations, developed as required by RIGL 42-72.7, allow for a process which accomplishes two major goals:

a) To improve collaborative planning, comprehensive services, and outcomes for children with complex special needs and their families;

b) To establish a new system of service funding that utilizes current state level funding but establishes a funding system that provides for locally determined and family centered decision-making about the best utilization of that funding for locally-based residential treatment services and wraparound services as an alternative to out-of-region or out-of-state residential treatment services for children in the pilot catchment areas of Pawtucket/Central Falls and Washington County.

This funding mechanism provides participating LCC's with blended funding from various state agencies and Local Education Agencies (LEA's) equal to the amount each agency currently invests in an identified child's residential treatment. These funds are designed to provide flexibility in the use of funds to purchase services based on the strengths and needs of children in need of education, care, and treatment and their families.

DCYF, RIDE, DHS, and other state and community stakeholders have collaborated to develop these regulations over the past three years. These regulations address agency responsibilities and coordination and also provide resolution mechanisms. The opportunity to implement these pilot projects dramatically align with the State's commitment to system-wide reform. This implementation process must be monitored and evaluated by the participating departments to inform the development of the Lead Agency-based Care Networks.

CHAPTER 3: STRENGTHENING DCYF AS A FAMILY CENTERED, REGIONALLY-BASED AGENCY

As previously indicated, the DCYF is the state agency responsible for leading this "paradigm-shift" to **a system of care that is family centered, culturally competent, school-linked, and community-driven**. It is the DCYF's responsibility to ensure that the limited state fiscal resources available to support and sustain this system are utilized more effectively than in the past with an emphasis on priority populations[11].

This shift recognizes that the current system is too fragmented, inhibiting the growth of a strong community-driven system. Currently, the DCYF is expected to provide services to much broader sectors of the population than is realistic. Contracted programs are generally statewide in nature with at best weak links back to the child/youth/family's community. Programs are frequently filled to capacity or above leading to:

- unnecessarily long lengths of stay,
- the placement of children and youth on a night-to-night basis until a permanent placement is made,
- "waiting lists" which frequently lead to children and youth symptoms escalating to a point where psychiatric hospitalization is needed, and
- a dependency on expensive out-of-state purchase of service (POS) placements which often greatly reduce effective family involvement.

It is recognized that the DCYF cannot and should not move abruptly to a system which significantly disrupts current practices. Such a sudden change in service delivery methods would have disastrous implications to the quality and quantity of services available for targeted populations. In the short-term, this will require the DCYF to continue to contract with individual providers for a specific number of beds or slots. During this transition, the DCYF must make prudent use of in-state and out-of-state Purchase of Service providers. However, it is imperative that the DCYF continue to move forward with their efforts to create a true "paradigm-shift" to a **family-centered, culturally competent, regionally-based service delivery system**. The full transition must occur in a well-planned, well-coordinated fashion with reasonable haste being balanced by prudent decision-making that is least disruptive to children, youth, and families.

The DCYF has made significant inroads over the past five years into moving the agency structure and the service delivery methods to a more family-centered, regionally-based

[11] Abused and neglected children and youth **requiring state intervention to ensure safety; c**hildren and youth who meet clearly defined criteria for Serious Emotional Disturbance **and who require publicly supported care and services;** and youth who are adjudicated as delinquent **and who require probationary supervision or incarceration.**

structure. Each of the four family service regions have physically relocated to offices within their respective service areas *(see Appendix F).* The Local Coordinating Councils' for Children's Behavioral Health (LCC's) have shown significant success in helping families to receive and agencies to provide family-centered, community-based services for many years.[12] The Review Team process for children with high-intensity service needs is being moved into the regions with full community partnership in the design of the Care Management Team (CMT). The DCYF has merged individual program contracts with the eight Community Mental Health Centers (CMHC's) into one master contract for each CMHC. A pilot Care Network was implemented last year for 60 youth in need of residential placement and early results are promising. Placement Solutions, a collaboration between the Providence Center and Communities for People, is providing much needed utilization review capacity for children and youth in out-of-state and in-state placements. Working in conjunction with the DCYF's Child By Child Project, the immediate goal of this effort is to move these children and youth back to their home communities with necessary supports as soon as it is clinically appropriate. Finally, Project Hope is working with RI Training School staff, families and their communities to reintegrate children from the Training School directly back into their neighborhoods.

STRENGTHENING DCYF AS A FAMILY CENTERED, REGIONALLY-BASED AGENCY RECOMMENDATIONS

Even with this progress, deeper structural and process changes must be made. To accomplish this, the DCYF must be supported by state leaders, advocates, providers and other key stakeholders in their efforts to further support an agency that is family centered and regionally-based. To this end, the following recommendations are made:

1. The DCYF must continue to move toward a structure which supports a family centered, community-based, culturally competent, and school-linked approach. To effectively manage this structure, the DCYF must provide regional directors and juvenile corrections administrators with greater authority to manage staff and resources, including fiscal and program resources.

a) $ **Regional Directors and the Training School Superintendent will be provided with concrete regional budgets and the concomitant responsibility and authority for managing these budgets;**

b) $ **The DCYF should expand the use of the Care Network Model** *(see Appendices G and H)* **to ensure that the majority of services to the targeted population groups[13] are provided by regionally-based Care Networks that are contracted through specified lead agencies;**

[12] See Kaufman, J.S., Tebes, J.K., Ross, E. & Grabarek, C. (2000) Project REACH Rhode Island Final Evaluation Report. New Haven, CT: The Consultation Center, Department of Psychiatry, Yale University School of Medicine, the Connecticut Mental Health Center and The Community Consultation Board, Inc.

[13] Abused and neglected children and youth **requiring state intervention to ensure safety; c**hildren and youth

c) Regional Directors and their staff will be expected to work with Care Network Lead Agencies, Lead Agency subcontractors, and other key community stakeholders, including *Community Prevention Partnerships,* to ensure that services provided by Regional Staff are family-centered, community-based, culturally competent, and linguistically appropriate.

Best practice standards across all three population domains served by DCYF call for social caseworkers, probation counselors, behavioral health practitioners, and other state agency staff to develop linkages and more effective collaborations with families and key stakeholders in the communities they serve. The DCYF has developed or assisted communities in developing several initiatives aimed at increasing these linkages and levels of collaboration. These include the *Child and Adolescent Service System Program(CASSP) for Children's Behavioral Health* which functions through the *LCC's*, the *Project Hope* program focused on enhancing transition and aftercare services for youth identified as seriously emotionally disturbed who are transitioning from the Training School, the *Youth New Futures* program which provides services to high-risk youth on probation through an interagency collaborative of providers[14], and the *Safe Streets*[15] program. Strengthening and providing increased supports to the four DCYF Family Service Regions and juvenile corrections administrators will enhance the ability of these locations to work more effectively and collaboratively in the communities they serve.

2. The DCYF must continue to develop a family centered practice model.

The DCYF has made significant strides in moving the agency to a service delivery model based on the principles of family-centered practice *(see Appendix B).* The DCYF is strongly encouraged to continue these efforts internally and with external stakeholders.

3. The DCYF must continue to expand efforts toward developing cultural competence among agency staff and vendors.

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who meet clearly defined criteria for Serious Emotional Disturbance **and who require publicly supported care and services;** and youth who are adjudicated as delinquent **and who require probationary supervision or incarceration.**

[14] *Youth New Futures*, funded through the DCYF, is a collaboration of Tides Family Services, the John Hope Settlement House and DAWN for Children. This program currently provides services only to youth from Providence and Pawtucket.

[15] *Safe Streets* currently operates only in the city of Providence and is a collaborative effort between the DCYF's Division of Juvenile Corrections' Juvenile Probation Units, the Department of Corrections' Adult Probation Office and the Providence Police Department. Juvenile and Adult Probation Counselors, working under the joint supervision of the two state agencies, join with Providence Police officers to provide intensive supervision services to very high-risk young adult offenders ages 16-24. Average caseloads are 15:1.

The DCYF has also made significant strides over the past two years in developing within the agency a stronger atmosphere of culturally competent *practice (see Appendix C)*. However, the agency recognizes and understands that there is still much progress to be made and that achieving cultural competency is a journey, not a destination. The DCYF is strongly encouraged to continue on this journey.

4. $ The DCYF must provide the Regional Offices and Lead Agency-driven Care Networks with the administrative support services necessary for them to succeed.

An essential management component for the Ideal System of Care is the capacity within DCYF to effectively support the Regional Offices with their responsibility to administer and manage the Care Networks. This capacity includes expanded **analytic, financial, and information management resources for the DCYF.** This administrative support function lies within the DCYF Central Office but ensures support to each DCYF region It works most closely with the management, budget, and planning and analysis staff, and incorporates the DCYF's utilization review functions.

5. $ The DCYF must enhance its research, analysis, and planning capacity to support the Ideal System of Care through the development of the Children's Services Research and Planning Center (CSRPC).

The Children's Services Research and Planning Center (CSRPC) is composed of a small, centralized group of DCYF staff and external researchers focused on management planning and analysis. This Center works in collaboration with other state agencies to ensure effective interagency planning. This group reports to the DCYF Director. Analysts have demonstrated competence in both data analysis and the clear presentation of complex information. They minimally possess masters' degrees in fields such as public administration, business administration, social work, social policy, and evaluation to ensure that they have the proper training to conduct analyses and think creatively about structure and process improvement.

This group supports the Director, Senior Executive Team, and Regional Directors by completing management, planning, and analysis tasks that continuously assess and improve the Ideal System of Care, including the management of performance measures and strategic plans. The CSRPC coordinates the following activities:

- Analysis of children, youth, and families' service needs by geographic location
- Mapping current capacity and usage by location
- Developing common regional boundaries for all divisions of DCYF including Child Welfare, Children's Behavioral Health, and Juvenile Corrections that are mapped to the CPP's, CMHC's, LCC's, LEA's, Comprehensive Strategy Planning Teams, and other key players

- Developing and managing a strategic planning process for the Department to implement the design recommendations contained in this report

- Developing and managing a set of management performance measures to help DCYF monitor and report on progress against established targets and to provide an early warning system for problems

- Analyzing the existing budget to develop regional budgets which are adjusted so that the areas of the state where the need is greatest are targeted with service dollars and resources

- Developing RFP's and certification standards for regional lead agencies

  This internal analytic capacity provides the data necessary to target services and resources, measure outcomes, and lead improvements. The CSRPC is the Senior Executive Team's resource for validating information and anecdotal reports and supports their ability to consistently focus on strategic plan implementation and performance indicators in the face of a daily barrage of unanticipated events. This office is invaluable to central office and regional managers alike.

6. The DCYF should continue its efforts to reform the RI Training School through the construction of a new facility, the implementation of the Resocialization Model, and the finalization and implementation of a sentencing and sanctioning advisory process for the DCYF to provide the Family Court with more individual and specific assessments and recommendations.

Each of these reform components except for the construction of the new facility were identified as recommendations in the report of the Governor's Task Force on Juvenile Justice Reform[16]. The construction of the new facility is supported by the Governor and the General Assembly provided its' support through the passage of 2001-R-340 Joint Resolution Approving The Financing Of A New Training School For Youth At The Pastore Center In Cranston. The DCYF is finalizing work with the National Council on Crime and Delinquency (NCCD) in regard to the development of risk assessment and structured decision-making tools which will allow the DCYF to provide more informed recommendations to the Family Court in regard to sentencing decisions. The DCYF is also entering into a contract with the Texas Youth Commission in regard to implementing the Resocialization Model at the Training School. The Resocialization Model provides state of the art assessments of strengths, risks, and needs of juvenile offenders with case plans that emphasize personal responsibility, increase freedom in phases based on achieving individualized measurable goals and objectives, holds youthful offenders accountable for their offenses, and requires youth to demonstrate sustained competencies.

[16] Stopping Youth Violence: Rhode Island's Response to the Crisis Facing Our Youth: Final Report, (July 1997). Providence, RI: Department of Children, Youth and Families. See Recommendation 1, Strategy 1 p. 19; Recommendation 1, Strategy 2, p. 20; Recommendation 1, Strategy 3, p. 20; and Recommendation 3, Strategy 1, p. 27; Recommendation 3, Strategy 2, p. 28.

7. $  **State leaders should support the plan provided by the DCYF to the Joint Legislative Commission to Study an Enhanced Role for Probation and Parole** *(March 13, 2001; See Appendix I)* **which calls for a shift to a community supervision model for juvenile probation, the expansion of community support services, the enhancement of early intervention and transitional services for young women offenders, enhanced recruitment efforts for minority probation counselors, enhanced training requirements for probation staff, and lower caseloads.**

The DCYF recognizes that the juvenile probation counselors have much greater opportunity for providing community-based services to youth on probation than do adult probation counselors. The DCYF also recognizes that juvenile probation caseloads are much lower than adult probation caseloads[17]. However, best practice standards for juvenile probation call for a shift to non-standard hours, increased community supervision and support, smaller caseloads, and better training. The DCYF believes that the recommendations submitted *(see Appendix I)* to the Joint Legislative Commission to Study an Enhanced Role for Probation and Parole in March 2001 are necessary for the DCYF to make this necessary shift.

8. **State leaders must continue to support DCYF in working with community leaders to site new and expand existing residential programs in RI communities.**

It is well known that the DCYF has historically depended on out-of-state purchase of service residential programs for youth with specialized treatment needs such as sexual offending or non-hospital residential psychiatric and/or behavioral treatment. This practice is of high cost to the state and reduces the ability of the DCYF to engage families and the community in treatment and transition processes.

It is imperative that DCYF have the ability to develop and implement residential programs within RI regions if the DCYF is to truly move to a family-centered, community-based model. However, the DCYF, as do other state agencies, frequently runs into the barrier of "not-in-my-backyard" attitudes from local communities when attempting to site new programs. The DCYF response must have the active support of key leaders throughout state government and within local communities when attempting to site new programs in the future.

9. The Director of the DCYF and the Chief Judge of the Family Court must continue to forge and maintain an effective, collaborative relationship between the Department and the Court.

Recent progress has been made in this area between the Family Court and the DCYF. The Court and the DCYF have agreed to create a formalized group comprised of members of each agency to address mutual concerns in a prompt fashion. An

[17]The highest probation caseloads for juvenile probation counselors may average about 41:1 while the adult probation caseloads can be as high or higher than 300:1.

agreement has been signed in response to FY 2002 State Budget Article 23 by which the DCYF and the Family Court developed an agreement clearly outlining the process to be used in making determinations for children and youth for "high-end" placement. Such collaborations need to continue.

CHAPTER 4: FINANCING THE SYSTEM OF CARE

Financing a comprehensive system of care for children, adolescents, and their families is one of the most complex aspects of system reform. Funding for services for children and families comes from a very broad range of federal, state, local, and private sector sources. In FY 2001 the DCYF budget exceeded $200 million and these funds were augmented from a number of other sources including but not limited to public and private insurance, federal government grants and contracts, federal entitlements, state general funds, trust funds or other set-asides, and local revenues.

On a State level, funding and supports were available from DHS in the form of RIte Care capitation, fee for service Medicaid claims, and a variety of supports available under TANF. DHS funding for programs for Families and Children in Medicaid alone exceeded $300 million in FY 2001 and covered 120,000 family members of whom over 80,000 were children. LEAs also were a resource available for this system, particularly in their growing role as Medicaid providers.

In the Ideal System of Care, DHS and DCYF have a strong partnership. DCYF is responsible for developing programs and services to meet the needs of its priority populations. DHS is the designated single state agency with responsibility and accountability for the Medicaid State Children's Health Insurance (SCHIP) programs. The majority of DCYF children, youth, and families are Medicaid/SCHIP eligible. Therefore, the opportunity exists to strategically leverage DCYF's and DHS's authorities and resources to expand services. DHS is a funder with a voice in program development. The responsibility for funding programs is accompanied by participation in design, development, and measurement of program effectiveness. Likewise, in the ideal system, DHS does not establish programs that directly affect DCYF children and families without DCYF's full and equal participation. These two departments operate as a strategic alliance.

The DHS plays an important role in partnering with the DCYF and other state agencies to maximize Medicaid support for eligible children and their families. They continue their work with DCYF in developing opportunities for access to RiteCare coverage and their work with DCYF and other state agencies developing opportunities for increased access to services through programs like CEDARR[18] and the LCC's. In the Ideal System, DHS ensures access to the full range of medically necessary prevention and treatment services through contractual language with RIteCare providers. DCYF funds provide non-Medicaid reimbursable services. In the Ideal System design, the case rate supports the non-Medicaid reimbursable costs while the Lead Agencies bill Medicaid for reimbursable services with the DCYF providing the State Medicaid share.

[18] CEDARR stands for Comprehensive Evaluation Diagnosis Assessment Referral and Reevaluation and is a collaborative effort of the following state agencies: DHS, DCYF, RIDE, DOH, and MHRH. DHS administers the CEDARR program.

For non-insurance government funding, the Ideal System creates a "state child and family budget" that includes all non-insurance sources of federal and state revenue and clearly organizes the resources to support the Ideal System. The Child and Family Budget also reflects Federal grants to communities. The Ideal System places an emphasis on attracting federal funds, maximizing federal financial participation, and creating a comprehensive child and family budget coordinating services across all of these policy domains. These federal funds are augmented by a number of state budget appropriations, themselves scattered across a number of state agencies.

A coordinated and organized system of care requires a deliberate ongoing financial strategy that supports the multiple and changing needs of children, adolescents, and their families, and the changing landscape of service opportunities available within the community of professional practice. The goals of the strategy are to marshal every resource available for the care and treatment of the child and family, private and public, across all funds and programs, to assure access to services and treatment and to use data to inform policy, program, and budgetary decisions within an overall strategy.

The principles of a successful financing strategy include:

- Programs and services within a coordinated system must be designed to support the needs of children and families rather than designed to fit the requirements of funding sources;

- The potential gain of maximizing financing from any single source of revenue must be evaluated in light of its impact on program and service delivery, system design, and accountability, as well as overall financial risk;

- The ongoing success (and therefore funding) of programs and services must be based on the outcomes they produce, rather than the activity they perform;

- Rates of payment must be adequate to create and maintain service capacity and rationalized in terms of the value they provide; incentives must support the long term outcomes desired for the system as a whole; and

- Formal and dynamic partnerships between and among units of state and local government, as well as the provider community, is essential.

Currently, 83,000 Rhode Island children receive Medicaid benefits through a variety of delivery systems. Medicaid funding provides a broad range of health care services to children and their families through DCYF, DHS, DOH, MHRH, and the local education authorities. Medicaid funds comprehensive health insurance for many DCYF children, including behavioral health services, through Rite Care as well as fee for service, and a large number of children "touched" by DCYF services are enrolled. Further, it is clear that Medicaid's value to the Ideal System can only be realized if, at a minimum, current eligibility standards are maintained – any change in this public policy reduces resources available for this system change.

At the same time, Medicaid is a broad entitlement program with very stringent requirements governing eligibility service definition, and reimbursement. Limits on utilization, provider participation, or consumer choice are not permitted. This set of standards has clear programmatic and budgetary implications, and may mean that Medicaid funding is not universally attractive. However, it is also clear that Medicaid, particularly in light of the mandate of EPSDT (Early Periodic Screening, Diagnosis, and Treatment), needs to be fully leveraged.

This leverage can be accomplished by Care Networks being sufficiently knowledgeable to be able to refer to and otherwise make use of services available to children throughout the rest of the Medicaid system. In this way, Medicaid-financed services can "wrap" around services provided by and through Care Networks. Care Networks do not need to control these dollars, but do need to be able to access them.

Similarly, development of one or more case rates can be phased in over time, as data becomes available to support and justify this structure. Case rates are simpler to administer than encounter-based claiming, but need to be designed to provide the same level of data feedback to inform ongoing decision-making.

For any financing strategy to be successful, it must be guided by constant review of clear, accurate, actionable data that describes the operation of the system overall. This data, at minimum, must include caseload (the number of active eligibles), expenditure (both on an individual level, as well as projected for the System as a whole, based on current eligibility and patterns), and outcomes (the result realized in consequence of the expenditure, based on an understanding of the need at the onset of the expenditure).

Rate structure is an essential element of any financing strategy. Rates must be established in a rational fashion that blends considerations of cost, capacity, and outcomes, and then maintained in a disciplined fashion. If we value evidence-based services, they should be reimbursed based on performance. The State should pay the same rates for like services across all programs and departments, but should not pay higher rates than other payors unless a sound rationale that supports the outcomes desired for the system can be articulated. Coordination and cooperation among state departments is critical to address these issues.

Development of funding strategies must be concurrent with continuum of care design and development, focused on maximizing resources that support the needs of the children. Program and fiscal staff, across departments and agencies, must both be intimately involved in planning and development.

The main financing challenges facing the Ideal System are:

- How to design a system of performance risk offset by financial reward;

- How to "transplant" monies invested in the current system to the allocation (sites, practices, and modalities) required by the Ideal System;

- How to do so without sacrificing the system as it is needed until the Ideal System is fully developed; and

- How to fund this transition in a reasonably controlled way.

Some type of all-encompassing rate(s) that reflect a fully mature "Ideal System's" operation and contribution may be optimal. The development of such a structure would take significant time and in-depth analysis.

In the interim, these challenges can be addressed with an interlocking strategy of "wrap-around" models and incentive rates. Care Networks would be paid one or more "base rates" for common core services provided to all children with whom they would become involved (embedding the costs necessary to provide general administrative supports to the Regional Offices). For the purpose of the DCYF Care Networks, the base rate would cover services not otherwise billable to other payors. Services required to support an individual child would be billed over and above the base rate to whatever payor was most appropriate, based on individual circumstances (including but not limited to Medicaid, health insurers, school systems, and parents): funding for any child is truly individualized, and all funding sources are involved. This is a demanding role for the Care Network entity, but one that can be rewarded with an accompanying set of payment incentives.

FINANCING THE SYSTEM OF CARE RECOMMENDATIONS

1. The DCYF should assure that they will make every effort to ensure that Care Networks are informed by, and incorporate as appropriate, the CEDARR certification standards for those functions that are embedded in the role of the Care Networks. Attention will also be paid to ensuring that appropriate service providers are enrolled as providers in the networks of the RIte Care health plans. The intent of this recommendation is to assure that existing system resources are effectively utilized and to avoid supplantation and duplication of services.

2. $ The Children's Cabinet should establish a permanent financing workgroup that complements and supports the Caseload Estimating Conference by examining trend data and projections for children served by all Children's Cabinet agencies.

a) The permanent financing workgroup of the Children's Cabinet makes recommendations to the Cabinet regarding consistent rates of payment for similar services across programs and populations and will address the following:

i) adequacy with respect to cost of service,

ii) incentives to develop needed capacity,

iii) routine updating of rates over time and evaluation in light of the outcomes achieved by each service and program

iv) transitioning of contracts and services to performance-based rates.

v) working with the Department of Human Services, the development of a capacity to routinely assign financial responsibility to private insurance carriers, where they should be the primary payor, including coverage for early intervention services as well as comprehensive mental health and substance abuse treatment for both the covered children and adults.

vi) identification of common outcomes for services affecting children across all departments and programs

vii) serve as a forum for the defining of uniform performance standards regarding service definitions to be recommended for use by state agencies for contractual purposes.

3. $ The DCYF must engage consultants to assist the agency in accurate expenditure and population projections for financial planning purposes. This must include partnering with DHS and other state agencies to proactively estimate caseloads in order to develop realistic budgets and spending plans.

The ability of the DCYF to accurately project populations and expenditures is key to the success of the DCYF and the System of Care to control costs while ensuring access to quality services for target populations. The consultants working with the DCYF must be experienced in interpreting historic data and developing utilization and expenditure trends. These consultants study data from both DCYF and from Medicaid and project utilization and expenditures for both sources of funds**.**

4. $ DHS must work with other state agencies, managed care vendors and their behavioral health subcontractors to develop a reimbursement system that attracts behavioral health providers and increases the number of such providers available through the Medicaid program and other health care insurers. In addition to adequate rates of reimbursement, this effort must also focus on ensuring the availability of financing to support system/capacity building (i.e., training, loan guarantees, community capitalization).

Feedback from numerous forums include criticism of the reimbursement rates for behavioral healthcare providers through the Medicaid program and other health insurers. This has led to a sharp decline in the number of behavioral health professionals, particularly child and adolescent psychiatrists and licensed social workers, practicing in Rhode Island. Although this must be addressed on several fronts, including the training programs for these professionals, it is extremely

important that the DHS lead state agencies and other key stakeholders in an effort to examine reimbursement rates and develop a reimbursement system that provides adequate reimbursement and can be easily adjusted to meet market demands.

5.  **The Rhode Island General Assembly recognizes the importance of parity in relation to the coverage by health care insurers for treatment of mental illness and substance abuse[19]. This Task Force fully supports this effort and urges the Departments of Health and Business Regulations to move forward with insurers to ensure full implementation as quickly as possible.**

The report of the Surgeon General on Mental Health[20] clearly articulates the need for mental health parity coverage by health insurers. Untreated mental illness in children and adults is a significant drain on our economy and devastating to individuals and families. Enhancing coverage of mental health and substance abuse in private health insurance programs can only serve to improve the quality of life for our children and families and to support our economy. The State's new mental health parity statute is a first step in this direction.

6. $ **The DHS must continue its efforts to ensure that all children are covered by health insurance through focusing on further reducing the number of uninsured children in Rhode Island through expanded Medicaid/SCHIP access. To accomplish this, DHS maintains RI Medicaid's current definitions of medically necessary services and assures that all Medicaid primary care providers deliver all EPSDT services. DHS must continue to extend Medicaid benefits to children and adolescents covered by SCHIP. In conjunction with the MHRH, the DHS assures that parents of both Medicaid and SCHIP covered children receive needed mental health and substance abuse treatment.**

The DHS is nationally recognized for expanding access to Medicaid for eligible children. This progressive approach has led to Rhode Island being the top state in regard to the number of children covered by health insurance[21]. Rhode Island's

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[19] RI Public Law 2001-409 An Act Relating To Insurance Coverage For Serious Mental Illness

[20] The foremost finding in the Surgeon General's report is that [nationwide] most children in need of mental health services do not get them (p. 180). The conclusion that a high proportion of young people with a diagnosable mental disorder do not receive any mental health service at all (Burns, et al., 1995; Leaf et al., 1996) reinforces an earlier report by the US Office of Technology Assessment (1986) which indicated that approximately 70 percent of children and adolescents in need of treatment do not receive mental health services. Only one in five children with a serious emotional disturbance used mental health specialty services although twice as many such children received some form of mental health intervention (Burns et al, 1995). Thus, about 75 to 80 percent fail to receive specialty services, and the majority of these fail to receive any services at all, as reported by their families (Surgeon General's Report, 2000, p180)"

[21] According to the Annie E. Casey Foundation's National KIDS COUNT data, only seven percent (7%) of Rhode Island children are uninsured compared to a national average of fifteen percent (15%). 200l KIDS COUNT Data Book Online at http://www.aecf.org/cgi-bin/kc2001.cgi?action=profile&area=Rhode+Island

Continuum of Care must continue this effort and support the DHS in expanding access to Medicaid.

7. $ **The DHS, in collaboration with other state agencies, must ensure that Medicaid eligible children receive timely and appropriate assessments throughout their development. The DHS must emphasize that primary care providers use age appropriate screening for child/adolescent mental health and substance abuse problems. The DOH, the DHS, and the DCYF must work collaboratively to ensure that children from birth to age three involved with the DCYF are referred to Early Intervention programs for screening, assessment, and treatment as needed.**

   There is a strong need for timely and quality assessments and evaluations for children and youth at all stages of the developmental continuum. Recent changes in the Early Intervention Program and the development of the CEDARR Family Centers show promise in being able to increase access to these services. State agencies must continue to work together in expanding this access and ensuring that a multi-disciplinary team approach be utilized.

8. **It is important that the System of Care include independent local providers** *(see Appendix J)* **who may be able to intervene with children and families before tragedies happen or the children need to be removed from their homes. The Children's Cabinet, through a designated agency or committee, must work with independent behavioral health providers and third party insurers to assure the prompt and appropriate reimbursement for services and to assure access to appropriate mental health services. Prompt and adequate payment from insurers and from the state will help to enhance and maintain a core of such providers. It is also important that subscribers receive appropriate treatment to effectively deal with their issues and not be cut short due to insurance limits.**

CHAPTER 5: WORKFORCE DEVELOPMENT

Workforce development is a critical component of the Ideal System of Care. Workforce development includes but is not limited to:

- Undergraduate/graduate education
- Recruitment
- Pre-service education
- In-service education
- Professional Development
- Retention

The children's' services area has historically lagged nationwide in a meaningful investment into this important area of infrastructure development. The Ideal System places a high priority on this investment in human capital. DCYF works closely with the Department of Health, the Office of Higher Education, colleges, universities, and public and private providers to address these important issues.

Rhode Island is fortunate to have well-developed higher education institutions at the associate, baccalaureate, and graduate levels. In the Ideal System, DCYF, through the Child Welfare Training Institute, works closely with relevant department chairpersons at these institutions to assure that the curriculum reflects up-to-date evidence-based best practices in the child welfare, mental health, juvenile justice, social work, and substance abuse fields. Appropriate undergraduate curricula are developed to prepare students for the varied functions needed in both the public and private sector children's services field including but not limited to:

- Family Based Care and Family Centered Practice
- Residential services and care
- Case management
- Clinical practice, especially child and family psychologists and child and adolescent psychiatrists
- Supervision
- Wraparound services
- Management and administration

Mechanisms exist to ensure that there is an appropriate supply of paraprofessional caregivers and licensed professionals at all levels, including family service coordinators, licensed social workers, licensed family therapists, licensed child psychologists, and child and adolescent psychiatrists. The Department of Health and the Office of Higher Education lead the Cabinet's efforts to work with institutions of higher education to train and educate these professionals. State agencies and private providers collaborate to develop and implement policies and practices which enable the recruitment and retention of highly qualified professionals to work in Rhode Island.

Recruitment of qualified candidates is essential for the work of the ideal system. DCYF and the community providers combine recruiting efforts on college campuses, job fairs, community center career fairs, etc. to maximize resources as well as to assist potential candidates to distinguish among career choices. Both DCYF and community providers establish minimum educational criteria required for positions and assure that new recruits meet or exceed these requirements.

While individuals may choose to move across the public and private sectors, it is also essential that, for those who desire a position in either sector, professional development plans are in place that enable them to develop professionally and to pursue upward mobility through advanced level training and expanded educational opportunities in each sector.

WORKFORCE DEVELOPMENT RECOMMENDATIONS

1. **The Director of the Child Welfare Training Institute must work closely with other DCYF administrators and community providers to ensure that quality training and support is available to biological parents and kin, foster parents, pre- adoptive and adoptive parents, court appointed special advocates, family service coordinators, and staff who provide care or services to children and their families.**

   Training and support are also essential for the large number of individuals, who, though not employed by the public or private sector make an essential and enormous contribution to the children's services delivery system. This group includes but is not limited to foster parents, court appointed special advocates, public and private agency staff and volunteers, and pre-adoptive and adoptive parents. The Director of the Child Welfare Training Institute and the Institute's staff are responsible for working with public and private agency staff and representatives of all these groups to design and implement appropriate training curricula and on-going support opportunities for these most important participants in the ideal system.

2. **The Department of Health, the Department of Elementary and Secondary Education and the Office of Higher Education should collaboratively lead the Children's Cabinet's efforts in developing strong relationships with RI's academic community to achieve the following goals:**

   a) **An increase in the quantity and quality of licensed professionals choosing to practice in Rhode Island, especially child and family psychologists, child and adolescent psychiatrists, and licensed social workers;**

   b) **An increase in the quality and quantity of learning opportunities (i.e., internships, residencies, clinical practice experiences) for students at all academic levels;**

   c) **The development of curricula reflective of current best practices in children's services, including children's behavioral health, juvenile justice, and child welfare.**

3. $ **Community providers, with appropriate assistance as needed from state agencies, must continue to develop compensation and benefits packages designed to retain workers in the community non-profit sector and reverse the trend of the non-profit sector serving as the training ground for movement into the public sector.**

   In order for the ideal system of care to be implemented it is essential to develop and retain a well-trained, well-organized private vendor system that retains workers and develops qualified and experienced supervisors and managers. Effective compensation packages are key to the success of this retention effort. While individuals may choose new positions for growth and increasing or different responsibilities, because of the increasing responsibilities of the private sector in the ideal system, it must be an attractive option for both new and experienced workers.

4. $ **The RI Child Welfare Training Institute must work with the academic and provider communities to formalize and expand cross training opportunities between the public and community non-profit sectors at all levels.**

   Quality in-service training is essential for quality services to be available to children and families. While there has been in-service cross-training in the past between DCYF and provider agencies these efforts must be formalized and expanded. A core orientation curriculum should be jointly developed so that beginning case managers in the community non-profit sector have the same foundation knowledge, values, and skills as case managers in the public sector. By training staff together, all workers will better understand and appreciate the nuances of each system, the complementing of roles and responsibilities, and the need for teamwork throughout the system. Following the development of a foundation curriculum, advanced level cross-training topics are developed that further solidify the partnership model. Because in many private agencies, training budgets tend to be limited, a pooling of resources and

dollars allow for maximizing resources. Multiple training methods must be utilized, including but not limited to computer assisted education and distance learning techniques.

5. $ **The DCYF must work with the Department of Administration and labor unions to build in a requirement that all supervisors within the DCYF must hold a minimum of a masters' degree in social work or a related field. The number of scholarships available to DCYF staff must be increased to support this requirement.**

High quality supervision is valued in the ideal system, thus supervisors are given reasonable worker caseloads; time is budgeted for weekly worker supervision; a system is in place to address worker problems early on; and clear personnel policies identify the supervision, worker evaluation, and progressive discipline plans. Supervision is an important element of each staff person's personal growth and development. It is extremely important that supervisors have the knowledge, skills, and experience needed to provide effective mentoring and supervision to other staff. Individuals with masters' level training have the minimum knowledge necessary to be successful as a supervisor. In implementing this recommendation, attention must be given to providing courses in the community and at times which allow for access by a diverse group of individuals. As well, it is critical that the DCYF increase the availability of scholarships to qualified staff for the purposes of pursuing graduate level training. Similarly, supervisors in DCYF provider agencies should be required to have a masters' degree.

6. **The DCYF must continue to embrace cultural diversity and cultural competence by expanding its efforts to build a culturally diverse and culturally competent workforce internally and within vendor agencies.**

Cultural diversity and cultural competency *(See Appendix C)* are essential for the Ideal System of Care at all levels. DCYF developed a plan to become an affective multi-cultural organization in response to Recommendation 14 of the Governor's Commission to Study the Placement of Children in Foster and Adoptive Care[22] DCYF will address issues of cultural and ethnic competency and diversity through training to staff and all participants in the children's services delivery system. The Department will consult with the National Technical Assistance Center for Cultural Competence and other national resources to assure that the ideal system provides services and supports that are sensitive to the importance of these issues.

[22] *Strengthening Partnerships for the Safety and Success of Rhode Island's Children: The Report of the Governor's Commission to Study the Placement of Children in Foster and Adoptive Care, (July 1999).* Providence, Rhode Island: Department of Children, Youth and Families. See Recommendation 14, p. 20.

CHAPTER 6: PERFORMANCE MEASURES AND OUTCOMES

Key to the success of the Ideal System is the ability to effectively measure and evaluate system performance and client outcomes and to use these evaluations to modify and further develop best practices. The Ideal System highly values the importance of effective performance and outcome measurement at all levels.

The Ideal System of Care's culture supports evaluation and employs a comprehensive evaluation strategy including the three components of **context evaluation, implementation evaluation and outcome evaluation** *(see Appendix K).* This provides a sophisticated analysis of how and why programs and services work, for whom they work, and under what circumstances they work. The ideal system evaluation component:

- Examines how the system functions within the economic, social, and political environment of its community and setting (context evaluation);

- Supports the planning, set up, and implementation of the system as well as documents the evolution of the system (implementation evaluation); and,

- Assesses the short and long-term results of the system (outcome evaluation).

These three measurements serve as the foundation and guide for the development of performance and outcome recommendations for the Ideal System of Care. The recommendations themselves are tiered to focus on the need for a higher level system reform that must be maintained within the authority of the Children's Cabinet and to recognize the work necessary at the level of state departments - individually and collectively.

On a direct agency level, there is a recognition that the DCYF is accomplishing two distinct goals. One is building system capacity. The second is developing a regionally based network system of care which is specifically designed to address increasing demands and changes in service needs for children and families at varying levels of intensity in a community context.

Moreover, the Children's Cabinet continues its work with RI KIDS Count to develop child indicators to assist the state in achieving the four outcomes adopted by the Cabinet and state agencies. Toward this end, the DCYF and other state agencies continue their work in building performance measures and outcomes into service delivery both internally and with providers.

PERFORMANCE MEASURES AND OUTCOMES RECOMMENDATIONS

1. $ The Children's Cabinet must develop, implement and fund an evaluation/accountability plan to comprehensively assess the State's effectiveness in implementing the recommendations of this report over the five year phase-in period. The development of this plan must include families (parents, kin, foster and adoptive families).

It must be recognized that there is a significant cost associated with developing the appropriate infrastructure to accommodate these information requirements, and the State must establish this as a priority investment. Each Department must identify its own financing needs for enhancing the data collection and analysis capability for its own services and population, and the provider community must to do the same. This data collection and analysis capability must be incorporated into state budget appropriations for the Departments within the Children's Cabinet. An overview of the five year phase-in plan and implementation process lays out the expectations for the critical work that will be necessary to achieve this first recommendation over the five year project period. *(See Appendix K)*

2. $ The DCYF must develop and implement a work plan that is geared to measure:

a) progress in system of care development and

b) the effectiveness of the interventions ascribed to the system.

The information gathered must also be distributed to identify problems, make adjustments to improve system design and to ensure public accountability.

The Department of Children, Youth and Families has established five goals to guide its System of Care Capacity Development. These broad goals reflect the Department's emphasis on community-based, family-centered services to ensure greater capacity for necessary placements close to the child's home/community. An overview of the workplan for the DCYF System of Care Capacity Development and Performance Measures provides a five year approach identifying the key objectives necessary to achieve the goals. *(See Appendix K)*

The priority reform performance measures in the system reform are:

- Eliminate night-to-night placements
- Eliminate medically unnecessary days in psychiatric hospitals
- Reduce out-of-state placements

All of the performance measures, however, identify key data elements being tracked for the Department's operations in promoting continuous quality improvement in

Child Welfare, Children's Behavioral Health, Juvenile Corrections, and Independent Living program functions.

3. $ **Rhode Island KIDS COUNT will continue to track child abuse and neglect, out-of-home placement, children's mental health, education, and juvenile justice indicators to measure results such as trends in numbers of out-of-state placements and foster care.**

The foremost public policy principle for the State is that, unless there is reason for a child to be removed from the home due to abuse or neglect, significant mental or behavioral health needs requiring out-of home care, or juvenile delinquency, **the needs of a child or youth are best met by maintaining them in their home with their family and providing the necessary support services to make this work**. However, when it is necessary to remove a child and place them in out-of- home care, it is the desire of the state that this substitute care be in the setting that is least restrictive and most effectively meets that individual child's needs. In this regard, the data collected by RI KIDS Count will assist the state in measuring what proportion of children and youth are in foster care vs. therapeutic foster care vs. congregate and institutional care. The expectation is for this data to show that a greater proportion of children and youth are being served in less restrictive settings as opposed to more restrictive settings, especially younger children.

4. $ **The DCYF will lead the development of performance measures and outcomes for Lead Agency Care Networks. This will be aimed at measuring both the Lead Agency itself as well as the performance of sub-contracted entities in meeting the needs of children and families served. The DCYF will develop utilization management and quality assurance mechanisms which will include family input/participation. These mechanisms will assess the implementation of a consistent standard of practice within the Networks that embodies the principles of the Ideal System of Care.**

The DCYF will use performance measures previously established in partnership with Yale University for outreach and tracking, foster care, shelter care, and residential programs. These and other standards, such as the CEDARR Family Center Standards, will be used to inform and guide the development and implementation of the development of a Care Network systems' evaluation component to include performance and outcome measures.

CHAPTER 7: IMPLEMENTATION

No plan of action is successful without clear articulation of roles, responsibilities, benchmarks, and time frames. The reorganization of Rhode Island's system of care for children, youth, and their families is no different. Numerous state, community, public, and private stakeholders are involved in each of the recommendations presented. The stakes are high for providers, state agencies, the Judicial Branch, and the Legislature and especially for the children and families served. It is imperative that there is clear designation of who, what, when, where, and how each of these recommendations will be implemented.

IMPLEMENTATION RECOMMENDATIONS

1. The Children's Cabinet is designated as the group responsible for oversight and implementation of this plan.

a) In order for the Cabinet to be able to effectively meet this and its other responsibilities, the Cabinet must be restructured in a manner which provides a greater depth of staff level involvement and commitment and a greater ability to provide forums for state agencies to work collaboratively on issues that does not interfere with the public's access to the Cabinet.

b)  **The Task Force should recommend to the General Assembly changes to RIGL 42-72.5 which will provide the Cabinet with the direction and flexibility needed to accomplish this restructuring.**

The systemic changes called for in this report require strong collaboration between and among state agencies as well as between and among the Executive, Legislative, and Judicial branches of government. The Children's Cabinet provides an existing structure within the Executive Branch to oversee and implement this plan. However, in order to accomplish this responsibility, it is clear that the Cabinet must restructure itself in a manner that provides for greater interagency collaboration as well as greater involvement from the Legislative and Judicial branches of state government. In this restructuring, the Cabinet must identify mechanisms which provide for the creation of interagency staff level work teams for prevention, financing and system management planning, development and implementation. In developing these teams, the Cabinet must consider how to most effectively involve the Legislative and Judicial branches of government, the Offices of the Attorney General and Public Defender, and non-governmental organizations and individuals.

2. $ **The DCYF must designate a key staff person who will be responsible for the oversight of the implementation of these recommendations. This individual must have the ability to work with all of the stakeholders involved, be willing and able to keep agencies and individuals within DCYF and from other agencies and stakeholder groups on task.**

Most of the recommendations contained in this report fall on the shoulders of the DCYF to implement or to collaborate with other stakeholders to implement. It follows that the DCYF be held responsible for overseeing the implementation process. However, it is imperative that the staff person designated be relieved of other duties in order to pay full attention to the goal of changing Rhode Island's System of Care. This is obviously no easy task and will require tremendous time, energy and skills from the Project Manager. This person must be at least temporarily added to the Senior Team for DCYF. This individual reports directly to the Director of DCYF.

3. The Task Force and its members must commit to the following implementation timeline:

YEAR ONE

A) Restructure the Children's Cabinet, including the introduction of legislation necessary to accomplish this restructuring.

B) Appoint a DCYF Project Manager

C) Clarify, measure, and affirm DCYF priority populations

D) Engage and mobilize key stakeholders (legislature, judiciary, community leaders, advocates, families, DCYF staff, providers etc) through mechanisms included but not limited to:

1) Legislative briefings

2) Meetings with the Judiciary and their staff

3) Public Hearings

4) Meetings with state agency administrators and their staff (DHS, DOH, MHRH, RIDE, etc.)

5) Meetings with LEA administrators (superintendents, special education administrators, etc.)

6) Memoranda of understandings between and among all involved parties

E) Establish DCYF Planning, Analysis and Evaluation capacity by identifying DCYF staffing capacity and, as necessary, subcontracting for specific expertise to:

F) Determine historical costs

1) **Analyze DCYF and Medicaid expenditures**

2) **Conduct provider profiling, needs assessment**

3) **Determine which, if any, services will be procured statewide (ex. Juvenile sex offender treatment)**

4) **Establish quality indicators, performance measures, and benchmarks**

5) **Facilitate program development**

6) **Analyze the feasibility of using a case rate payment mechanism for Care Networks**

7) **Begin development of RFP's for Lead Agency-based Care Networks**

8) **Begin to produce reports to be used as a baseline for the evaluation process**

G) Establish Children's Cabinet functions and performance measures

1) **Review and revise RI statutes and agency regulations as necessary**

2) **Begin development of Information and referral system**

3) **Establish Community Prevention Partnerships**

4) **Develop five year projected Child and Family budget (including federal, state and local funds) to support the implementation of the Ideal System**

5) **Develop performance measures for Children's Cabinet functions**

H) Implement Coordinated Children's Services System Regulations

1) **Operationalize pilot project**

2) **Evaluate project and use information to inform Lead Agency procurement process and guide the CMT process.**

I) DCYF to establish and implement agreements with the Family Court, RIDE, DHS, DOH and MHRH

J) Redesign DCYF Organizational Structure

1) **Restructure DCYF Central Office to support new regional structure**

2) **Establish DCYF Regional structure, staffing patterns, and regional budgets**

3) **Establish DCYF Regional Directors with regional budget authority, reporting requirements**

K) Establish Workforce Development focus

1) **Develop curricula for pre-service and in-service training**

2) **Support training for public and private provider staff with emphasis on best case management and clinical practices**

L) DCYF to review substance abuse system with MHRH and determine how to move collaboratively forward

M) Issue first annual System of Care progress report

YEAR 2

A) Implement DCYF Regional Structure

B) Expand DCYF Planning, Analysis and Evaluation capacity

1) **Review and utilization of reports used for baseline**

2) **Enhance and integrate DCYF and provider MIS systems as necessary**

C) Expand DCYF Workforce Development responsibilities

1) Charge Child Welfare Training Institute to develop provider fiscal, management, and clinical skills

2) Establish on-going required and recommended pre-service and in-service training

D) Develop DCYF/Medicaid Provider Capacity

1) Address provider reimbursement issues

2) Develop/expand key services in treatment continuum

E) Phase in the transition of youth placed out-of-state to newly developed in-state capacity on fee-for service basis as possible

F) Develop behavioral health requirements for private insurers

1) Examine current state statutes (i.e., parity) and regulations

2) Amend statutes and/or regulations as needed to assure behavioral health screening, assessment and treatment coverage

G) Establish DCYF Lead Agency procurement policies through the development of the Care Network RFP Identify vision, mission, roles and responsibilities

1) Establish appropriate payment mechanism

2) Develop fiscal accountability structure for providers

3) Establish Lead Agency performance indicators

4) Identify incentives/penalties for lead agencies

5) Bring Regional Lead Agencies on-line

H) Establish Lead Agency-based Care Networks

1) Determine sub-contract requirements and financing arrangements

2) Establish sub-contractor quality indicators and performance measures

3) Procure lead agency subcontractors

I) Transition youth in traditionally contracted and POS out-of-home care from current system to Lead Agency care network system

J) Issue annual System of Care progress report

YEAR 3

A) Adjust payment rate structure (and risk arrangements) as necessary

B) Continue emphasis on DCYF workforce development and DCYF/Medicaid program development

C) Continue the transition of youth in traditionally contracted and POS contracted out-of-home care to lead agency networks

D) Continue the design and implement evaluation of Lead Agency care network for out-of-home care

E) Design and implement evaluation of Lead Agency-based Care Networks for home and community-based services

F) Begin longitudinal study of children and youth involved in Lead Agency-based Care Networks

G) Issue annual System of Care progress report

YEAR 4

A) Refine fiscal and management reporting

B) Continue evaluation of Lead Agency Care Networks for out-of-home services

C) Transition children and families receiving home and community-based services at point of entry to Lead Agency-based Care Networks

D) Continue evaluation of Lead Agency-based Care Networks for home and community-based services

E) Issue annual System of Care progress report

YEAR 5

A) Produce comprehensive System of Care Evaluation report including but not limited to analyses of access, services utilization, quality and performance measures, and cost-effectiveness.

B) Revise System of Care design/implementation based on evaluation findings and recommendations

C) Issue annual and five-year comprehensive report

APPENDIX A: IDEAL SYSTEM OF CARE DESIGN COMMITTEE LIST OF PARTICIPANTS

Participant		***Agency***
Margaret	Alves	RI Foster Parent Association
Janet	Anderson, Ed.D.	Department of Children, Youth and Families
C. Lee	Baker	Department of Children, Youth and Families
Jennifer	Bowdoin	RI KIDS COUNT
Mary	Brinson	Butler Hospital
Michael	Burk	Department of Children, Youth and Families
Elizabeth	Burke Bryant	RI KIDS Count
Linda	Carlisle	Consultant
Doreen	Cavanaugh	Heller School, Brandeis University, Consultant
Michael	Cerullo	Private Therapist
Cathy	Ciano	Parent Support Network
Thomas	DiPaola, Ph.D.	Department of Education
Elizabeth	Earls	RI Council of Community Mental Health Organizations
John	Farley	Department of Children, Youth and Families
Hon. Michael B.	Forte	Associate Justice, RI Family Court
Marie	Ganim	RI State Senate, Office of the Majority Leader
William	Guglietta	Department of the Attorney General
Jim	Harris	RI Council of Residential Programs
Calittia	Hartley	Department of Human Services
Jane	Hayward	Department of Human Services
Mitzie	Johnson	Parent Support Network
David	Lauterbach	Kent County Community Mental Health Center
Jay G.	Lindgren, Jr.	Department of Children, Youth and Families
Dennis	Murphy	United Way for Southeastern New England
A. Kathryn	Power	Department of Mental Health, Retardation and Hospitals
Michael	Reeves	Harmony Hill School

Participant		***Agency***
Kimberly	Rodrigues	RI Council of Residential Programs
Kathleen	Spangler	Department of Mental Health, Retardation and Hospitals
Susan	Stevenson	The Groden Center
Elizabeth	Wheeler, MD	Bradley Hospital/Children's Policy Coalition

APPENDIX B: PRINCIPLES OF FAMILY CENTERED PRACTICE AS ADOPTED BY THE RI DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

The principles of family centered practice embraced below reflect the Department of Children, Youth and Families investment in developing and maintaining a family centered system of care[23]

- **Recognizing that the family is the constant in the child's life, while the service systems and personnel within those systems fluctuate. (This recognizes that "family" may have many interpretations, but maintaining a child(ren)'s connection to his/her family holds significant meaning in their lives).**
    - **"Family includes biological families, foster families, concurrent planning families, adoptive families, extended family relationships, kinship, etc.**
    - **Adolescents involved in the Independent Living Program still have need of a family experience and Family-Centered Principles work at assisting maturing youth to identify valuable connective relationships in their life and to build the inner capacity for developing healthy relationships as they reach adulthood.**
- **Facilitating family/professional collaboration at all levels of well-being**
- **Recognizing and respecting the racial, ethnic, cultural, sexual orientation, special needs and socioeconomic diversity**
- **Recognizing family strengths and individuality and respecting different coping methods**
- **Sharing information between DCYF staff and parents on a continuing basis and in a supportive manner**
- **Facilitating Family-to-family support and networking. (This includes parent support organizations, interactions between concurrent planning families, foster families, adoptive families, biological families and extended family relationships.)**
- **Understanding and incorporating the developmental needs of infants, children and adolescents and their families into service delivery systems**
- **Designing accessible service delivery systems that are flexible, culturally competent and responsive to family needs**

[23] Adapted from Family-Centered Principles found in What is family-centered care? (1990) [brochure] Washington, DC: National Center for Family-Centered Care.

APPENDIX C: DEFINITIONS, CORE VALUES AND STANDARDS OF CULTURAL COMPETENCE FOR RHODE ISLAND'S SYSTEM OF CARE FOR CHILDREN, YOUTH AND THEIR FAMILIES

DEFINITIONS[24]

CULTURE

The thoughts, ideas, behavior patterns, customs, beliefs, values, skills, arts, religions and prejudices of a particular people at a given point in time.

CULTURAL DIVERSITY

The rich mixture of ethnic, racial, religious, national and individual characteristics that colors the landscape of the world in which we live.

CULTURAL COMPETENCE

The ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds and religions in a manner that recognizes, affirms and values the worth of individuals, families, and communities and protects and preserves the dignity of each.

CULTURAL COMPETENCE CORE VALUES[25]

CULTURAL COMPETENCE IS FOR EVERYONE

Cultural competence is a personal and organizational commitment to learn about one another and how individual culture affects how we act, feel and present ourselves in the work place. The purpose of cultural competence is the sharing of knowledge about all aspects of culture [gender, religion, age, sexuality, education, etc.], not just the racial/ethnic culture of people of color. Cultural competence is an enrichment process, which allows everyone to share and learn. We have to be as willing to share our culture as to learn about another person's.

The vision, mission and goals are the tools the organization can use to create an organizational culture where employees feel comfortable discussing cultural difference and learning about the cultures of other employees and the population served. The organization can also further discussion of diversity by holding events or meetings which encourage people to explore different cultures and have open and honest discussions about difference. Organizations should be willing to allocate resources - money, time , people - to ensure that cultural competence is a priority in the organization.

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[24] Adapted from *Advancing Cultural Competence in Child Welfare Initiative,* Child Welfare League of America, September 1997.

[25] Adapted from *Advancing Cultural Competence in Child Welfare Initiative,* Child Welfare League of America, September 1997.

Each organization has a culture. The communication of the organizational culture should start at the initial interview and continue throughout an employee's time with the organization. While the organization should value difference and be willing to mediate between individual and professional needs of employees, employees should be equally committed to the organizational culture and be willing to make any necessary compromises in order to be successful in the workplace.

Cultural Competence is Integral to Best Practice

In order to efficiently and effectively carry out all the processes that are encompassed by best practice, i.e., the planning, organization and administration of social work services; establishment of state and local regulations; content training and teaching in schools of social work; inservice training and staff development; board orientation and development; fiscal planning; and community relations; cultural implications should be identified and integrated into all agency operations. The integration of cultural competence in an organization leads to the development of programs, policies and procedures which value and respect employees, the population served, visitors and others who come in contact with the organization.

Cultural Competence is an Ongoing Process

Cultural competence is a journey not a destination. As the challenges facing agencies change, organizations will continuously have to evaluate their ability to meet the needs of their external and internal customers [employees and children, youth and families] in a way that is responsive, effective and culturally competent. When agencies face a new challenge, the cultural competence implications should be identified and addressed. The planning process should include discussion of the cultural implications involved in making any changes.

Cultural Competence is Part of the Overall Organization Goal of Excellence

In today's arena, program structure, policies and procedures can be duplicated, however, the quality with which they are administered will determine how well the customer is served and how satisfied they are with the service provided. The competition for scarce resources will determine which child welfare agencies emerge on top. Excellence will be defined by the way organizations are run internally, how well programs are administered to the population served, the quality of their staff and image of the organization in the community. The "human factor", i.e. how well employees perform their duties, will be the key to achieving and maintaining excellence. Organizations will be able to distinguish themselves in the marketplace based on how adept their staff is at delivering quality products/services to the customer. The quality of the staff will have more influence on the ability of the agency to compete in the marketplace than the services that are provided. Organizations will need to hire /promote employees who are culturally diverse and dedicated to the mission, core values and goals of the organization. Additionally, they should be willing to continuously cultivate their skill set to learn more about their jobs, the population they serve and their fellow employees.

Cultural issues arise in everyday decision-making. Organizational and/or departmental values are the guidelines which should be used when evaluating options and making decisions. By establishing values that emphasize cultural competence, organizations can ensure that employees have the necessary tools to integrate cultural competence into their daily work routine.

CULTURALLY COMPETENT ORGANIZATIONS ARE CUSTOMER DRIVEN

To be successful in today's environment, agencies will need to be customer-driven. What the population served by the agency expects, needs, wants and is willing to tolerate are considerations which have to be entertained by the agency when designing programs, policies and procedures involved in delivering services. It is important for child welfare organizations to encourage feedback from the population served and to actively solicit their feedback and input for modification.

Agencies also have to understand and value both their internal and external customers. How employees are recruited and retained and how well they service and support one another is as critical to the efficiency of the agency as how well products/services are delivered to children and families. Therefore, organizations have to encourage feedback from within the organization regarding internal policies, procedures and processes as well as those which affect the population served. Staff members should be as concerned about giving assistance to one another as an external customer. Good internal customer service increases efficiency via the timely transmission of information which is ultimately used to service external customers.

CULTURALLY COMPETENT ORGANIZATIONS FOSTER LEADERSHIP THROUGHOUT THE ORGANIZATION

The environment agencies are exposed to today is in constant flux. The formal leaders of the organization face a new set of challenges which require their attention to keep the organization competitive. By sharing the responsibility of running the organization with the staff of the organization, the formal leaders can create more time for long-range planning themselves. By creating opportunities for leadership throughout the organization, among those who do the work, formal leaders are able to get better information about how the organization is running and what modifications are necessary. Effective team building allows the entire staff to have an impact not only on their own work, but on the overall success of the organization. This instills a sense of pride and ownership which result in commitments the organizational goals of excellence, customer service and quality delivery of a quality service.

Fostering leadership on every level of the organization gives all employees the opportunity to take on responsibility and allows them to hone the skills which will allow them to move up within the organization. The organization benefits because employees are being cultivated to be leaders, which gives the organization a pool of qualified candidates when managerial positions are available. Because there is a lower percentage of people of color when looking for higher level positions, this is another way to increase staff diversity while ensuring quality.

STANDARDS FOR CULTURAL COMPETENCE IN PRACTICE[26]

1. ***Ethics and Values:*** Individuals working within all levels of the System of Care function in accordance with the values, ethics and standards of their respective fields, recognizing how personal and professional values may conflict with or accommodate the needs of diverse children, youth and families.

[26] Adapted from *Standards for Cultural Competence in Social Work Practice*, National Association of Social Workers. Online. Available at http://www.socialworkers.org/pubs/standards/cultural.htm 23 June 2001.

2. ***Self-Awareness:*** Individuals working within all levels of the System of Care seek to develop an understanding of their own personal, cultural values and beliefs as one way of appreciating the importance of multicultural identities in the lives of people.

3. ***Cross-Cultural Knowledge:*** Individuals working within all levels of the System of Care have and continue to develop specialized knowledge and understanding about the history, traditions, values, family systems and artistic expressions of major client groups they serve.

4. ***Cross-Cultural Skills:*** Individuals working within all levels of the System of Care use appropriate methodological approaches, skills and techniques that reflect their understanding of the role of culture in the helping process.

5. ***Service Delivery:*** Individuals working within all levels of the System of Care are knowledgeable about and skillful in the use of services available in the community and broader society and are able to make appropriate referrals for their diverse children, youth and families.

6. ***Empowerment and Advocacy:*** Individuals working within all levels of the System of Care are aware of the effect of policies and programs on diverse client populations, advocating for and with children, youth and families when appropriate.

7. ***Diverse Workforce:*** Individuals working within all levels of the System of Care support and advocate for recruitment, admissions, hiring and retention efforts in programs and agencies that ensure diversity within the system.

8. ***Professional Education:*** Individuals working within all levels of the System of Care advocate for and participate in educational and training programs that help advance cultural competence within the system.

9. ***Language Diversity:*** Individuals working within all levels of the System of Care seek to provide or advocate for the provision of information, referrals and services in the language appropriate to the client, which may include the use of interpreters.

10. ***Cross-Cultural Leadership:*** Individuals working within all levels of the System of Care are able to communicate information about diverse client groups to other professionals.

APPENDIX D: VALUES AND PRINCIPLES FOR THE FAMILY-CENTERED, COMMUNITY-DRIVEN SYSTEM OF CARE FOR RHODE ISLAND[27]

VALUES AND PRINCIPLES FOR THE FAMILY-CENTERED, COMMUNITY-DRIVEN SYSTEM OF CARE FOR RHODE ISLAND

CORE VALUES

1. The system of care is child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care is community based, with the locus of services as well as management and decision making responsibility resting at the community level.
3. The system of care is culturally competent, with agencies, programs and services responsive to the cultural, racial and ethnic differences of the populations you serve.

GUIDING PRINCIPLES

1. Children, youth and their families have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
2. Children, youth and their families receive individualized services in accordance with the unique needs and potentials of each child and family and guided by an individualized service plan.
3. Children, youth and their families receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and/or surrogate families of children and youth are full participants in all aspects of the planning and delivery of services unless such involvement is clearly detrimental to the safety of the child.
5. Children, youth and their families receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.
6. Children, youth and their families are provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

[27] Stroul, B.A. & Friedman, R.M. (1986). A system of care for children and youth with severe emotional disturbances. (Revised edition). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, p. 18.

7. Early identification and intervention for children, youth and families in need of support and intervention is promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children, youth and their families are ensured smooth transitions to programs and services in the the adult service system as necessary as the youth reaches maturity.
9. The rights of children, youth and their families are protected and effective advocacy efforts for children, youth and their families are promoted.
10. Children, youth and their families receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics and services are sensitive and responsive to cultural differences and special needs.

APPENDIX E: COMPONENTS OF THE CONTINUUM OF CARE WITHIN RHODE ISLAND'S IDEAL SYSTEM OF CARE

THE COMPONENTS OF THE CONTINUUM OF CARE INCLUDE:

- General and specialized targeted prevention
- Early Intervention
- Quality child care and youth care services
- Educational Services
- Medical and dental services
- Social Skills development
- School-based mental health services
- Comprehensive assessments and evaluation
- Mobile crisis intervention services
- Case Management
- Short-term in-home acute care services (i.e., CIS, CES)
- Outpatient therapy (family, group, and individual)
- Outpatient Substance Abuse services for children, youth and their families
- Child abuse and neglect prevention and investigation
- Therapeutic Recreation
- Therapeutic child care
- Out of School Time programs
- Mentoring
- Day Treatment programs
- Community-based programs and services for juvenile offenders, including:
- Outreach and Tracking
- Day Reporting Centers
- Inter-agency Intensive Supervision programs for high-risk probationers (i.e., *Safe Streets)*
- Out-of-home care:
    - Kinship and foster care
    - Therapeutic foster care
    - Group home care, general and specialized
    - Specialized Residential treatment including residential substance abuse treatment and hospital diversion/stepdown
    - Out-of-home Respite care
    - Acute psychiatric hospitalization
    - Incarceration
    - Residential alternatives to incarceration, including staff secure programs

APPENDIX F: DCYF FAMILY SERVICE REGIONAL OFFICE SERVICE AREAS AS OF APRIL 2001

As of December 2001, the RI Department of Children, Youth and Families is divided into four geographic catchment areas for ongoing child welfare case management purposes. Probation offices overlap have some overlap with these regional offices but do not have direct reporting relationships to Regional Directors, instead reporting through the probation chain-of command. Children's behavioral health cases with ongoing case management needs that have no probation or child welfare involvement are also handled by the Regional Office staff.

The four Regional Offices and communities that lie within their service areas are:

- **Region 1: Providence Region - City of Providence**

- **Region 2: East Bay Region - Newport, East Providence, Barrington, Warren, Bristol, Tiverton, Little Compton, Portsmouth, Middletown, and Jamestown.**

- **Region 3: South County Region - New Shoreham, Narragansett, South Kingstown, North Kingstown, Charlestown, Westerly, Hopkinton, Richmond, Exeter, West Greenwich, East Greenwich, Warwick, West Warwick, and Coventry.**

- **Region 4: Northern Rhode Island - Central Falls, Pawtucket, Woonsocket, Cranston, Johnston, Scituate, Foster, Glocester, Smithfield, North Smithfield, Burrillville, and Lincoln.**

APPENDIX G: LEAD AGENCY CARE NETWORKS

LEAD AGENCY CARE NETWORK: FUNCTIONS AND RESPONSIBILITIES OF KEY STAKEHOLDERS

LEAD AGENCY KEY EXPECTATIONS

- The lead agency is responsible for ensuring the effective delivery of a continuum of services within their contracted region to all children and families referred by DCYF **and may not refuse services or treatment for these referrals or reject any of these referrals.** The Lead Agency will be required to fund specialized services not available within their Care Network through the established case rate.

- The lead agency is expected to provide services as proximate to the child/youths' community as possible, which reduce the number of children and youth placed outside of their community and which allow for the child/youth to maintain connection to their local school system.

- Lead agencies may provide no more than twenty-five percent (25% - based on total service dollars for the region) of direct service within their region but may subcontract with lead agencies in other regions for direct service programming.

LEAD AGENCY MANAGEMENT FUNCTIONS

- Developing a flexible network of service providers that meet identified needs of the region

- Providing a single point of entry to the service system

- Coordinating services throughout the course of treatment, placement and aftercare

- Working with the DCYF case managers and families to develop family and child service plans

- Family conferencing

- Implementing "no reject, no eject" policies

- Implementing standard service definitions and common clinical protocols

- Treatment planning and conducting treatment team meetings with family members and clinicians

- Implementing Continuous Quality improvement

- Collaborating with schools, law enforcement, court, medical providers and others to

ensure goals and treatment needs are being met

- As necessary developing, implementing and evaluating written interagency agreements with LEA's.
- Maximizing Medicaid/SCHIP, private insurance and education funding
- Coordinating, reviewing and authorizing direct care providers' claims and bills for clinical and non-clinical services
- Submitting required reports (fiscal, performance, outcomes, etc.) to the DCYF
- Care Network budget management
- Providing supports and services not currently funded by the current payment methodology (e.g., class trips, recreation, music lessons, tutoring, other special needs of children and families)

DCYF REGIONAL OFFICE FUNCTIONS

- Overseeing and participating in gate keeping into the lead agency
- Serving as the primary liaison to the lead agency
- Case management and clinical conferencing with the lead agency
- Monitoring day-to-day service utilization, program performance and performance indicators
- Participating in planning and coordinating services among the lead agency, network providers, DCYF staff, *Community Prevention Partnerships* and other parties
- Technical assistance and training
- Participating in service expansion and new service development
- Developing network protocols and procedures
- Conflict resolution
- Regional budget management

DCYF CENTRAL OFFICE FUNCTIONS

- Oversight of the Care Network Initiative
- Establishing gate keeping procedures and arrangements with other state agencies (particularly DHS)
- Planning and developing system enhancements
- Developing blended funding solutions with DHS
- Identifying issues and trends and devising plans with other parties to address those issues and trends
- Participating in service expansion and new service development
- Developing common service taxonomy
- Establishing capacity to better understand Medicaid
- Monitoring outcomes of services
- Establishing reporting requirements
- Providing administrative support services to Lead Agencies and Regional Offices)
- Establishing case rates and other funding mechanisms
- Oversight and monitoring of Lead Agency contracts in collaboration with Regional Offices
- Reporting to the legislature and administration
- Establishing and maintaining relationships with RIDE, Family Court, DHS, DOH, MHRH and key stakeholders
- Establishing a model for handling grievances and resolving conflicts

CARE NETWORK SERVICES

1. Preventive services
2. Crisis intervention (available 24 hours/day, 7 days/week, 365 days/year)
3. Initial assessment

4. Specialized assessments (e.g., caretaker safety; sex offender; physical health, mental status and substance abuse screening, etc.)

5. Development of family-centered family/child service plans

6. Family conferences

7. Day treatment and reporting

8. Outreach and tracking

9. Family respite

10. Wrap-around services

11. Behavioral health services

12. Outpatient/community-based counseling services

13. Outpatient substance abuse treatment

14. Medication evaluation, management and re-evaluation

15. Family support and parent education

16. Parent Aides

17. Counseling

18. Home Visitation Services for Newborns

19. Tutoring

20. Recreation

21. Transportation

22. Residential services including:

    a) Respite Care

    b) Shelter Care

    c) Regular Foster Care

    d) Specialized and Therapeutic Foster Care

    e) Group Homes

f) Staff Secure Residential Group Homes

g) Intensive Residential Treatment

h) Specialty Residential Treatment (i.e., sex offenders, substance abuse)

23. Ability to access In-patient Psychiatric hospital services as needed through affiliation agreements with psychiatric hospitals

24. Aftercare

APPENDIX H: COMPARISON CHART OF LEAD AGENCY CARE NETWORKS/CEDARR FAMILY CENTERS/LOCAL COORDINATING COUNCILS

	Lead Agency Care Networks	**CEDARR Family Centers**	**LCC's**
Geographic Access	Specified Geographic Areas	Statewide, with requirement for local accessibility	Specified Geographic Areas
Target Population	DCYF -defined populations: ❑ delinquents ❑ in custody for abuse/neglect ❑ voluntary due to behavioral health needs requiring state assistance	Families with children with special health care needs, i.e., with condition or risk of condition requiring health or related services of a type or amount beyond that required by children generally.	Families with children at significant risk for or identified as seriously emotionally disturbed.
Presenting Needs	❑ wayward/disobedient ❑ at risk for out-of-home or out-of-community placement	Issues associated with special needs unresolved. May include: ❑ Risk for out-of-home or out-of-community placement ❑ Difficulties within family support system ❑ Need for specialty diagnosis; more information re: condition ❑ Difficulties with current services/services coordination ❑ Information /advocacy about services, resources, programs' various eligibility rules ❑ Problems associated with transitions	Emotional or behavioral challenges that significantly disrupts functioning at home, school or in community

	Lead Agency Care Networks	CEDARR Family Centers	LCC's
Family Choice	❑ Legal status - case plan driven ❑ Non-legal status - voluntary participation by families	❑ Participation by families is voluntary. ❑ Families have choice of provider.	Participation by families is voluntary.
Funding	State/Federal funding: ❑ Title XIX, IV-E ❑ Private sources ❑ Grants	State/Federal funding: ❑ Title XIX, XX, XXI ❑ Private sources ❑ Grants	State funds.
Payment Mechanism	Case rate for services.	Fee for service.	DCYF contracts.
Scope of Service	❑ Assessment ❑ Care Planning ❑ Referral ❑ Evaluation ❑ Coordination ❑ Lead agency restricted to providing no more than 25% of direct services within their Care Network	❑ Assessment ❑ Care Planning ❑ Referral ❑ Evaluation ❑ Coordination	❑ Service coordination ❑ Family Support ❑ Information, education, advocacy ❑ Non-traditional wraparound support not covered by other funding sources
Utilization Management Function	❑ State provides utilization management of Lead Agency. ❑ Lead agency is responsible for ensuring that subcontractors meet expectations.	❑ Case based data tracking. ❑ CEDARR Direct Services authorized when included in approved Family Care Plan.	None

	Lead Agency Care Networks	CEDARR Family Centers	LCC's
Services Provided	Comprehensive array of services from general outpatient to respite to residential treatment (with affiliation agreements with hospitals for psychiatric hospitalization needs). Includes case management No reject - no eject policy for Lead Agency	❑ Basic services and supports – service identification/referral, special needs resource information, system mapping/navigation, peer support ❑ Initial Family Assessment ❑ Specialty Evaluation; Treatment consultation ❑ Family Care Plan Development; periodic review and revision, service tracking ❑ Crisis Intervention Direct services to be provided only by "CEDARR Direct Service Providers"	Family Service Coordinators: ❑ meet with families to prepare for case review process ❑ assist in identifying appropriate support for parents in the team meetings ❑ coordinate and schedule team meetings ❑ support and advocate for family needs ❑ maintain documentation ❑ complete data collection requirements for system evaluation ❑ follow-up on team assignments ❑ provide community education and information ➢ The - Coordinated Children's Services System - provides for non-traditional, wraparound services through community planning teams.

	Lead Agency Care Networks	CEDARR Family Centers	LCC's
Oversight and Monitoring ❑ Certification/ Accreditation	❑ System oversight by DCYF ❑ Lead Agency responsible for monitoring service utilization	❑ System oversight - DHS, CEDARR Policy Advisory Committee ❑ Certification by DHS. Oversight and Monitoring • Identification of key program issues • Comprehensive data system/data reports/analyses • Provider compliance w/standards • Service delivery process/outcomes • Site visit compliance reviews	N/A
Contracting	❑ Specific contracting responsibility ❑ Specified timeframe ❑ Limited number	❑ Rolling certification of CEDARR Family Centers by DHS ❑ Certification for any applicant that demonstrates compliance with standards.	Functions contracted by DCYF.

	Lead Agency Care Networks	CEDARR Family Centers	LCC's
Data Requirements	To be defined during development process but my include, although not exclusively, the following: ❑ DCYF - RICHIST - • Network referrals • Presenting needs ❑ Network Data Reports - • Systems evaluation • Performance indicators • Outcome data ❑ Child Welfare Performance - YALE • Demographic information • Presenting issues • Service needs/referrals • Educational Need/Performance ❑ Placement Solutions - • Service utilization reports for youth placed in and out of state • Service plans for moving youth from high-end residential to community-based support	CEDARR electronic case coordination system provides consistent management tool and establishes uniform centralized data base. Core data elements in such areas as: ❑ Demographic information ❑ Referral sources, presenting issues, other service system involvement of child/family. ❑ Assessment of Family Care Plan components (identified strengths, needs, goals, objectives, interventions) ❑ Process of care (timelines, completion, referrals, services received) ❑ Service gaps experienced ❑ Outcomes of family care plans	Project Hope Evaluation Data Collection for youth with SED leaving RITS with aftercare support: ❑ Demographic information ❑ Presenting needs ❑ Identified services, referral sources for mental health, social services, educational, operational, recreational, vocational, health and juvenile justice ❑ Barriers to services being delivered ❑ Child and Adolescent Functioning Assessment Scale (CAFAS)

	Lead Agency Care Networks	CEDARR Family Centers	LCC's
Collaboration - Required Partners	❑ Networks must develop as many connections and linkages to the community as possible. ❑ All subcontractors required to attend regular team meetings to review any case as necessary and appropriate. ❑ Monthly team meetings with contractors and DCYF case workers allows ability to move children, youth and families flexibly within the network up, down and across treatment levels based on the immediate needs; review standards; cross -agency training; and the collaborative planning of events.	Collaboration/coordination required with: ❑ Families ❑ LEAs ❑ LCCs ❑ Early Intervention ❑ DCYF case workers ❑ Primary physician ❑ DHS ❑ RIte Care health plan, commercial payers ❑ Other community natural supports	The voting membership of Local Coordinating Councils must include broad community representation of at least 19 participants, of which no more than 4 may be employees of the fiscal agent.
Case Management	Provided within Network; DCYF caseworker also responsible.	Not required.	Case management provided by some LCCs, but not all.

	Lead Agency Care Networks	CEDARR Family Centers	LCC's
Care Coordination		Family Care Coordination Assistance- Activities to: ❑ Support initiation of Family Care Plan –assist, help arrange for and coordinate key interventions to meet goals and objectives ❑ Promote development of family empowerment and self advocacy skills Reimbursable service by CEDARR Family Center; level of effort at 4-6 hrs/month Limited to six months duration as start of Family Care Plan; may be renewed based on need/transition.	All LCCs provide care coordination.

APPENDIX I: DCYF RECOMMENDATIONS TO THE JOINT LEGISLATIVE COMMISSION TO STUDY AN ENHANCED ROLE FOR PROBATION AND PAROLE (MARCH 2001)

ADMINISTRATION AND MANAGEMENT

- Enhance services for young women offenders
- Develop standards based on American Probation and Parole Association (APPA) Best Practices
- Establish curriculum for staff training and development
- Implement continuous quality improvement process
- Utilize computer mapping to identify geographic "hotspots" based on probationer and criminal activity

COMMUNITY SUPERVISION

- Study feasibility of one probation counselor for each youth throughout the system
- Re-validate the current risk assessment tool
- Develop comprehensive assessment component
- Develop case profiles
- Establish contact standards
- Establish caseload forecasting model
- Review assignment of offenders to probation caseload
    - transfer policy between probation counselors and DCYF social caseworkers
    - convicted adults in Family Court
    - transition from RI Training School to probation

COMMUNITY SERVICE AND SUPPORT

- Expand community support service system:
    - Outreach and tracking
    - Gang intervention
    - Mentoring
    - Substance abuse counseling
    - Sex offender monitoring and treatment
    - Employment services
    - Family support services
    - Mental health counseling
- Enhance early intervention and transitional services for young women offenders

STAFF RECRUITMENT AND TRAINING

- Formalize current outreach efforts to recruit minority probation counselors
- Negotiate a modified civil service exam
- Develop core staff training curriculum specifically tailored for juvenile probation and parole staff
    - New staff = 120 hours in first year
    - Veteran staff = 40 hours annually

COMMUNITY PARTNERSHIPS AND LINKAGES

- Expand information sharing and collaboration with police departments throughout the state
- Expand *Safe Streets* model to all five (5) core cities
- Expand Day Reporting Centers to all five (5) core cities
- Support the continued development and enhancement of Juvenile Hearing Boards
- Support the expansion of Juvenile Drug Courts and Truancy Courts within agreements outlining roles and responsibilities between the DCYF and the Family Court as to case management and service delivery functions

CASELOAD MANAGEMENT

- Achieve target caseloads as follows
    - Probation supervisor to probation counselor: 1:8
    - Probation caseload: 30:1 (Current = 41:1)
    - Parole caseload: 35:1 (Current = 47:1)
    - *Safe Streets* caseload: 15:1 (Current = 17:1)

APPENDIX J: LISTING OF LICENSED AND BOARD CERTIFIED PROFESSIONALS

Licensed Psychiatrist, Board Certified (American Board of Medical Specialties) in Child and Adolescent Psychiatry (M.D.)

Licensed Psychologist (Ph.D./Psy.D.)

Certified Registered Nurse Practitioner (CRNP)

Licensed Independent Clinical Social Worker (LICSW)

Licensed Clinical Social Worker (LCSW)

Licensed Marriage and Family Therapist (LMFT)

Licensed Mental Health Counselor (LMHC)

Licensed Practical Nurse (LPN)

Registered Nurse (RN)

Licensed Physician Assistant (PA)

Certified Nursing Assistant (CNA)

APPENDIX K: PERFORMANCE MEASURES AND OUTCOMES FOR THE IDEAL SYSTEM OF CARE

Performance Measures and Outcomes - Recommendation 1: The Children's Cabinet must develop, implement and fund an evaluation/accountability plan to comprehensively assess the State's effectiveness in implementing the recommendations of this report over the five year phase-in period. The development of this plan must include families (parents, kin, foster and adoptive families.

Overview -

Department(s)	Action Steps – Year 1-2	Indicators - Establish Baseline In Year 1	Data Sources	Performance Measures – Year 2-5	Outcomes - Year 2-5
Within the Children's Cabinet - DCYF DHS RIDE DOH MHRH	❑ Establish MOA for Implementation Team with identified funding resources. ❑ Assign key staff. ❑ Establish implementation milestones and schedule.	**Identify relevant percentage of service utilization for tracking -** ❑ Utilization of prevention services ❑ Utilization of emergency services ❑ Utilization of health plan child/family services ❑ Utilization of HBTS (EPSDT)	❑ DHS - • Rite Care • HBTS (EPSDT) • CEDARRs • Medicaid FFS expendi-tures ❑ DCYF - RICHIST: children/youth receiving of out-of-home mental health or therapeutic tx services	❑ Data infrastructure operational. ❑ Data elements being shared, trends tracked. ❑ Systems alignment evolving. ❑ Services accessed. ❑ Waiting lists reduced/eliminated.	**Compare with Year 1 - baseline data** ❑ Prevention service capacity - expected increase ❑ Emergency services care- expected decrease ❑ Community-based support - expected increase ❑ Court referrals - expected decrease

Overview (continued)

Department(s)	Action Steps – Year 1-2	Indicators - Establish Baseline In Year 1	Data Sources	Performance Measures – Year 2-5	Outcomes - Year 2-5
	❑ Identify data elements within each Department and create reporting formats and schedule. ❑ Report quarterly. ❑ Establish protocols to address systems' barriers. ❑ Establish action plan(s) for necessary adjustments. ❑ DesignCommunity Prevention Partnerships	❑ Utilization of IEPs ❑ Utilization of community-based support ❑ Utilization of out-of-home placement ❑ Utilization of out-of-district placement ❑ Utilization of psychiatric hospitalization ❑ Utilization of out-of-state placement ❑ Agency/service specific data on community level	❑ DOH -Early Intervention ❑ RIDE – • IEP Services • Private Special Education Schools ❑ MHRH – • Substance Abuse • Adult MH • DD Services	❑ Service gaps/needs identified and addressed with new service development; targeted capacity enhancement. ❑ Community trends: • school attendance • school performance • school suspensions • expulsion rates • arrests • detention rates ❑ placement out of community rates	❑ Psychiatric hospital care - expected decrease ❑ Out-of-state placements - expected decrease

RECOMMENDATION 1 - Children's Cabinet must develop, implement and fund an evaluation/accountability plan to comprehensively assess the State's effectiveness in implementing the recommendations of this report over the five year phase-in period. The development of the evaluation/accountability plan must include families.

Implementation Process -

Action Steps	Year 1	Year 2	Year 3	Year 4	Year 5
❑ Task Force issues final report including Implementation Plan ❑ Implementation Plan elaborated and refined including: • action steps • responsible parties • timelines ❑ Governor and Assembly designate Children's Cabinet to monitor Implementation Plan. ❑ MOA for Implementation Project with identified funding resources.	**Within 3 months of Report Issuance:** ❑ Children's Cabinet agrees to Implementation Project. ❑ A cost analysis is conducted across Departments to determine current capacity for data collection/analysis and budget needs for a comprehensive MIS infrastructure. ❑ MOA is developed and signed. ❑ Family participation is identified and accommodated. ❑ Project staff are assigned. ❑ Implementation goals are set. ❑ Budget requests are developed for future investment in data management/analysis.	Monitor key indicators for investment shift from high-end service to less restrictive and community-based care.	Monitoring implementation continues with Children's Cabinet.	Implementation and monitoring process ongoing.	Implementation and monitoring process ongoing.

Implementation Process (continued)

Action Steps (cont.)	Year 1	Year 2	Year 3	Year 4	Year 5
❑ Identify data elements within each Department and create data reports that are needed.	**Within 6 months of Report Issuance:** ❑ Each Department identifies the current set of data files for relevant services. ❑ The necessary programs are written for data exchange and compilation that will allow for comprehensive profile of service delivery and access needs. ❑ Identify the data elements that are necessary, but need to be developed. ❑ Create infrastructure to establish baseline data.	❑ Infrastructure is in place and operational. ❑ Needed data elements are developed within the information systems.	New data elements are reported and tracked as part of overall trend and benchmarking analysis.	Continued refinement of data elements as need is identified.	Continued refinement of data elements as need is identified.

Implementation Process (continued)

Action Steps (cont.)	Year 1	Year 2	Year 3	Year 4	Year 5
❑ Protocols established to address systems' barriers.	**Within 6 months of Report Issuance**: ❑ Children's Cabinet creates a workgroup of staff attorneys, information systems specialist and program staff to identify existing statutory requirements and authorities within each Department. ❑ Workgroup identifies where the statutory authority assists or impedes implementation and recommends necessary accommodations. ❑ Cabinet determines necessary action to remove systems barriers.	❑ System alignment is assessed and necessary changes are made to facilitate seamless service delivery at state and community level. ❑ Waiting list trends are reported as they relate to service access and delivery performance. ❑ Community-based trends are analyzed for local level performance measure achievements.	Ongoing assessment of systems' coordination and necessary adjustments are made.	Ongoing assessment of systems' coordination and necessary adjustments are made.	Ongoing assessment of systems' coordination and necessary adjustments are made.
❑ Information reported quarterly.	❑ Initial data compilation begins among between Departments within the first six months of project implementation. ❑ Baseline data track is established for all elements collected.	❑ Data elements are tracked regularly for trend analysis. ❑ Indicators in service areas across Departments are analyzed. ❑ Problem areas are identified.	❑ Service utilization and cost trends are analyzed quarterly. ❑ Trends represent service concentration in levels of restrictiveness/ community-based care and prevalent geographic utilization.	Data collection and analysis is ongoing.	Data collection and analysis is ongoing.

Implementation Process (continued)

Action Steps (cont.)	Year 1	Year 2	Year 3	Year 4	Year 5
❑ Action plan(s) for necessary adjustments.	❑ Focus on systems needs. ❑ Focus on service and program needs.	❑ Correction plans are developed as necessary. ❑ Service gaps and capacity needs are identified. ❑ Strategies are devised to address service needs.	❑ Ongoing service development and capacity building is monitored and assessed. ❑ Plans developed for increasing/changing service capacity.	Services increased or changed to meet identified population needs.	❑ Monitoring and adjustments are ongoing. ❑ Children/ families are receiving appropriate services in timely manner.

The Department of Children, Youth and Families - System Enhancement

The Department of Children, Youth and Families represents an integrated System of Care comprised of Child Welfare, Children's Behavioral Health and Juvenile Corrections. The Department's five goals for the System of Care Capacity Development are broad, but inclusive of the Department as a whole, interconnecting with each of the distinct operating divisions. The Divisions function both separately and together to provide a full array of services and programs to meet the needs of children, youth and families.
The performance measures themselves are tailored to the specific operations within the department, as part of the department's overall goals to improve the system capacity.

Performance Measures and Outcomes - Recommendation 2: The DCYF must develop and implement a work plan that is geared to measure: (a) progress in continuum of care development and (b) the effectiveness of the interventions ascribed to the system.

The information gathered must also be distributed for public accountability and to identify problems and make adjustments to improve system design.

System of Care Capacity Development	Year 1	Year 2	Year 3	Year 4	Year 5
Goal 1: Create a community-based, family-centered service system Goal 2: Establish a continuum of high quality, culturally relevant placement resources in proximity to each child's home by expanding and improving Rhode Island in-state system of care Goal 3: Promote adoption/guardianship as a permanency option when reunification is not achievable Goal 4: Transition all children and youth from public supported care with the supports, skills and competencies in place to ensure stability and permanency. Goal 5: Enhance the capacity of employees, foster parents and providers to deliver high quality care to children and families.	❑ **Begin to implement Family-Centered Practice** ❑ **Implement concurrent planning for children in substitute care** ❑ **Begin implementation of Care Management Team (CMT) community-based placement mechanism** ❑ **Increase in-state residential capacity** ❑ **Continue utilization review management** ❑ **Establish first Regional-based Network** ❑ **Enhance opportunities and preparation for older youth leaving state care** ❑ **Enhance training and support for substitute care providers** ❑ **Enhance training and support for staff**	❑ **Phase-in of Family-Centered Practice continues** ❑ **Increase hospital step-down capacity in-state** ❑ **Establish CMT in all DCYF Regions** ❑ **Expand Regional Networks** ❑ **Monitor concurrent planning activity and adjust as necessary** ❑ **Continue to identify and implement training and support services**	❑ **Family-Centered Practice ongoing** ❑ **Assess and maintain hospital step-down capacity** ❑ **Assess and modify CMT operation as necessary** ❑ **Expand Regional Networks** ❑ **Assess and adjust as necessary** ❑ **Assess and adjust as necessary**		❑ **Assess and adjust as necessary** ❑ **Maintain according to plan** ❑ **Maintain according to plan** ❑ **Maintain according to plan** ❑ **Assess and adjust as necessary**

System of Care Performance Measures	Year 1	Year 2	Year 3	Year 4	Year 5
Reform Priority Measures - ❑ Eliminate night to night ❑ Eliminate medically unnecessary days in psychiatric hospitals ❑ Reduce out-of-state purchase of service (POS) placements	❑ Reduce number of medically unnecessary days ❑ Increase family support services[28] ❑ Night-to-night Placement eliminated	❑ Reduce number of Wayward/Disobedient placements ❑ Eliminate medically unnecessary days		Continue to monitor and adjust system functioning as necessary	Continue to monitor and adjust system functioning as necessary

[28] Family Support Services includes parent aide, home visiting for newborns, substance abuse treatment, and mental health treatment for parents

System of Care Performance Measures (continued)	Year 1	Year 2	Year 3	Year 4	Year 5
Child Welfare - Safety ❑ Reduce recurrence of child abuse and/or neglect ❑ Reduce the incidence of child abuse and/or neglect in foster care Permanency ❑ Increase permanency for children in foster care ❑ Reduce time to reunification without increasing re-entry ❑ Reduce time in foster care to adoption ❑ Increase placement stability ❑ Reduce placements of young children in group homes or institutions Well-being ❑ Educational attainment ❑ Families report improvements in ❑ parent/child interaction ❑ Chafee Foster Care Independence Measures[29] • Improved/satisfactory grades • Improved/satisfactory school attendance • Classroom stability improved	❑ Enhance recruitment of foster care and adoptive parents ❑ Reduce number of ❑ children/youth free for adoption who are not adopted ❑ Increase annual number of adoptions from state care ❑ Enhance staff competence with regard to preparing children and families for permanency ❑ Reduce number of times children/youth disrupt from placements ❑ Reduce number of children removed from home or foster care placements. ❒ Develop "well-being" data elements.	❑ Increase number foster care providers and therapeutic foster care providers ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Ongoing training ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Begin tracking "well-being" indicators	❑ Continue recruitment and training activities ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess trends and address needs as appropriate	❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary	❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary

[29] Chafee Foster Care Independence Program Measures included in Appendix K.

System of Care Performance Measures (Continued)	Year 1	Year 2	Year 3	Year 4	Year 5
Children's Behavioral Health - ❑ % of children receiving appropriate level of behavioral health service as needed ❑ % of children still not receiving appropriate level of behavioral service as needed ❑ % of children admitted into a psychiatric hospital who remain for 21 days or less ❑ Consumer satisfaction rate for Department funded psychiatric hospital and community-based services	❑ Establish baseline for service needs including extent of waiting lists ❑ Assess and redesign as indicated - outpatient services ❑ Restructure CIS services ❑ Reduce hospital recidivism rates ❑ Assess adequacy of psychiatric hospital stepdown programs ❑ Enhance community-support capacity ❑ Increase provider rates where insufficient	❑ Assess and revise based on performance measures ❑ Implement outpatient services design ❑ Continue enhancement of community-support capacity	❑ Monitor and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary	❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary	❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary

System of Care Performance Measures (Continued)	Year 1	Year 2	Year 3	Year 4	Year 5
Juvenile Corrections - ❑ Performance measures covering five broad areas in Security, Order & Safety; Programming; Health; Mental Health; and Justice are included in the National Performance-based standards for Juvenile Corrections of which the RITS is a partner (see Appendix K) ❑ % of adjudicated and detained RITS youth passing GED exams ❑ % of adjudicated RITS youth admitted during the fiscal year after release within the prior 12 months ❑ % of former adjudicated RITS youth who have temporary community assessment revoked	Monitoring of indicators and performance measures continues	Monitoring of indicators and performance measures continues	Assess and adjust as necessary	Assess and adjust as necessary	Assess and adjust as necessary
Provider Performance Measures - Developed in partnership with Yale University - necessary training for data collection ongoing	Data collection and analysis continues - adjustments as necessary	Data collection and analysis continues - adjustments as necessary	Assess and adjust as necessary	Assess and adjust as necessary	Assess and adjust as necessary
Workforce Cultural Competency Performance Measures Quality and Executive Capacity Initiatives	To be developed during first year	Workforce initiatives implementation prioritized and phase-in workplan established.	Workplan implementation continues	Assess and adjust as necessary	Assess and adjust as necessary

THREE FORMS OF MEASUREMENT

Context Evaluation

Context evaluation focuses on assessing the needs, assets, and resources of the state and local communities in order to plan relevant and effective interventions within the context of the community. It also identifies the political atmosphere and human services context of the community to increase system design support by community leaders and local organizations.

Implementation Evaluation

Implementation Evaluation addresses a broad array of elements. In the Ideal System purposes include:

- Identifying and maximizing strengths in development
- Identifying and minimizing barriers to implementing activities
- Determining if project goals match target population needs
- Assessing whether available resources can sustain project activities
- Measuring performance and perceptions of the staff and children, youth and families
- Documenting systemic change.

Outcome Evaluation

Assessing outcomes employs five levels of measurement:

- Individual child and family outcomes –individualized assessments for a specific client
- Program measures (outcomes of a group of children, youth and families receiving specific services)
- Agency or departmental indicators (results of all children, youth and families served by an agencies services)

- System-wide data (child serving system data from multiple agencies)
- Community population statistics (a description of the wider community demographics)

In the Ideal System the development of the outcome evaluation builds on the work completed to date by state agencies in developing common outcomes to use across the system. This process involves stakeholder participation to determine what outcomes are expected or hoped for and to think through how individual participant/client outcomes connect to specific program or system level outcomes. These outcomes measures:

- Help answer questions about what works, for whom, under what conditions and how to improve program delivery and service
- Determine which implementation activities and contextual factors are supporting or hindering outcomes and overall program effectiveness
- Demonstrate the effectiveness of the system and make the case for its continued funding.

A formative evaluation approach is used integrating evaluation processes into the routine operation of service provision. In the Ideal System, evaluations develop useful, accessible findings that bridge the gap between research and practice, informing decision-making and improving service programming. It shifts the focus from outputs to results –from how a program operates to the good it accomplishes[30].

[30] Stroul, 1993/Woodbridge and Huang, 2000.

Rhode Island DCYF Child Welfare Performance Measures

CES	Early Start	Family Preservation	Outreach and Tracking	Youth Diversionary	Residential, Shelter, Foster Care
# of families reported for abuse or neglect during reporting period					
		For children with goal of home preservation, # of children at home			
		For Children with goal of reunification, # of children reunified			
			# of children who go into out of home placements and # that are planned placements		
			# of children with new charges or adjudication		
# of families with improved/stable parenting skills (North Carolina Assessment Instrument)	# of children assessed w/subtypical development in any area of Ages to Stages				# of children with improved adaptive functioning scores (GAF) (Ages 4 and over)
# of families where the risk of abuse/neglect has decreased/ remained low (North Carolina Assessment Instrument)	# of children who have achieved new developmental milestone (Ages to Stages)				
# of families with changes in each of the domains (North Carolina Assessment Instrument)	# of children with subtypical development in one or more domains who showed improvement in that domain from previous Ages to Stages assessment				

Rhode Island DCYF Child Welfare Performance Measures (continued)

CES	Early Start	Family Preservation	Outreach and Tracking	Youth Diversionary	Residential, Shelter, Foster Care
	# of families showing improvement (Selected Child Well Being Scale				
	# of families with reduction of stress (Parenting Stress Index-Short Form)				
			# of adolescents who received their GED during reporting period		
			# of adolescents who received their HS diploma during reporting period		
			# of children/youth with improved/satisfactory grades		
			# of children/youth with improved/satisfactory school attendance		
			# of children/youth whose classroom stability improved		
			# of children/youth with time out of school (detentions; suspensions; expulsions)		
			# of children/youth with in-school (detentions, suspensions)		

PERFORMANCE-BASED STANDARDS FOR JUVENILE CORRECTION AND DETENTION FACILITIES

I. SECURITY, ORDER AND SAFETY

A. Security

1) Completed and uncompleted escapes, walk aways and AWOLs per 100 person-days of youth confinement
2) Incidents involving contraband (weapons, drugs and other forms) per 100 pers0n-days of youth confinement

B. Order

1) Major misconduct by youth per 100 person-days of youth confinement
2) Staff involvement in documented misconduct per 100 staff-days of employment
3) Physical restraint use per 100 person-days of youth confinement
4) Mechanical restraint use per 100 person-days of youth confinement
5) Use of isolation and room confinement per 100 person-days of youth confinement
6) Average duration of isolation and room confinement
7) Percent of idle waking hours (i.e., hours when there is no scheduled program or activity

C. Safety

1) Injuries to staff per 100 staff-days of employment and to youths per 100 person-days of youth confinement
2) Suicidal behavior by youth per 100 person-days of youth confinement
3) Percent of days during the assessment period when population exceeded design capacity by 10 percent or more
4) Youths injured during the application of physical, mechanical and chemical restrains per 100 person-days of youth confinement
5) Assaults on youth and staff per 100 person-days of youth confinement
6) Percent of staff and youth who report that they do not fear for their safety

II. PROGRAMMING

A. Improve education and vocational competence

B. Provide an educational program that is tailored to each youth's education level, abilities, problems and special needs and that improve education performance and vocational skills while confined.
   1) Youths reading and math scores of admission, every 90 days and at discharge for youths confined more than 90 days
   2) Percent of youth who report that they received education while in isolation

C. Provide vigorous programming that is culturally competent and gender specific, that minimizes periods of idle time, that addresses the behavioral problems of confined youth and that promotes healthy life choices.
   1) Percent of youth whose records indicate they have received a health assessment
   2) Percent of youth whose records indicate they have received a mental health assessment
   3) Percent of youth whose records indicate they have received a substance abuse assessment
   4) Percent of youth whose records indicate they have received reading and math tests
   5) Percent of youth whose records indicate they have received a social skills assessment
   6) Percent of youth whose records indicate they have received a vocational assessment
   7) Percent of youth whose records indicate they have received a physical fitness assessment
   8) Percent of youth confined for more than 60 days whose records include a written individual treatment plan
   9) Percent of youth confined for more than 60 days whose records indicate that they received the education programming prescribed by their individual treatment plans
   10) Percent of youth confined for more than 60 days whose records indicate that they received the social skills programming prescribed by their individual treatment plans
   11) Percent of youth confined for more than 60 days whose records indicate that they received the vocational skills programming prescribed by their individual treatment plans

12) Percent of youth confined for more than 60 days whose individual treatment plans have monthly progress notes
13) Percent of youth continued for more than 1 year whose records include an annual summary of treatment progress
14) Percent of released youth who were confined for more than 60 days whose records indicate that they have completed the health curriculum
15) Percent of released youth who were confined for more than 60 days whose records indicate that they have completed a social skills curriculum.
16) Percent of released youth who were confined for more than 60 days whose records indicate that they have completed a vocational skills curriculum
17) Percent of youth interviewed who report receiving at least one hour of large muscle exercise each day on weekdays and two hours each day on weekends
18) Percent of interviewed youth who report receiving education materials while in isolation

D. Promote continuity in programming and services for youth after they are released
   1) Percent of released youth who were confined for more than 60 days whose reintegration plans address the remaining elements of their individual treatment plans

E. Open facility to the community via telephone, visitation and volunteer involvement.
   1) Percent of youth who report that policies governing telephone calls are implemented consistently
   2) Percent of youth who report that they have placed and/or received telephone calls from a parent or guardian
   3) Visitation per 100 person-days of youth confinement
   4) Percent of youth getting visits
   5) The number of community volunteers providing programming in the facility
   6) The number of different programs that engage community volunteers

III. HEALTH AND MENTAL HEALTH

A. Identify youths at time of admission who have acute health problems or crisis mental health situations and following evaluation, ensure delivery of appropriate health or mental health services.

1) Percent of staff completing training in administering the health and mental health intake screening who passed a competency test at the end of the training
2) Percent of youth presented for admission who have a health and mental health intake screening completed in one hour or less

B. Provide health appraisals for all youth not released quickly, as well as behavioral, mental health and substance abuse evaluations where indicated.
    1) Percent of youth presented for admission whose health assessments were completed within seven days, or sooner as required by law
    2) Percent of youth presented for admission whose health assessments were completed within seven days, or sooner as required by law
    3) Percent of youth needing a substance abuse assessment for whom it was completed within 14 days of admission or within 14 days of referral

C. Develop or continue individual treatment plans for each confined youth to respond to health, mental health, substance abuse or behavioral problems.
    1) Percent of youth confined for more than 30 days whose records include a written individual treatment plan
    2) Percent of youth confined for more than 60 days whose records indicate that they received the health treatment prescribed by their individual treatment plans
    3) Percent of youth confined for more than 60 days whose records indicate that they received the mental health treatment prescribed by their individual treatment plans
    4) Percent of youth confined for more than 60 days whose records indicate that they received substance abuse treatment prescribed by their individual treatment plans

D. Respond in an appropriate and timely manner to the new and chronic health and mental health problems of youth in confinement.
    1) Percent of youth who report receiving at admission written and oral instructions for obtaining health, mental health and substance abuse care.

2) Average duration between when youths filed a sick call request and the time they were seen by health care personnel, qualified counselors or mental health care providers
3) Percentage of youth whose records indicated that they required urgent off-site medical services who received the services in less than an hour

E. Promote continuity of treatment for youth undergoing treatment at the time they leave the facility.
1) Percent of youth undergoing treatment for a chronic or acute illness, injury or medical condition at the time of their release who have arrangements for continuation of treatment in their reintegration plans
2) Percentage of youth undergoing treatment for a mental health problem at the time of their release who have arrangements for continuation of treatment in their reintegration plans
3) Percent of youth undergoing treatment for substance abuse problem at the time of their release who have arrangements for continuation of treatment in their reintegration plans

F. Provide a clean and healthy environment where confined youth are safe and ensured adequate nutrition and exercise.
1) Percent of youth whose records indicate that they have been abused or neglected by staff
2) Injuries to youth from (a) other youth and (b) staff per 100 person-days of youth confinement
3) Incidents of suicidal behavior per 100 person-days of youth confinement

IV. JUSTICE

A. Operate the facility in a manner consistent with applicable regulatory, statutory and case law requirements.
1) Grievances or complaints filed per 100 person-days of youth confinement, or per 100 staff-days of employment
2) The percent of interviewed staff and youth who filed a grievance or complaint who received a hearing

B. Ensure that youth, their custodians and other appropriate parties know their legal rights and how to protect them.
1) Youth understand facility rules and their legal rights
2) youth know how to pursue their legal rights

C. Administer the rules and policies for staff and youth fairly and consistently and offer effective means of redress of grievances or violations of rights.
    1) Percent of interviewed youth who believe that grievances are fairly, consistently and effectively redressed.
D. Provide confidential and reasonably prompt communications between youth and their lawyers and to make youth available for legal or administrative proceedings.
    1) Percent of youth who report that they have timely and reasonable access to their attorneys when requested
    2) Attorney visits per 100 person-days of youth confinement
    3) Percent of person-days of confinement during the assessment period attributable to missed hearings or administrative proceedings

John H. Chafee Foster Care Independence Program
Draft Performance Measures

✦ Performance Measure 1: Increase the percentage of youth who have resources to meet their living expenses.

✦ Performance Measure 2: Increase the percentage of youth who have a safe & stable place to live.

✦ Performance Measure 3: Increase the percentage of youth who attain educational (Academic or Vocational) Goals.

✦ Performance Measure 4: Increase the percentage of youth who have positive personal relationships with adults in the community.

✦ Performance Measure 5: Increase the percentage of youth who avoid involvement with high risk behaviors.

✦ Performance Measure 6: Increase the percentage of youth who are able to access needed physical and mental health services.

✦ Performance Measure 7: Increase the percentage of youth who have or know how to obtain essential documents.