

Rhode Island

Department of Children, Youth and Families

Concept Paper

Developing an Integrated Family and Community System of Care for Rhode Island

5-2-07

RHODE ISLAND DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

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I. INTRODUCTION

In this concept paper, the Rhode Island Department of Children, Youth and Families (DCYF) describes its goals and preliminary plans for introducing integrated Family and Community System of Care (FCSC) into DCYF's community services for children and families at risk. The care coordination of six current DCYF programs will be consolidated into the functions of one or more Family Care Coordination Partnerships (FCCPs). The six current programs are: Child and Adolescent Service System Programs (CASSP); Children's Emergency Services (CES); Project Early Start (PES); Project Hope; Positive Educational Partnerships (PEP); and Title IV-B.¹

FCSC will be a "wraparound" model of service planning and delivery. In the wraparound model, services and supports are "wrapped" around each child and family according to their unique needs. These services are flexibly adjusted as their needs change. Wraparound is driven by established system of care principles that call for coordinated, flexible, individualized, family centered, community based and culturally competent services.²

FCSC will include flexible wraparound funds and a family centered method for purchasing family support services and interventions. At its core the FCSC wraparound model is strength based, always seeking to identify the strengths of a family, no matter how challenged that family

¹ CASSP is a home-based family support and intervention program; CES is a Child Protection Services (CPS) urgent assessment and stabilization program; PES is a home-based parent training and support program for children 0-3 years of age in low income families; Project Hope is a home-based family support and intervention program for adjudicated adolescents returning home from the Rhode Island Training School; PEP is a school-based prevention that includes care planning for elementary school students in need of family support and intervention; Title IV-B funds Project Family, a family support program for CPS-involved families, and the Washington County Juvenile Justice Project, designed to prevent court involvement of 11-17 year old youth. Please see Appendix A for a more detailed description of the populations and services of these programs.

² Stroul, B. and Friedman, R. (1986).

might be. Building on strengths is the key to making gains, and hence this is emphasized even when child protection issues are significant. For those families whose children are safe, there can be autonomy to select, supervise and change service providers to improve services. For other families with children whose safety is at risk, ongoing strength-building may be required before they can make these decisions on their own. The goal is for families to be at or get to a “place” where they plan their own services with their provider team in a process that is based on the principles of Family Voice and Choice.³ For those families in which child safety has been an issue, a collaborative assessment by the FCCP and the family will determine the family’s role in purchasing services or selecting providers with the primary goal of identifying necessary services and supports to ensure the child’s safety in the home. In every case, care planning must be child and family centered and must include a specific set of supports and services that are wrapped around the family in ways that are respectful of the challenges of parenting and of what parents want for their children.

The FCSC will include three main organizational components: Family Care Coordination Partnerships (FCCPs); a Fiscal and Data Agency (FDA)⁴; and Family and Community Advisory Boards (FCAB). The FCCPS will engage families and coordinate care through Care Planning Teams. Managed by the FCCPs, Care Planning Teams (CPTs) will engage families in determining goals, identifying needed services and in managing family service and support budgets. The needed services that are not available through other funding streams will be purchased by the FCCP using Flexible Fund dollars. The FDA will manage the accounting of Flexible Fund dollars, collect individual client demographic and encounter data and produce aggregated family demographic, utilization and outcomes data, and support the service system by finding and credentialing service providers in collaboration with the FCCPs. The FCABs will be a new, system-wide iteration of the CASSP LCCs, and will serve an advisory function for all of the services in the Family and Community System of Care.

This phase of FCSC development will be the beginning of a DCYF service system transformation that is designed to result in more effective and seamless services for families that moves Rhode Island closer to the wraparound fidelity mode of family-directed care. In the past,

³ Salls, M. and VanDenberg, J. (2007). Moving from collaboration to integration. Training conference presentation, January 17-18, 2007, Warwick, RI.

⁴ Please note that the term Administrative Services Organization (ASO) has been replaced with the term Fiscal and Data Agency (FDA) to better reflect its systems support (as opposed to decision-making) role and changes to its role based on community feedback. Its new role is described in the following pages.

most families would have been assigned to one or more independent service programs. In FCSC, services and funds will follow the child and family. DCYF will make it a priority to ensure that the aspects of the current system that are working well will be preserved and enhanced through community integration and greater care coordination. With this concept paper and through an extensive series of community focus groups, DCYF has sought input from youth, families, service providers and other stakeholders in the children's service system in order to further develop and refine this plan.

II. BACKGROUND

A. Current Gaps

Rhode Island's current system for serving children and families is a nationally recognized model of family centered care. It has many strengths but it also has limitations that DCYF is trying to address with these changes. These are identified below:

- Intensive Family Intervention and Stabilization programs have not been sufficiently individualized. Too often, the family must fit into a specified program with limited availability, one level of intensity, and a fixed length, rather than getting individualized services;
- Access to critical services, such as parent aides, substance abuse services and outreach and tracking, is limited because they are not available in sufficient quantity to meet the need on a timely basis;
- Local Coordinating Councils that currently guide CASSP programs differ in the monitoring and technical assistance they have received from DCYF and in their staffing levels, resulting in different levels of progress in implementing family driven wraparound care; and
- There is insufficient coordination and integration among DCYF's children's behavioral health and family preservation programs, leading to unnecessary obstacles in accessing services, and fragmentation in service delivery for families and case managers who have to negotiate among them. For example, families have complained of having to repeat their stories to multiple providers and disclose often intimate and sometimes embarrassing details of the family history to case managers and other staff they hardly know.

B. Moving DCYF to the Next Level of Family and Community Service Coordination

FCSC is totally consistent with the values and principles of family centered and family driven care.⁵ Rhode Island has made great progress in implementing wraparound and system of care practices. FCSC will more fully realize these values by:

- Modifying contracts to require providers to develop plans for more individualized services with more flexible payment methods;
- Expanding the number of people available to provide support and skill-building services to families whose children are at risk of abuse or neglect (such as respite and parent aides) by employing friends and family who are not directly employed by human services providers, but who are willing and qualified to provide needed services to a specific child;
- Creating Family and Community Advisory Boards (FCAB) to partner with DCYF's redesigned service system. These Boards will have membership that includes families involved in family preservation and families with children facing the challenges of serious emotional or behavioral health issues. The function of these Boards will be similar to CASSP Local Coordinating Councils, and they will be challenged to strengthen, integrate and ensure the quality of each community's children's service system;
- Integrating care by braiding⁶ funding streams and consolidating service coordination functions.
- Expanding federal Medicaid funding to include CASSP services.

The Department intends to implement FCSC on a phased basis, beginning with services for children at risk of being removed from their homes, children with serious emotional disturbance, very young children at risk and adolescents at risk for court involvement or who are returning home from placement at the Rhode Island Training School. This system will give DCYF and the contracted providers more flexibility in working with families in developing their service plans.

To achieve these goals, DCYF proposes to conduct two procurements to create a consolidated FCSC system: procurement of four or more Family Care Coordination Partnerships, and

⁵ Toward an Organized System of Care, Task Force Report. January, 2003.

⁶ Braiding is the process by which major sources of funding (such as Medicaid, IV-B and general revenue funds) are structurally integrated to fund an initiative such as FCSC.

procurement of a Fiscal and Data Agency to support the system through financial payment, accounting, data management and service system development. These procurements will braid funds from the current Comprehensive Emergency Services (CES), CASSP, PEP, Project Hope, Project Early Start (PES) and two Title IV-B contracts (Project Family and the Washington County Juvenile Justice Project). Where appropriate, these funds will be accounted for separately to preserve adherence to federal and state requirements as well as the integrity of the different services and program functions they were designed to purchase. Care coordination contracts will include clear specifications for timely access, assurances for child safety and protection, engagement with the full range of families in the service population, and reporting of child and family outcomes.

DCYF believes that it is important to preserve and expand upon the community partnerships that have developed through the current CASSP Local Coordinating Councils, and seeks to maintain eight local service coordination sites. DCYF will establish no less than four FCCPs. Each FCCP must have a local presence in each of the key communities that make up the four DCYF regions, e.g. both Woonsocket and Pawtucket for Region IV. DCYF strongly encourages partnerships among providers in each region to assure that providers, who are well known in these communities for meeting local needs and the unique demographics of their community, are able to continue to serve children and families. A single provider can apply to be an FCCP in more than one region, but the provider will be required to write a separate proposal for each distinct FCCP. DCYF will have the discretion to award fewer FCCP contracts than all those that a single agency or collaborative has applied for. DCYF recognizes the value that provider partnerships can bring in meeting the different needs among the target populations, and encourages interagency collaborations and/or joint ventures that offer creative solutions to the challenge of consolidating and integrating care coordination.

C. What the Research Says About Wraparound Service Outcomes

Wraparound systems of care, when implemented with fidelity to core principles and procedures, have been shown to produce outcomes for families and children that are significantly better than more traditional programs.⁷ These include:

- Decreased risks and increased safety in families
- Decreased mental health symptoms

⁷ Salls and Vandenberg, *op. cit.*

- Increased protective factors in families
- Improved family engagement in services
- Increased permanency and stability for children
- Improved behavior
- Improved outcomes in school and early care settings
- Increased family resources to support their children
- Increased family satisfaction with services

D. Family and Community Care Coordination vs. Traditional Care

In traditional service provision, the state determines a family's eligibility for services and contracts with providers for a defined set of services to the child and family. Often the services are organized as a program with all families receiving the same intensity and amount of services at a defined location. The family participates in the assessment and service planning with providers or state staff, but has access only to the traditional providers and programs purchased by the state. Should the family be dissatisfied with the services, or should the nature of their needs change, they must work through the authority of a provider or a case manager to make changes. As a result, traditional methods often lack the flexibility needed to tailor and continuously adapt services to meet family needs. Adding flexible funds to this model increases individualization, but expenditures continue to be controlled by a case manager or program director, which can be disempowering for the family, and may cause delay in making needed adjustments.

With the family centered model of family care coordination proposed here, the goal is for families to have or be able to develop a more direct role in developing treatment plans and selecting from a wider variety of services. Not all families are willing or ready for this level of autonomy right away, but a number of them are. Many families will be able to make use of FCSC to improve their level of autonomy over the course of intervention.

Eligibility will still be determined at the point of DCYF referral or FCCP intake. Family Service Coordinators (FSC)⁸ will work with the family to assess their individual needs, and develop a

⁸ Note that we are only using the term "Family Service Coordinator," rather than also the term "Care Coordinator," used in our first concept paper draft to capture the current "Care Manager" child protection function. The team of FSCs in each FCCP will serve the coordination functions called for in each current service, necessitating an FSC staffing in each FCCP that has a range of

service plan. "Family Service Coordinator" is a generic term that combines all the functions of case coordinators, case managers and family service coordinators currently operating in all of the programs that will be part of the Family and Community System of Care. FSCs will include parents of consumers in the DCYF system as well as individuals with education and training (such as B.A. or M.A. level) who may not have children. FCCPs will be required to employ the full range of these coordinators and provide them with cross-training, so that their FSC staff can meet the needs of all the populations served by the FCSC. Families requiring highly specific skills, such as those required in intensive child protection, early childhood parenting or juvenile justice will be matched with the appropriately qualified FSC. All FSCs will have sufficient cross-training to be able to back each other up, and are expected to develop expertise in all areas through FSC team supervision and daily interchange. FSCs will be supervised by child-family competent Master's level clinicians, who will also step in to provide assessment assistance for families with complicated clinical or protective issues. The clinicians will also be culturally competent in the diverse communities they serve.

The needs in the service plan that cannot be addressed through entitlements or other community services and natural supports will be translated into individual family budgets. Approved family budgets will be transmitted to the FDA. Once the FDA confirms the request and availability of funds in the family budget, the family will convene their Care Planning Team (CPT), made up of the FCCP Family Service Coordinator, local stakeholders, and providers already working with the family to develop a care plan that will allow the family to access the funds in their budget flexibly, for services from any approved provider, and for goods designed to improve family functioning and ensure the child's safety when the family is referred from the Intake Unit at DCYF. The FCCP will be accountable to DCYF for the service plan involving children who are at risk. Under this model, families can select from a wider range of services and providers and the FSC/FCCP will assist the family with the purchase of the requested intensity, timing and location of the needed services. Through their contract with DCYF the FCCPs will be expected to accept all referrals. Service providers will also be contracted to accept all referrals when they have capacity. The FDA and the FCCP will communicate closely to ensure that services are delivered according to plan and within family budgets, with monthly budget reports from the FDA. The FDA will pay providers for approved services on a monthly basis.

FCCPs will collect family demographic data at intake and individual encounter data once

skills appropriate for the different populations and coordination of services provided, of which child protection is one example. This will be described in the following pages. Please see Attachment B for a list of specific duties of the FSC.

services have begun. They will forward this information to the FDA weekly. The FDA will aggregate these data across the state, and send monthly reports to DCYF for analysis and reporting.

It is helpful to consider the FDA as providing a family and systems support function rather than adding another layer of administration. The FDA does not make service or funding decisions, and operates side-by-side with and at the same organizational level as the FCCP. The FDA is not a managed care organization, and will not reap a profit from any savings in the system. The cost of the FDA and the FCCPs will come from current LCC/CMHC contracts, and will also be garnered through the efficiencies of more centralized data systems and more integrated coordination systems. These savings will also be plowed back into the service system, to expand needed services in the system.

The family, with the help of the Care Planning Team, can change providers as appropriate if the service is not accessible or satisfactory, to respond to a crisis or changing needs, or because a better alternative has become available. In some cases, the family may become the employer of record, with support from the FDA regarding contracting and tax reporting. This will foster direct communication between the family and their service providers, with the coordination and guidance of the FCCP.

The FDA will report expenditures against budget to family Care Planning Teams so that families don't end up without access to needed services at the end of the budget period. In addition, the FDA will have a primary network development function, working together with the FCCPs to locate specialized and family support services needed to meet the individual needs of families. The local Family and Community Advisory Boards will also provide service access information from their community. The goal of network development is to develop as comprehensive and diverse an array of community based service providers as possible - one that provides multiple options for the unique needs and cultures of each community. The empowering nature and flexibility of this model will add new services and preserve the integrity of services that are already working, which will increase family engagement, choice, participation and satisfaction with services. Rhode Island has already proven that this type of self direction works.⁹

⁹ Since 1986, Rhode Island has had a consumer driven personal care program serving adults with physical disabilities with state only and Medicaid waiver funds. In 2004, the Department of Human Services implemented a Center for Medicare and Medicaid Services funded Community-Integrated Personal Assistance and Supports (CPASS) program for children with special health care needs. In 2006, the Department of Human Services received a Robert Wood Johnson grant to broaden the program, establishing

III. FCSC IMPLEMENTATION

A. The Current System

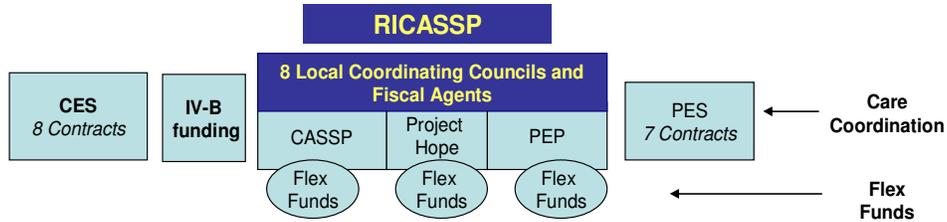
Programs to be included in Phase 1 include the six current programs that DCYF plans to transform into the Family and Community Service System, **CES, Title IV-B, CASSP, Project Hope, PEP** and **PES**. (See diagram on the following page). Each of these programs seeks to build on family strengths to enhance each family's capacity to provide for their children's needs. They also work with families as members of a broader community to identify and develop natural supports in their extended family and community.

In current CASSP programs, Local Coordinating Councils are composed of 25 members and include representatives of families with SED children, specialized mental health and community children's providers, members of the general community with an interest in serving this population, and up to two representatives of the fiscal agent. One member of the LCC represents the CES program serving the region. School representatives are being added as part of the implementation of the PEP program. RI CASSP is a statewide organization with two members from each of the LCCs, and provides a means for the LCCs to coordinate, support each others' learning, and identify common issues that affect their progress. These LCCs and RICASSP will be transformed in the FCSC to better represent the full range of families in the FCSC, and will have a more advisory and quality improvement set of functions. LCC-type functions will be carried out by FCABs, and the functions of the new Statewide Advisory Board will be similar to those of the current RI CASSP, which it will replace. It is anticipated that some of the membership of these Boards will remain the same as before

a Medicaid Cash and Counseling Program, known as Personal Choice, to also serve adult disabled and elderly. The state procured a fiscal/employer agent for the expanded program. These programs primarily cover personal assistance services, allowing participants to directly control who will provide these highly sensitive, personal services in their homes. Positive experience with these models provides a strong foundation upon which to build the new FCSC system.

Current System

DCYF Programs Proposed for Family Directed Care



B. The New Family and Community System of Care

1. Goals of the Family and Community System of Care

In redesigning these public children's safety and wellness services, DCYF will create a system infused with family centered, family driven values and principles to reach the following goals:

- Child safety
- Family permanency
- Individualized and responsive services
- Timely access to services
- Quality of care driven by core standards
- Family centered practice
- Family driven service planning
- Strength based partnerships with families
- Integrated services that are community based
- A seamless service continuum with step down and ongoing support
- Enhanced parent peer support, e.g. 'Circle of parents'
- Family self-sufficiency, including connections with natural supports
- Culturally competent responsiveness to diverse cultures, communities and languages
- Reduced recidivism
- Reduced recurrence of maltreatment

2. Pathways to Care in the new system

The diagram on P. 13 shows details of the proposed "pathways to care" in the redesigned system.

Children eligible for DCYF services and not in DCYF “legal status” (e.g. not in the legal custody of DCYF) will enter or be referred to the Family and Community System of Care. DCYF Intake Unit workers will refer families whose investigations indicate the child is “at risk” but no legal action will be taken (meaning the family still has child custody). Intake workers will determine if families need and can benefit from community based support and intervention services and refer them to the FCCP serving their community. In situations where a report of abuse or neglect is substantiated, the case will be opened by CPS and will continue with FCSC and/or other services when indicated. The FCCP will be required to provide timely intervention to families for these referrals. FSCs assigned to CPS referrals will have the necessary experience and training to monitor for child abuse or neglect and report these child safety issues to CPS as required by law. Monitoring of child safety and of possible family abuse and neglect will continue to be a priority, especially for families in which this may have been a pattern. Children with SED or young children determined to be at developmental, health or social-emotional risk can be referred directly to the FCCP by families, community agencies, health care providers, schools, early care and education programs, and other programs serving children and families. Priority access to FCCP or community services will be given to those families in which there is a safety risk or very serious issues.

This system consolidates current coordination functions, but does not limit current access. Families will continue to come into the system through the same points of access as they have before, as well as into expanded services through whatever door they are most comfortable with. While some programs, such as CES, for example, will no longer exist per se, all of the functions and services of those programs will continue, as will the funds that have been designated to support those functions and services. It is planned that the service system or the population served will not be reduced, but rather expanded through the efficiencies of a more highly integrated and coordinated system.

All FSCs will be cross-trained to have the ability to provide quality service to the range of families in the system. The FCCP will assign an appropriately qualified FSC to families where the children’s safety is at risk, as well as to families with SED children, very young children, or adolescents in or at risk for juvenile justice involvement. FCCPs must ensure that their FSC team has resources for consultation or service in areas requiring special expertise, and that the FSC team has regular opportunities for team supervision and exchange of knowledge.

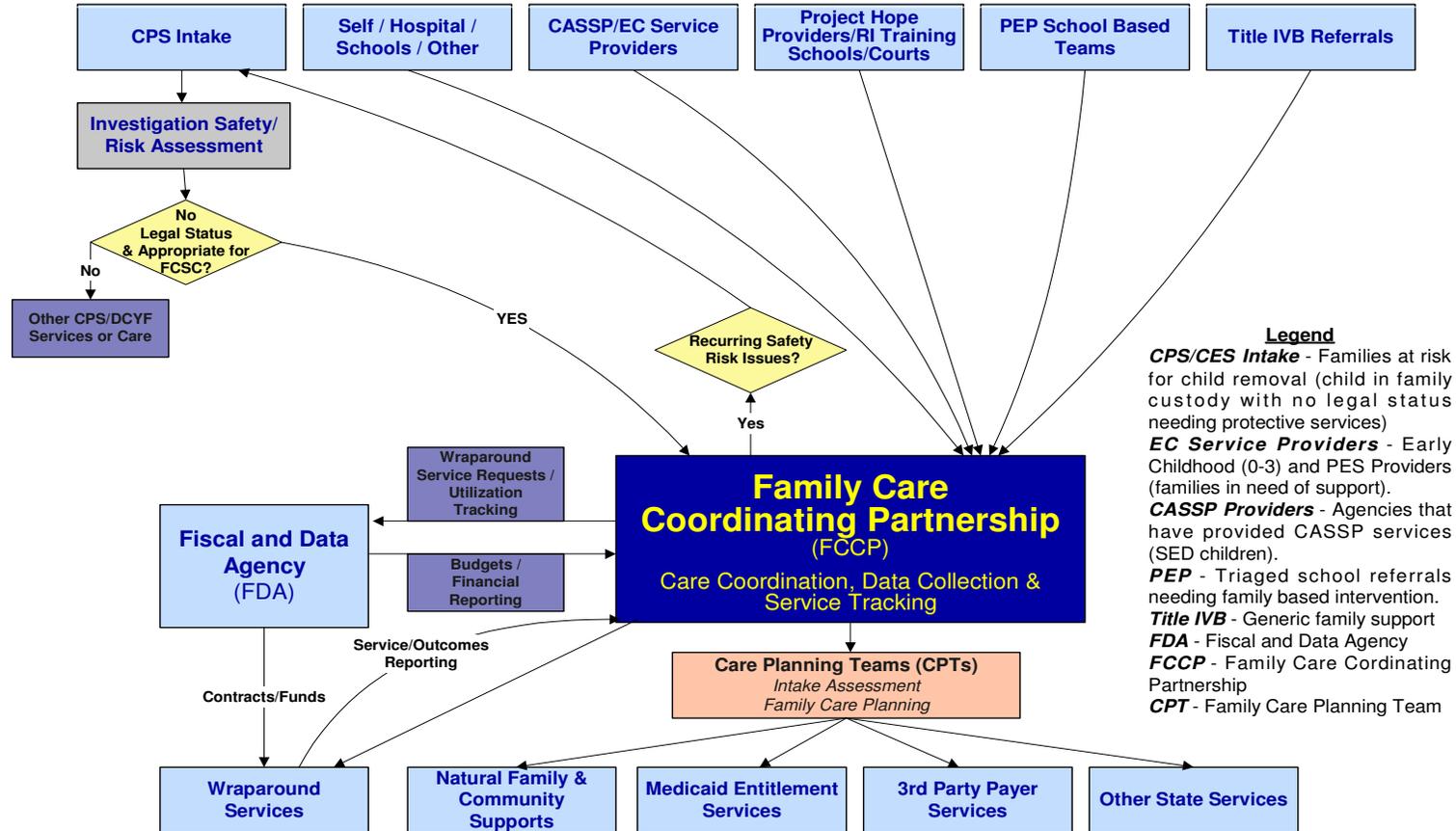
Families in crisis who are referred by CPS will receive immediate short-term (30-90 days) family intervention and stabilization services designed to engage and motivate the family to undertake

longer term efforts to reduce risks to their children. When needed urgently, these services will be provided immediately by the FSC and/or purchased with Flexible Funds for stabilization until the Care Planning Team process is in place for the family. The assigned FSC will communicate the family's status to the CPS Intake Unit according to protocols and procedures specified by DCYF. Once any crisis has been stabilized, the FSC will facilitate a comprehensive family needs assessment, bring in clinical expertise for assessment as needed, and determine options for further service. If ongoing needs are identified, the FSC will assist the family in taking as much responsibility as is appropriate to convene a family team and direct the service planning process. The assessment will include the expertise of a Master's level supervisor whenever appropriate. If a family has been assessed previously, for example in CEDDARS, the previous assessment(s) will be collected, reviewed and updated rather than duplicated. Pathways to care are depicted on the following page.

The FSCs and families can consult the FDA for a directory of credentialed services, or for help locating other needed services. The need for service funds will be identified, a family budget will be developed,¹⁰ and services and supplies will be purchased as planned by them and their team. FSCs will remain involved to maintain family engagement, provide home and community based support, and assist families to access entitlement and community services, monitor progress on any safety goals, and manage Flexible Funds. Flexible Funds will be used when no other payer source is available. Service plans will be reviewed and updated periodically until such time as service and safety goals have been met.

¹⁰ Please see attachment B for examples of possible Flexible Fund goods and services purchases.

RI Family and Community System of Care Referral And Service Pathways



3. Care Coordination Overview

The FCCPs have primary responsibility for integrated care coordination. The core functions of the FCCP will be strengths based child and family needs assessment, service planning, care coordination, and data collection, aggregation and reporting (services, client demographics and outcomes). Each FCCP must work with its local Board and the FDA to support development of comprehensive care coordination services and a diverse network of providers supported by different payers. With DCYF as payer of last resort, the FCCP will make maximum use of third party payments, entitlement services and natural supports. Though the target populations of the CES, CASSP, PEP, Title IV-B, Project Hope and PES programs differ (with some overlap), FCCPs must assess each family's unique needs and access a comprehensive set of individualized services and supports. FCCPs will be responsible for providing regular reports to involved DCYF staff to keep them informed about child safety status, family service utilization and progress. This includes documentation of cash payments and services utilized (supplied by the FDA), so that these are not duplicated elsewhere in the system.

The system will no longer be characterized by programs, but rather by services for specific population needs. DCYF will contract with FCCPs and/or FCCP collaborations that have the capacity to meet the differing needs of the entire range of families included in the target population. Providers will be expected to hire culturally competent Family Service Coordinators who are experienced and trained in working in specific services with specific populations. The FCCPs must have the capacity to collaboratively engage parents who may appear resistant, or who have substance abuse or mental health issues that can increase the potential for abuse or neglect. In all instances, clinically indicated continuity of FSCs and services for families will be a top priority as families move through the system, both during the transition to the new system and in ongoing family service work. It is a core value of the FCSC that quality services and child and family outcomes be achieved through consistent partnerships between families and their service providers.

FCCP organizations must have well developed policies and procedures for ensuring children's safety and referring protective cases to CPS when necessary. Contractors must train their case Family Service Coordinators to translate the portion of any service plan that includes services purchased through Flexible Funds into family budgets, and to support families in managing their budgets. The FCCP must also have the technical capacity to collect and aggregate client demographics, outcomes and service utilization data and transmit them electronically to the FDA.

DCYF encourages local collaborations that integrate the strengths and features of community

based providers into an integrated model. It is DCYF's goal to achieve systems change that to the greatest extent possible results in an increase in high quality service providers to continue to do what they do well and expand capacity to improve family strengths and skills through the use of community-based formal and informal supports. A key FCCP function will be to work with the FDA to help enhance and expand a network of providers that have established expertise in specific services and are uniquely suited to the needs and cultures of their communities. Each of the local or regional service sites will also work closely with their local Family and Community Advisory Board.

4. Required components of Care Coordination

- a. Provide and/or coordinate critical services for children and youth, which include, but are not limited to family stabilization, service coordination, system navigation, wraparound flexible fund purchases, and facilitating access to both non-traditional and agency-based supports and services;
- b. Maintain 24/7/365 emergency beeper coverage for families enrolled with the FCCP;
- c. Maintain care goals of safety, well-being, success, and permanency for children and youth in home, school and community;
- d. Report all instances of suspected abuse or neglect to CPS.
- e. Promote strength based voice and choice for child, youth and family at all levels of the process, information provided, practice and service options, and the organization of the system of care;
- f. Demonstrate high levels of flexibility in approaches, funding, and service provision;
- g. Manage and track Family Care Planning Team meetings for each family served;
- h. Maintain documentation of Family Care Plans;
- i. Conduct case management and coordination in a strength based, family centered, family driven and culturally competent manner through a wraparound team-based process in which youth and families participate as partners;
- j. Maintain accurate and confidential client records
- k. Perform Quality Assurance record reviews at least bi-annually;
- l. Maintain a culturally competent staff familiar with communities served;
- m. Obtain and document consent from youth and families to participate in the program and outcome evaluation;
- n. Maintain up-to-date contact information for the families involved; and
- o. Adhere to State and Federal regulations, DCYF performance standards and CASSP system of care principles.

DCYF fully recognizes the issue of continuity during transition to the new system, not just for families with their providers, but for current care coordination and direct service staff. DCYF is committed to minimizing disruption for staff, who may be hired by the new FCCP in their area, or who may continue to work for an agency that has a subcontract for services with the new FCCP. It is clear that neither access nor services will be reduced, nor will there be a diminished need for services. Hence any individual providing quality services has reason to believe that there will be a strong chance of continued employment, either at the same or a different agency.

5. QA/Program Evaluation for FCCP

Program Evaluation and Providers

Child welfare has increasingly placed greater importance on child, family, and system outcomes in the child welfare system. Quality Assurance and program evaluation outcomes, integral in other disciplines (ie public health, education, etc), have recently become an integral part of the child welfare system.

Toward that end, RI DCYF and its child welfare community partners endorse program evaluation and efforts aimed at assessing child welfare outcomes. A step in this process has been the development of the Data Analytic Center as well as the collection of data and performance indicators and reporting out on those measures by the DAC. Building on those efforts and in step with the development of the FCCP, is the adoption of a valid instrument(s) uniformly conducted throughout the child welfare system aimed at assessing outcomes.

The objective/purpose of the instruments:

1. To provide data and information for program evaluation outcomes on the child, family, and system level
2. To assist in guiding the treatment/program plan

Intended Use/Frequency:

Given the proposed structure of the FCCP, the assessment could occur in at least two stages.

Stage 1:

The initial stage of assessment would occur at the FCCP level, upon child and family entry into DCYF. At this stage, FCCP would administer the baseline assessment instrument. The assessment would be a validated broad-based, multi-system (child, family, system level) assessment administered to all youth and families. The findings would serve both objectives as noted above, baseline data to assess impact outcomes, outcomes revealed after receiving services, and assist in guiding the treatment/program plan. Upon discharge, the FCCP would re-

administer the instrument, allowing for comparisons between baseline and discharge outcomes. The outcomes (detailed below) would be on the child, family and system level allowing for the assessment of changes in child function, family function, program function and system function.

Stage2:

The second stage would be an assessment(s) based on the FCCP broad-based assessment findings and would vary depending on the needs of the child and family. For instance, based on the initial broad-based assessment findings if a family had mental health areas of need, the assessment may be more mental health based.

6. Fiscal and Data Agency (FDA) Overview

The FDA will manage accounting for all of the Flexible (wraparound) Funds currently managed in the six programs: CASSP and PEP fiscal agents, Title IV-B funds, funds that are part of Project Hope and those that may be designated for CES and PES families. The FDA must have the capacity to account for service dollars according to the different funding streams that DCYF administers, as well as for the budget of each family. For example, PEP funds will have to be accounted for separately to ensure accurate reporting on use of the SAMHSA grant funds that finance it. The FDA will not be managing any other funds besides the service and wraparound funds. The FDA will not have any involvement in deciding what services are purchased, at what level of intensity, for whom or for how long. This responsibility will be that of the FCCP, parents and the Care Planning Team. DCYF will determine the amount of the wraparound funding account for each FCCP, as well as the amounts for wraparound Flexible Funding from each of the current funding streams for the six merging programs. The FDA will help ensure that where possible services are funded by third party payments: e.g. RIte Care or straight Medicaid.

The FDA will be responsible for working with the FCCPs and Local Boards to develop a network of individuals and organizations that are trained and experienced in providing family¹¹ support and wraparound services. It will recruit, credential and contract with qualified providers of a wide variety of services that families are likely to need. It will maintain a directory of approved services and providers that care coordinators, treatment providers, and families can access easily and quickly in seeking needed services. The FDA will have the ability to screen and report on the employment of individuals providing services. The FDA will also work with families and FSCs to locate unusual or hard to find services. The FDA will respond to the unique needs of local communities, as identified in conjunction with the local and statewide

¹¹ *QA/Program Evaluation for FCCP –Item Measures – Please see Attachment C*

Boards, through active development of new services and supports.

Once a service plan has been developed and the need for Flexible Funds has been identified, the FSC will develop individual budgets for families from their agency's allocation of the funds for the specified target group. The Flexible Fund pool will be held by the FCCPs. Payments to the selected providers will be applied to the budget for services provided to a specific family. Weekly reports will be provided to the family and the family's FSC to account for the use of funds. The FDA will develop reports to provide ample warning to families and their care coordinator when the budget is at risk of being overspent or when resources are not being utilized.

DCYF will contract with, manage and oversee the FDA. The FDA will have periodic meetings with DCYF, and as necessary the Statewide Board, to review its performance in supporting the Family and Community System of Care. The FDA will provide a monthly, and semi-annual reports needed for the state and the state Board to monitor expenditure rates, clients served, and services purchased. In addition, it will provide a specified number of ad hoc reports to the state Board and to DCYF to inform the CQI process and the process of identifying gaps in service and recommending approaches to meeting them.

7. Required Components of the Fiscal and Data Agency Scope of Work

a. Accounting, Information and Record Systems

- Establishing the managing the accounting and information systems necessary for authorizing, making payment and managing information, in accordance with generally accepted accounting principles and all Internal Revenue Service and Department of Labor (IRS-DOL), Medicaid, State and DCYF requirements

b. Eligibility Determination

- Evaluating the possibility of child and family health insurance coverage and eligibility for Medicaid and other entitlements
- Informing the FCCPs of pathways to those services

c. Providing Financial Services to Families

- Monitoring family budgets and updating family and family team with family-friendly monthly and Year-To-Date financial reports, with real-time reports upon request
- Assisting families with the payments and any needed tax documentation where

families serve as employers of record (Unemployment, FICA, etc.)

d. Funds Management and Monitoring

- Managing and accounting for revenue from multiple State and Federal funding streams
- Rate setting for services, subject to DCYF approval
- Claims payment/adjudication for vendors

e. Supporting Network Development

- Approval/"Credentialing" of flex fund providers, including DCYF Criminal background checks
- Maintaining an updated approved provider list

f. Reporting

- Reporting family service utilization and budget financials to the FCCP (which reports the data to Care Planning Teams), weekly and upon request
- Reporting service demographics, utilization, costs, outcomes and satisfaction per family and in aggregate on a monthly basis
- Preparation of all needed federal and state tax reports needed for families
- Reporting on project activities to DCYF on a quarterly, bi-annual and annual basis.

8. State and Local Family and Community Advisory Boards

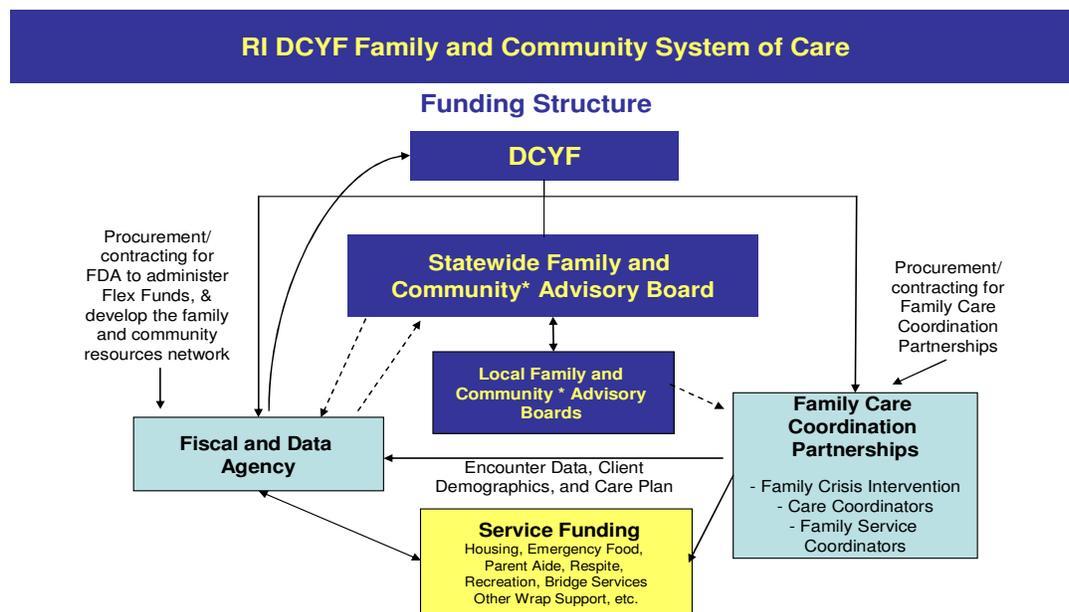
The advisory and coordinating structure for the Family and Community System of Care will be similar to the LCCs of the CASSP programs. The role of the existing LCCs will be expanded in the new Family and Community Advisory Boards (FCAB). The FCABs and the State Board will include representation of all populations to be served, so that Boards can respond to all community voices and develop an integrated perspective. FCABs will communicate with the State Board to ensure that the overall system will continue to be adjusted according to the needs of local communities. DCYF's intention is to make use of the commitment and knowledge of family and community stakeholders to improve the ability of the children's service system to individualize care on a family and community specific basis.

Local Board responsibilities will include general oversight of services for all families served in this system. Among the FCAB goals are to ensure culturally relevant staffing and practices, family centered intensive intervention, stabilization and case management for at-risk families, and family driven and youth guided service development for families of children with SED and

or other needs. Local Boards should also identify gaps in services, monitor quality and utilization of services, and inform the State Board of local needs. Each of the FCABs may choose to have a subcommittee to address unique needs of at-risk families and another to address the needs of children with SED, while the State Board will concern itself with the entire range of child and family needs in the combined target populations. Each local Board will have representatives on the State Board, which will address state level issues and have an important role in overseeing the performance of the FCCPs and FDA and service needs. The State Board will serve as the informing body for quality assurance and review of data kept by Yale, by Placement Solutions, and other consulting agencies.

9. Governance and Oversight

DCYF will retain primary responsibility for all FCCP/FDA contracts and will manage the relationships and collaboration between DCYF and the FCCPs, the FDA and the State and Local Advisory Boards. The contracting and governance structure of FCSC is depicted below:



10. Financing the Family and Community System of Care

DCYF will pay the FDA for its administrative services. Flexible Funds will be administered from a separate Trust Account. DCYF will have ultimate responsibility for allocating flexible funds between target populations and designated regions. The FDA will support the allocation process with reports on approved budget and spending. FCCPs will develop methods for allocating services equitably and according to level of need from the pool for the families in its caseload. DCYF will also develop methods for reallocating funds between areas or regions on a periodic basis as needed, to ensure that all available funds are appropriately distributed and fully utilized.

Care Coordination functions will be Medicaid reimbursable when provided to Medicaid-eligible children. In addition, it may be possible to get Medicaid administrative support for certain of the FDA functions. Wraparound funds will be used when no other public or 3rd party sources of reimbursement are available. Any state funds that are freed up through efficiencies and better coordination of reimbursable services can support additional Flexible Funds. Start-up and transition will be funded by a limited one-time allocation of funds. DCYF will refine this financing plan as the system evolves.

DCYF recognizes the financial leverage provided by the current coordinating agencies to ensure that families receive the services they need. We hope that existing public-private partnerships, fund-raising and leveraging of different state and federal contracts will continue to support our families and communities. For families whose needs exceed Flexible Fund allocations, DCYF will continue to attempt to provide services and supports for those families through other funding sources, as before.

These plans may be affected by the policy and health plan changes included in the 2008 Budget, when passed. They will have to be adjusted accordingly.

IV. THE BENEFITS OF SYSTEM TRANSFORMATION

System transformation carries many challenges, and will require that the community and providers embrace system of care values. A system that remains static is one that will not survive. Rhode Island has successful models of family centered systems of care, and can look to the proven successes of other states. Just as the system requires flexibility, flexible and creative thinking will also be required of providers and the community to make this system flourish. Through collaborative vision and adaptation, the DCYF Family and Community System of Care will benefit children, families and community stakeholders through flexible, coordinated, family-centered and culturally appropriate community based services.

ATTACHMENT A
RESPONSIBILITIES OF FAMILY SERVICE COORDINATORS

Note that Family Service Coordinator is a generic term that combines the functions of all of those who are coordinating care in the current programs that will become part of the Family and Community System of Care. It will be incumbent upon FCCPs to employ an FSC staff that can respond both to these generic requirements and to the requirements of families with specialized needs, such those with very small children, those with safety issues, or those whose child is involved in juvenile justice.

- a. Meet with families, preferably in their home, prior to the initial planning meeting to offer support and information to families;
- b. Obtain HIPAA compliant consent (including Privacy Notice);
- c. Identify emergency or urgent needs according to protocols;
- d. Engage parents in strength based partnerships;
- e. Conduct strength-based family needs assessments;
- f. Link families to appropriate services and informal supports for their children;
- g. Provide informal child and family counseling;
- h. Engage and support families in the care planning process;
- i. Assist agency representatives and families to understand the service planning process; CASSP and wraparound principles, and each others' perspectives and concerns;
- j. Schedule and facilitate service planning meetings;
- k. Identify transportation or other supports that may be necessary for full family participation and assist the family in securing such supports;
- l. Identify providers for the service network;
- m. Document and revise Family Care Plans;
- n. Advocate with and for families within the care planning and care coordination process in a collaborative manner;
- o. Support family education, advocacy, and empowerment;
- p. Assist families to access parent advocacy organizations, including PSN and RIPIN, and work

collaboratively with them;

- q. Obtain documentation of needed release forms and safe confidentiality of client records;
- r. Follow up with team members on their assigned tasks resulting from the service plan and coordinate implementation of the service plan;
- s. Monitor child safety and make regular reports and reports of abuse or neglect to DCYF as required by law.

**ATTACHMENT B
FLEXIBLE FUNDS**

A. Examples of Services that can be purchased by Flexible Funds

CLINICAL SERVICES

Family Therapy
Individual Therapy
Dental Service
Scheduled Medical Service
Medication Assessment/
Management
Medical Insurance Co-Pay
Medical Supplies
Assessment
Specialty Assessment
Day Treatment

MENTORING

Agency Mentor 1:1
Agency Mentor 1:3+
Non-Agency Mentor

HOUSING

Rent/Mortgage
Security Deposit
Electric
Gas
Phone
Furniture

GOODS

Assistive Technology
Computer Hardware
Computer Software
Educational Equipment

INDIVIDUAL STAFF

SUPPORT

Tutor
Childcare Support
Babysitting
Attendance at Planning
Meeting

STIPENDS

Clothing Stipend
Food Stipend
Membership
Camp
Activity
Adult Education Course
Recreation

RESPITE

Agency Respite 1:1
Agency Respite 1:2
Agency Respite 1:3+
Non-Agency Respite

TRANSPORTATION

Cab Fare
Public Transportation
Vehicle Payment/Lease
Vehicle Repair
Vehicle Insurance
Vehicle Fuel

B. Examples of Individualized Services

- Purchase of ear muffs to block all sound. For purpose of soothing target child and allowing her to sleep.
- Alarm device for client and her 5-year old sister to assist with reduction of bedwetting
- Tutoring in math three hours per week to improve C.'s math skills so she can pass the test on the first day of school to be promoted into the next grade.
- Regular therapy sessions; approximately once per week, as a means of support for mother of identified client.
- Six months of dial up internet for mother to pursue degree on line.
- Instruct S. on how to repair her bedroom window and the dry wall that she damaged. This will include labor and materials.
- Monthly bus passes to provide transportation for mother to attend mental health services for herself.
- Family is moving into new residence and needs assistance paying first month's rent. Parent paid for security.
- One month intensive reading program.

ATTACHMENT C ITEM MEASURES

Safety, Permanency, Well-being

Multilevel – child, family, community/environment, system

Proposed child, family and system outcome data elements for comment

Below is a list of proposed child, family and system level process and impact outcomes that are of interest to collect. This does not suggest that all indicators listed would be collected, rather, the list suggests the nature of the items that would potentially be collected as part of the FCCP service of care system.

Capture the different levels of analysis – child, family, system.

Within each level, capture the following:

Child Level

- Demographics
 - Age, race, ethnicity, gender
- Age groups across population served
- Function :
 - Child behavior
 - risk behaviors to self
 - substance use/abuse, history of,
 - self harm
 - risk behaviors to others
 - Relationships with parents/caregivers
 - Relationships with siblings
 - Relationships with peers
 - School performance
- Child mental health (branch to different degrees of severity)
 - Diagnosis – psychosis, depression, etc.
 - Anxiety, anger control, etc.
- Strengths
- Child satisfaction with services (Family-centered practice scale, see system level)

Family Level

Parental/Caregiver

- Demographics
 - Age, race, ethnicity, gender
- Supervision of child(ren)

- Provision of developmental/enrichment opportunities
- Care-giving practices/style
- Parent/caregiver mental health (branch to different degrees of severity)
 - Diagnosis – psychosis, depression, etc.
 - Anxiety, anger control, etc.
- Parental/caregiver substance abuse
- Parental/caregiver satisfaction with services (Family-centered practice scale, see system level)

Family Function

- Family Safety
 - Absence/presence: physical abuse, sexual abuse, neglect, domestic violence between caregivers
- Family Interactions
 - Bonding with children
 - Expectations of children
 - Mutual support within family
 - Relationship between parents/caregivers

Community/Environment

- Housing stability
- Safety in community
- Habitability of housing
- Income/employment
- Financial management
- Food and nutrition
- Transportation
- Personal hygiene
- Learning environment

Program and System Level Factors - Includes Process Evaluation

- Family / Youth satisfaction via Family Centered Practice Instrument (validated)
- Program data will include information about:
 - referral source
 - referral type
 - discharge disposition
 - discharge placement
 - service plan characteristics
 - barriers to services
 - program-specific outcomes
 - child maltreatment status
 - juvenile arrest status
 - juvenile incarceration status
 - staff characteristics

- Service system data will include information about:
 - length of stay
 - continuity of care
 - placement stability
 - readmission rates
 - transition to more or less restrictive levels of care
 - length of time to engagement in appropriate services

Process

A. Stage I

Administration of the stage 1, broad-based measures would be administered by the FCCP at entry into DCYF and upon discharge from services and/or DCYF. This would allow for baseline and discharge measures. The FCCP would enter in the assessment and outcome data electronically. The information would then be analyzed by RI DCYF and the RI Data Analytic Center and report on outcomes to providers, family and youth involved in DCYF services. The submission of the assessment findings and outcome data would be electronically submitted and benefits are highlighted below:

- Matches the QA and program evaluation system to demands of a complex child welfare system with multiple parts
- Allows for timely data for all involved, the youth, family, provider, and DCYF
- Reduces data entry errors and enhances data integrity
- Reduces time for data cleaning and aggregation
- Reduces time for release of findings and results to better inform/guide service plans
- Allows for timely analysis of data and release of outcomes on the individual and aggregate level
- Allows for children and families to be tracked throughout the child welfare system. This will enable the ability to track progress over time and look at the data longitudinally

B. Stage II

Stage II involves assessments that may occur based at later stages in the youth and families treatment plans as well as services received by providers. The process for the capture of this information could be channeled to the FCCP.