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July 9, 2012

Mr. Bryan Samuels
Commissioner
Administration for Children and Families
U.S. Department of Health and Human Services
370 L'Enfant Promenade, S.W.
Washington, D.C. 20447
cwwaivers@acf.hhs.gov

Re: Proposal for FFY2012 Title IV-E Child Welfare Demonstration Waiver

Dear Commissioner Samuels:

The Commonwealth of Massachusetts Department of Children and Families is pleased to submit this proposal for a Title IV-E Child Welfare demonstration project. The Department would like to thank you for the opportunity to apply for a waiver in FFY2012, and we look forward to working with the Children's Bureau to negotiate terms and conditions.

As agreed, we request that this proposal remains confidential until such time as we notify you that the Request for Proposals to purchase the services detailed in our proposal has been released publically.

Sincerely,

A handwritten signature in cursive script that reads "Angelo McClain".

Angelo McClain, Ph.D, LICSW
Commissioner

Commonwealth of Massachusetts Department of Children and Families
Title IV-E Demonstration Waiver
Federal Fiscal Year 2012 Application

July 9, 2012



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Background and Waiver Overview

Over the past several years the Commonwealth of Massachusetts Department of Children and Families (DCF), in collaboration with the Department of Mental Health (DMH) has been working to redesign our congregate care system. The Department plans to begin purchasing residential and community-based services as a closely integrated array of services. As we will describe on the pages that follow, this new system offers families continuity of services and service providers whether a child is in a residential program “bed” or receiving services in their community, in order to better support community transitions and strengthen child and caretaker capacity.

This reform was initiated by the families we serve. Through family and youth engagement, we learned that families tired of telling their stories again and again ***and they want continuity and consistency in those who work with them.*** With the goal of meeting this need for families, the Department first looked within its own case practice model and implemented changes that minimize the number of staff assignments during the life of a family’s involvement with DCF. The Department then looked to the Building Bridges Initiative, as well as research in positive youth development and trauma informed systems of care, to reform the service provider system.

Together, DCF and DMH plan to:

- Jointly design, price, and procure residential program models that best support child, family, and system outcomes and incorporate family and youth engagement;
- Implement a structure for cross agency governance, administration and operations of residential services that supports future integration with home and community-based services; and
- Implement performance-based contracts that utilize fiscal incentives where feasible to leverage desired outcomes.

Significant planning, inter-agency collaboration, and stakeholder engagement has already occurred; therefore the Department is prepared to implement the new system over the next 6-12 months. In addition to traditional residential program services, the new service system will offer four new services: Follow Along, Stepping Out, Continuum, and Family Partners, all of which aim to improve transitions into the community, strengthen child and caretaker capacity, and improve continuity of care.

1. Description of the waiver project

Despite Massachusetts being a leader in the development of structures and processes to better coordinate services to create a more seamless service delivery system, Massachusetts Health and Human Services Agencies still have to employ micro-level service coordination strategies to surmount the institutionalized fragmentation of the system that is a consequence of categorical funding streams, separate regulatory requirements, and unique State Agency mandates. When multiplied by the number of state agencies and services that a family may encounter in their journey toward wellness, it is understandable that they are experiencing the system as fragmented. The chief complaint of families is that they have to tell their story over and over, and re-educate each service provider about their history and their strengths and needs. A more efficient way to achieve system integration (greater continuity of

care and consistency in approach for families) is to purchase services that are already structurally integrated.

To address this, DCF and DMH are integrating congregate care treatment and community-based treatment under a unified service model. This joint procurement is titled “**Caring Together: Strengthening Children and Families through Community-Connected Residential Treatment**” (Caring Together). This method of purchasing provides several important benefits. First, it allows providers to serve children and families on a continuous basis regardless of where the child is living. If a child meets the criteria for a residential level of service, the Caring Together unified model allows for provision of that intensity of service in the child’s home or within a residential program. It also allows for eligible programs to be primarily community-based models with placement as an adjunct service, or to be primarily out-of-home treatment models with services that follow the child back into the community. The preferred Caring Together models will deliver all services along the continuum of out-of-home and community treatment by the same provider in order to maintain the connections that children and families build with program staff.

Our primary goal in this joint service procurement is to achieve better and more sustainable positive outcomes for children and families who come to the attention of either DCF or DMH. This requires full family engagement during the course of the residential service in all aspects of a child’s care and treatment unless there are safety concerns that require alternative planning. The objective is to prepare families, including foster, kinship or adoptive families, to manage their children successfully at home and promote their capacity to sustain their child’s and the family’s well-being.

With the flexibility offered by the Title IV-E waiver, DCF can divert funds that would have been used to support residential bed days into services that follow children into the community to support them and their caretakers. Services will be integrated in a manner that provides continuity of treatment and therapeutic relationships between residential and community services. Caring Together allows children and families access to the right level of service at the right time for the right duration.

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

Families, advocates, and youth in Massachusetts and across the country have had concerns about the level of integration of residential programs with community services. When children are placed in residential settings, they may be placed a long way from that home community. After residential services, parents and guardians frequently are faced with navigating a confusing array of providers in the community, scarcity of appropriate services, confusing eligibility rules, and challenges obtaining agency approval to fund community services. As a result of these challenges, families and children may not receive the right services in a timely manner after the child returns home. The result can be an increased risk of re-entry, possible repeat maltreatment, and increased family chaos and stress. Over the last decade, DCF has restructured and improved residential and community services; however Caring Together represents a unique opportunity to fully integrate service provision in a holistic manner.

Caring Together will use flexible Title IV-E funding to support four new programs (Follow Along, Stepping Out, Continuum, and Family Partners), as well as a consolidated management approach, to make improvements in permanency, well-being, and safety, and child abuse and neglect rates. The new programs are a comprehensive transformation of the current DCF congregate care system using the

principles and values laid out by Building Bridges, a national initiative of SAMHSA to create “systems of care” between families, youth, communities, and residential treatment providers.

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

DCF’s overarching hypothesis for the demonstration project is that the implementation of flexible funding in an integrated set of residential and community services with family-driven and youth-guided (person centered) care allows for continuity of the needed intensity of services back in a community setting. This will result in:

- Improved permanency outcomes;
- Increased child well-being, resiliency, and other positive youth outcomes;
- Strengthened families;
- Reduced risk and rates of child maltreatment;
- Increased tenure in the community;
- Reduced lengths of out-of-home placement;
- Increased investment in community services; and
- Maintenance of cost neutrality.

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

DCF has already implemented many innovative initiatives including differential response, safety and risk assessment tools, family engagement, the residential services practice, and an integrated case practice model. This demonstration project will fundamentally change the business model. The Figures 1 and 2 below illustrate how the new framework will differ from the current framework.

**Figure 1
 Traditional Purchase of Services... Purchased and Structured in a "Siloed" Fashion**

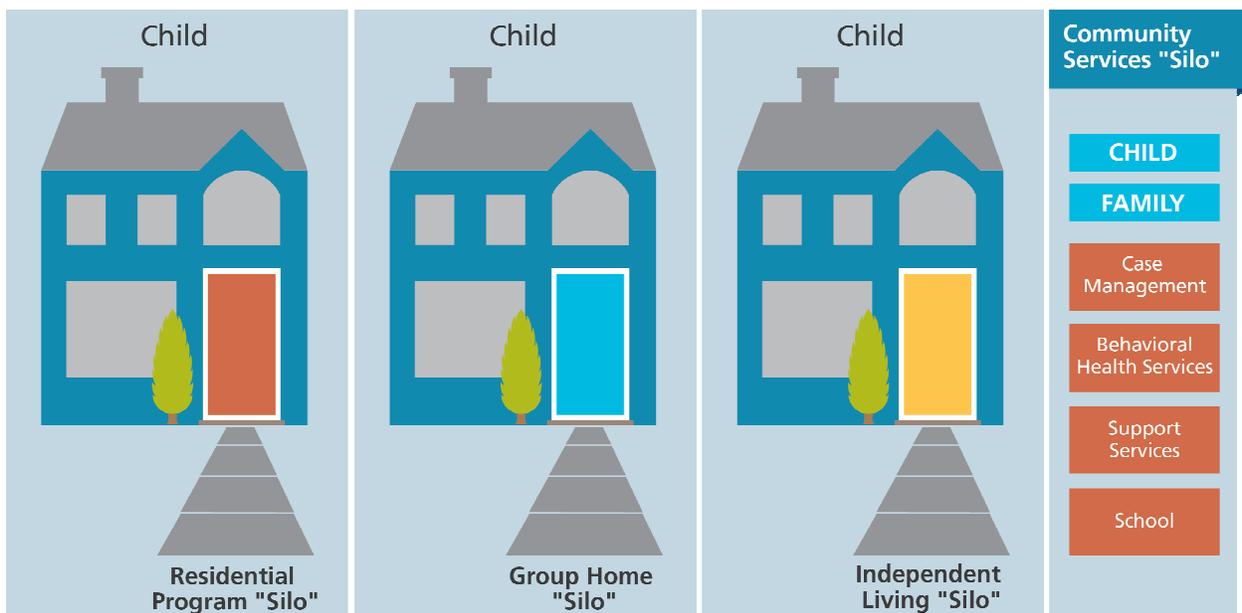
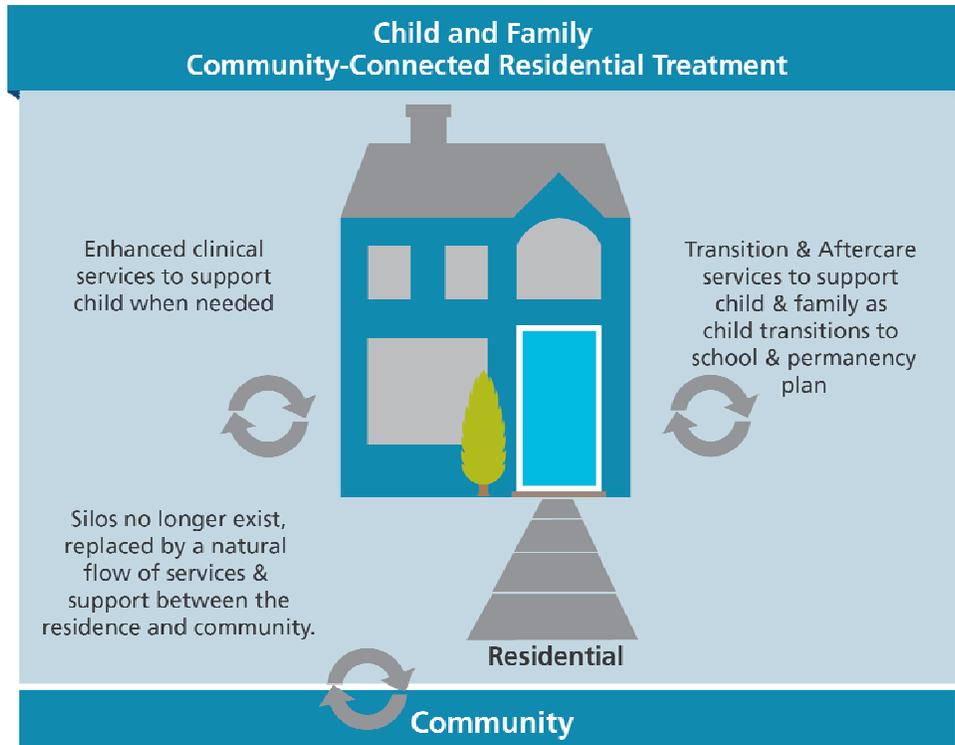


Figure 2

New System Of Care



Key innovative aspects of the new framework include:

1. **Enhanced clinical services** to support the child whenever and wherever they are needed;
2. **Transition and aftercare services** to support the child and family as the child transitions into the community; allowing them 24/7 access to care wherever they reside;
3. **Continuity of treatment approach and providers**, including teams of service providers who remain involved with children as they transition into community;
4. **Post discharge services** allow children and youth to participate in recreational and treatment activities offered within residential facilities post discharge; and
5. Implementation of **performance-based contracts** that utilize fiscal incentives as the project progresses.

While each of the new service models: Follow Along, Stepping Out, Continuum, and Family Partners (explained more thoroughly in Section 5, see page 12) is slightly different, all of the services focus on increasing child and caretaker capacity with a goal of improving community tenure and facilitating smoother transitions back into the community.

As we will also discuss below in Section 7 (on page 16), the innovations associated with this demonstration project are supported by research in the Building Bridges Initiative, trauma informed systems of care initiatives, strengthening families approach, and positive youth development.

Through these innovations, the Department expects to foster improved child and family well-being. The Department expects to reduce rates of child maltreatment, improve placement stability, reduce residential and hospital recidivism rates, and more successfully transition children and youth back to their home communities. The Department expects the following improvements in child and family well-being as measured primarily by the Child and Adolescent Needs and Strengths (CANS) assessment and secondarily through information collected in DCF's SACWIS information system (FamilyNet):

- Improvements in child well-being and safety measures;
- Improvements in positive youth development items such as social functioning, recreation/play, self care, interpersonal and community connections, resiliency, school behavior, school achievement, and school attendance; and
- Caregiver resources improvements including items such as supervision, involvement, organization and natural supports, and parent/child interaction.

2. The goals identified in statute that the project is intended to accomplish

The project is intended to accomplish all three of the goals identified in the enabling statute:

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

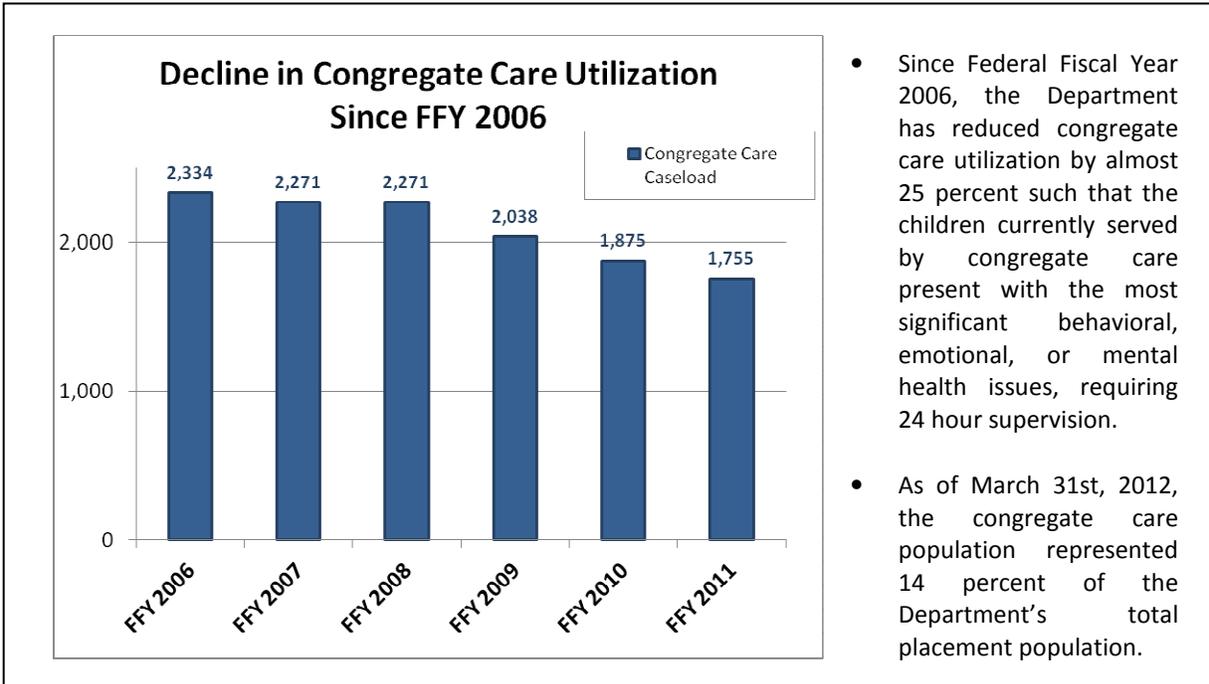
Please refer to Section 7 (on page 16) of this proposal for how the Department plans to measure outcomes against the goals above.

3. The target population that the agency wishes to serve

Services will be targeted toward children and youth who are transitioning out of congregate care, independent living, or pre-independent living settings into the community. Additionally, services will be targeted toward children and youth who are at risk of congregate care placement.

The target population will include most children in congregate care settings. Children and youth who are likely to require long term care, due to substantial developmental delays, highly specialized needs, or severe physical disabilities, will not be primary candidates for the demonstration project, as the services would not adequately meet their needs. Virtually all other children and youth meeting the criteria for a residential level of service will be eligible for the demonstration project, although actual participation will depend on individual case circumstances. The total number of children in the target population as of March 31, 2012 was 1,334. On the following page, Chart 1 illustrates the decline in the congregate care population in Massachusetts over the last several years.

Chart 1



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

In the first full year of implementation, DCF expects to serve approximately:

- 150 children and youth with Continuum community and wrap services
- 500 children and youth with Follow Along services
- 80 youth and young adults with Stepping Out services

The Department expects to increase the number of children and youth served incrementally each year going forward. The Department will also provide 32,000 hours of Family Partner support to families each year.

Estimated number of Title IV-E foster cases involved

Currently, about 15 percent of the Department's children and youth in congregate care settings are eligible for Title IV-E. Absent a Title IV-E waiver, by applying the current Title IV-E eligibility rate to the 1,334 children and youth in the target population, we calculate there would be 200 Title IV-E foster care cases in the target population. However in this proposal, the Department requests to waive the regulatory and statutory eligibility requirements related to all youth covered under Title IV-E of the Act.

Demographic information

Charts 2, 3, 4, and 5 on the following page provide a snapshot of the 1,334 children and youth in the target population as of March 31, 2012.

- The vast majority (73 percent) are adolescents between 12-17 years old, with more males (57 percent) than females (43 percent).
- Most of the children identified as White (43 percent), Hispanic/Latino (29 percent) or Black (19 percent).
- The vast majority speak English as a primary language (89 percent), with five percent speaking Spanish as their primary language.

Chart 2

Age

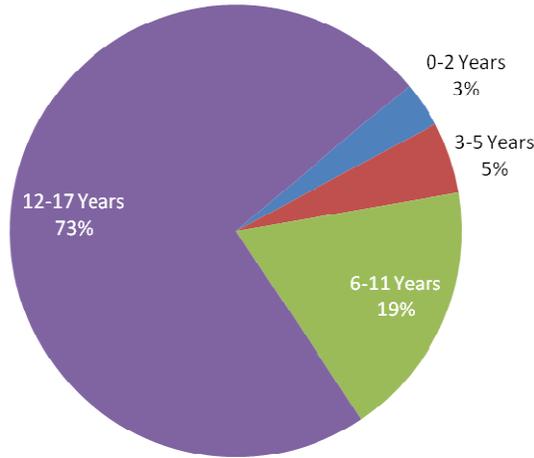


Chart 3

Gender

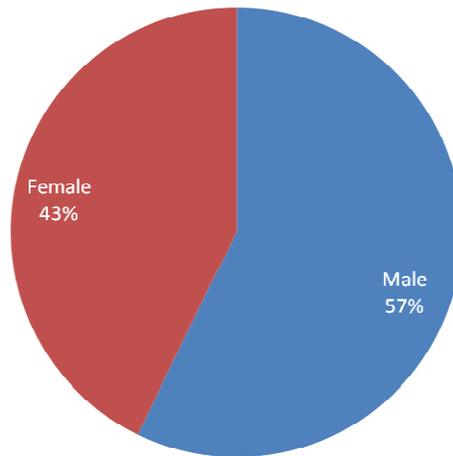


Chart 4

Race

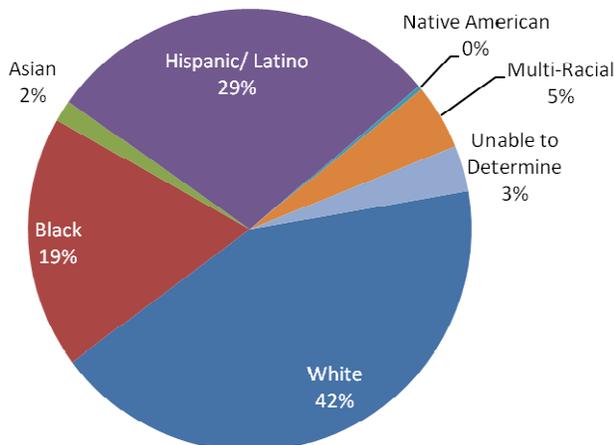
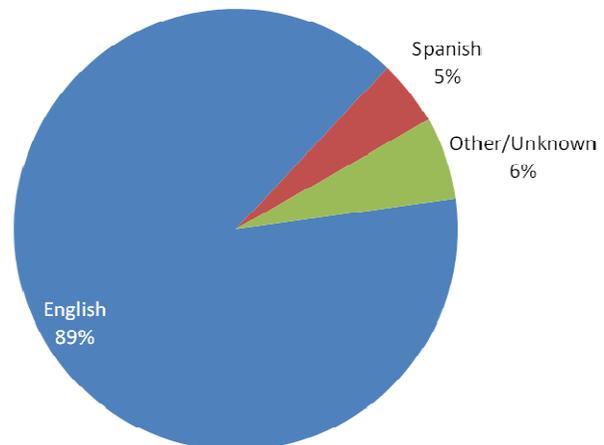


Chart 5

Primary Language



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

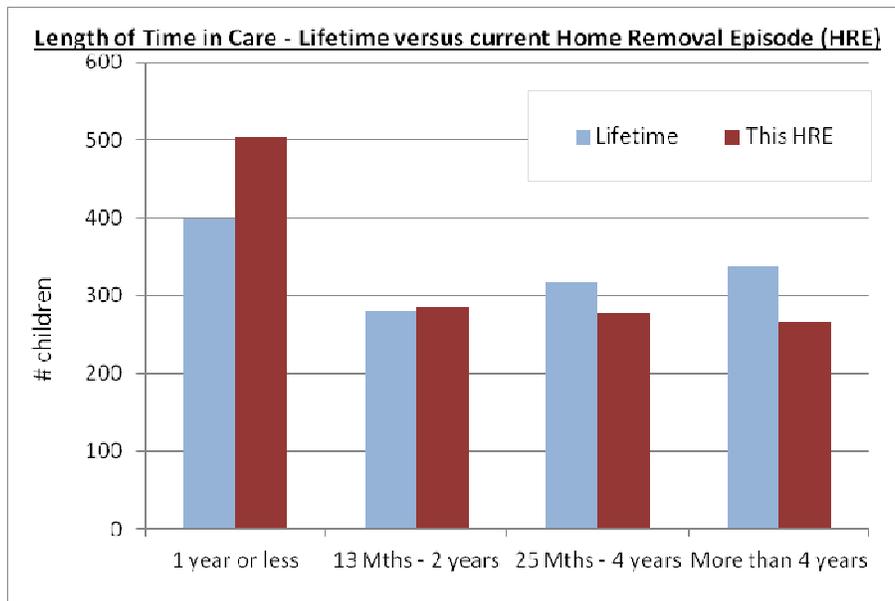
History with the Department

- 69 percent of the population is in care as a result of a report of abuse or neglect.
- 20 percent came into care through the courts as Children in Need of Services (CHINS). Child in Need of Services petitions can be filed by parents, schools, or police as a result of disorderly and disobedient behavior at home, school absenteeism, or running away.
- 25 percent of the population had two home removal episodes, and 12 percent had three or more.

Time in Care

- As shown in Chart 6 below, during the current home removal episode, 38 percent of the children had been in care for one year or less. However, about 21 percent of the children were in care between one and two years, another 21 percent between two and four years, and the remaining 20 percent more than four years.
- As shown in Chart 6 below, over the course of their lifetimes, these children have spent significant time in care. 49 percent have spent more than two years in placement, while 25 percent have spent more than four years in placement.

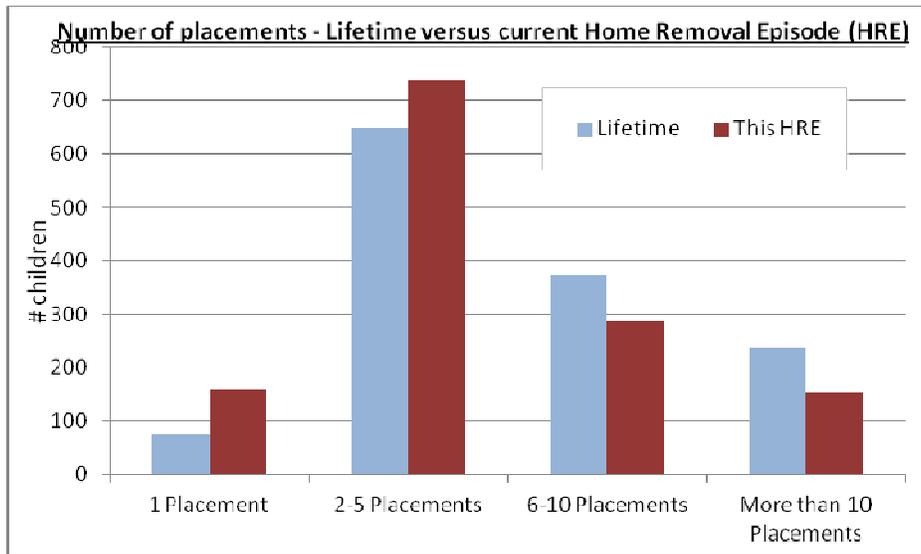
Chart 6



Placement Stability

- As shown in Chart 7, 12 percent of the target population had one placement during the most recent home removal episode, 55 percent had between 2-5 placements, and 33 percent had more than 5 placements.
- As shown in Chart 7, over the course of their lifetimes, 46 percent of the children had experienced more than 5 placements, with 18 percent experiencing more than 10.

Chart 7

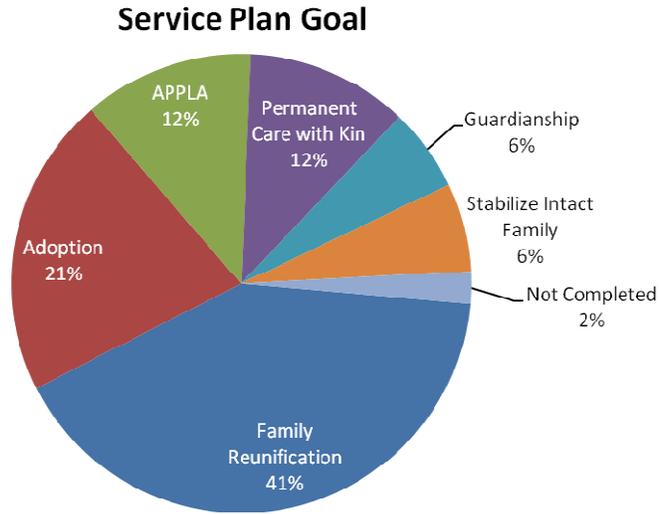


Note: Over the past few years, the Department has implemented strategies to address placement stability. We have improved stability for children in care 12 or fewer months from 72% to 79% (a 10% improvement)

Service Plan Goals

- As shown in Chart 8 on the following page, approximately 41 percent of the population had a goal of family reunification and 21 percent a goal of adoption.

Chart 8



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

Through changes to our service system, tighter management of congregate care referrals, and changes in our agency culture, the Department has already significantly reduced congregate care utilization. In order to meet the criteria for residential services, children and youth must require 24 hour supervision. These children and youth typically have a range of behavioral and mental health issues from severe emotional disturbances and mental illness that substantially interferes with or limits their ability to function at home, at school, and in the community to other less complex mental health, medical, cognitive, and behavioral challenges. Many have had prior psychiatric hospitalizations.

Many of the children and youth have families struggling with a range of issues including substance abuse, domestic violence, and mental health concerns, as well as economic stressors. There is a wide range of family involvement. Some families have long standing involvement with the child, while others may have been recently identified as a resource. Some children and youth have no family resource identified and some may be parents themselves.

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

The demonstration project will be conducted statewide.

5. Service interventions to be implemented

With this new procurement, DCF aims to implement a new service framework for children and youth eligible for residential levels of care. The following new services will be provided in order to implement the Caring Together vision:

Follow Along Services

Follow Along Services will provide intensive home-based family intervention and support to children, youth, young adults, and families, both while they are being prepared to return to home/community from congregate care settings and after this return has taken place. The focus is on comprehensive family skill-building to improve parental capacity to support their children and effectively utilize the systems in their lives. Services will be provided by a team consisting of an experienced master's level licensed clinician, along with a direct care level staff person. In order to ensure continuity of care, this team will be integrated into the residential component of the service and will be familiar to the youth and family. The Follow Along team will continue working with the family after the youth transitions back to the community. After returning home, youth receiving Follow Along services will have continued access to treatment and support services, such as groups and recreational activities within the congregate care setting. They will be able to utilize respite, as needed and available (day and overnight), within the congregate care setting. They will also receive care coordination including joint planning with the schools and facilitation of community connections. Staff will be available 24/7 by phone to provide consultation and assistance.

Stepping Out Services

Stepping Out Services will serve youth who have transitioned to living independently after receiving Pre-Independent Living and Independent Living Group Home Services. Stepping Out Services will provide ongoing supports to help the youth with this transition, including Individual support to achieve independence and build relationships and lifelong connections. To ensure continuity of care, Stepping Out services will be provided by the case manager who worked with the youth in the Pre-Independent Living or Independent Living residential placement. The youth receiving Stepping Out Services will have continued access to services (groups, recreation, etc.) within their former residential settings. Staff will be available 24/7 by phone to provide consultation and assistance.

Continuum Services

Continuum services will be provided to children and youth at risk for residential placement where the family is identified as able to care for the child at home, or work toward return home, with intensive supports. Services are delivered by a core group of Continuum staff including a master's level clinician, outreach workers, an occupational therapist, a psychiatrist, Family Partner, and staff from the referring agency. The Team is responsible for family treatment, care coordination, outreach, and crisis support within the community even when the youth receives out-of-home services. To ensure continuity of the team and the treatment approach, the team will remain involved with the youth and family regardless of level of service being provided by the Continuum. In addition, families receive:

- Youth and family outreach;
- Crisis prevention and intervention support; and
- Long-term and short-term out-of-home care if needed.

Family Partners

Family Partners will be offered on a voluntary basis to families. Family partners will have lived experience with the child welfare and/or child behavioral systems themselves and will support families during the residential experience and stay with the families during a youth's transition back to the home or community, when requested.

Fiscal incentives

As the project progresses, the Department plans to implement performance-based contracts that utilize fiscal incentives.

Evidence-informed interventions

The new service framework is grounded first and foremost in family engagement and feedback. Families and youth served by the Department initiated this reform by asking for greater continuity of care and caregivers. In response, the department researched various initiatives and systems that would both incorporate the family feedback and further the Department's goal of trauma-informed care. The final program design is evidence-informed.

The new system of care is informed by the Building Bridges Initiative (BBI) and the evidence that supports that initiative. The BBI seeks to "Identify and promote practice and policy initiatives that will create strong and closely coordinated partnerships and collaborations between families, youth, community- and residentially-based treatment and service providers, advocates and policy makers to ensure that comprehensive services and supports are family-driven, youth-guided, strength-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes."¹

Consistent with the goals of the BBI, the Department has developed a framework and service models that emphasize continuity of care and community support. Positive outcomes related to continuity of care and community support have been demonstrated by research including:

*"work with family issues and on facilitating community involvement while adolescents are in residential treatment" may have assisted these adolescents to maintain gains for as much as a year after discharge."*²

Residential-specific research shows improved outcomes with shorter lengths of stay, increased family involvement, and stability and support in the postresidential environment.³

The new system is also consistent with the National Child Traumatic Stress Network's definition of trauma informed systems of care, which emphasizes appropriate trauma assessment, treatment, and continuity and collaboration across child service systems:

"A service system with a trauma-informed perspective is one in which programs, agencies, and service providers: (1) routinely screen for trauma exposure and related symptoms; (2) use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (3) make resources available to children, families, and

¹ <http://www.buildingbridges4youth.org/about/mission>

² Leichtman, M., Leichtman, M. L., Cornsweet Barber, C., & Neese, D. T. (2001). Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. *American Journal of Orthopsychiatry*, 71(2), pp. 227-235.

³ Walter, U. & Petr, C.G. (2008). Family-centered residential treatment: Knowledge, research, and values converge. *Residential Treatment for Children and Youth*, 25(1), 1-16.

providers on trauma exposure, its impact, and treatment; (4) engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; (5) address parent and caregiver trauma and its impact on the family system; (6) emphasize continuity of care and collaboration across child-service systems; and (7) maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience.”⁴

Over the past several years, the Department has worked with residential service providers to promote trauma-informed practices and interventions. Together with the child serving agencies within the Executive Office of Health and Human Services, DCF developed a charter to reduce the use of restraint and seclusion within residential provider settings. The charter was grounded in the “Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool”.⁵ The Department is actively tracking restraint and seclusion incidents and has trained providers to support the initiative. The new system framework builds upon that work.

In addition, the Department was recently awarded an Integrating Trauma-Informed & Trauma-Focused Practice in CPS Delivery grant from ACF. With this grant, the Department will train DCF staff and caretakers on trauma-informed approaches to child welfare practice and will train providers on evidence based trauma treatment. The Department already utilizes the Child and Adolescent Needs and Strengths (CANS) assessment, but will be expanding use of that assessment tool under the new service framework in order to better track child needs and progress.

Caring Together promotes a Strengthening Families approach to services recognizing the benefits of building parental capacities. The protective factors that form the basis of Strengthening Families include supporting Nurturing and Attachment, Parental Resilience, Understanding of the Child’s Social and Emotional Needs, Concrete Supports, and Social Connections.

The new service framework, the periodic CANS screening, and the training for DCF staff, caretakers, and providers in how to more effectively serve children dealing with trauma will combine to create a comprehensive trauma-informed system of care for DCF.

And finally, DCF is committed to achieving positive outcomes for children and youth through this initiative. Research in positive youth development supports the new service framework. The National Research Council identified the following characteristics for programs that **promote positive youth development**:⁶

- Physical and psychological safety
- Appropriate structure

⁴ <http://www.nctsnet.org/resources/topics/creating-trauma-informed-systems>

⁵ Huckhorn, Kevin Ann, “Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool,” October 2005. The development of the Six Core Strategies model was funded by the US Substance Abuse and Mental Health Services Administration (SAMHSA) and created by National Association of State Mental Health Program Directors (NASMHPD), Office of Technical Assistance

⁶ *Community Programs to Promote Youth Development Committee on Community-Level Programs for Youth*, Jacquelynne Eccles and Jennifer Appleton Gootman, Editors, National Research Council and Institute of Medicine 2002

-
- Supportive relationships
 - Opportunities to belong
 - Positive social norms
 - Support for efficacy and mattering
 - Opportunities for skill-building
 - Integration of family, school and community efforts

This demonstration project will allow the Department to serve children safely in the most appropriate setting, whether that setting is within a residential facility or the community. Children and youth will be able to maintain the relationships they develop with their service providers throughout the course of their involvement with the Department. The focus of interventions will be on helping parents build the skills necessary to better support their children and helping parents, children and youth maintain and develop lasting relationships and connections to their community. These elements are all consistent with the research on positive youth development.

Why the project was selected to meet the needs of the identified target population

As described in Section 3 above, the target population has tended to have significant involvement with the Department, including long periods of time in placement. Many have also experienced multiple placement settings. They are frequently adolescents and they present with a variety of family and individual issues such as substance abuse, mental illness, and emotional disturbances. The Department wishes to improve well-being, decrease the length of time these children and youth spend in congregate care, improve placement stability, and reduce re-entries to congregate care post discharge by better supporting transitions into the community. Through the Building Bridges Initiative, projects that emphasize family and youth engagement as well as integration of community and residential services, similar to the demonstration project described herein, have been shown to improve such measures in similar populations.

Further, this is a population that has experienced significant trauma over the course of their lives. The majority of these children are in care due to a substantiated report of abuse or neglect. They are placed outside of their homes, away from their families, and many have been in care for several years. Many of the children are from families affected by homelessness, poverty, domestic violence, substance abuse, and mental illness. The department aims to better support and treat the emotional and behavioral manifestations of trauma exhibited by these children and youth. By aligning DCF's system of care with the National Child Traumatic Stress Network's definition of trauma informed systems of care the Department aims to improve child and family well-being, placement stability, permanency, and to assist caretakers and youth to maintain and develop lasting relationships and community connections.

And finally, the demonstration project weaves the principles of Strengthening Families and positive youth development, such as appropriate structure and safety, developing supportive relationships, and integrating community, family and school throughout the system of care. The project emphasizes these principles as they have been found to promote positive development in children and youth, whether those youth are troubled are not.

6. Describe time period in which project will be conducted

The demonstration project will be implemented no earlier than **January 1, 2013** and would end no later than **December 31, 2017**, with the possibility of an extension agreement between Massachusetts and the Administration for Children and Families extending the completion date to no later than September 30, 2019.

7. Impact the intervention(s) is expected to have on outcomes related to safety, permanency, well-being

The specific goals for the Caring Together initiative and the Title IV-E waiver include all three ACF goals as well as two others that DCF and DMH collaboratively developed:

1. Increasing permanency;
2. Increasing positive outcomes through improved well-being and safety and the child and family experience of care;
3. Prevention of abuse and neglect
4. Strengthening families (building parental capacity) and
5. Promoting positive youth development

These will be accomplished through a comprehensive program and system change for residential treatment and congregate care services in Massachusetts. Program and system change is critical for Massachusetts because we seek to build a new residential system of care that is family driven and youth guided and better linked to the community. This is consistent with the Building Bridges principles, principles of Positive Youth Development, and trauma informed systems of care. To accomplish this we need families and young adults who are actively engaged in their care, in the programs delivering services, and in system oversight. Our families, guardians, youth, providers and state officials envision a system of residential services that are fully integrated with community supports and community resources and that empowers them to change their lives. This requires a system that has family engagement at every level including this evaluation.

The specific outcomes that DCF seeks to achieve are described below. These derive from the input of families and youth, but they also will need further review by youth, families and provider stakeholders prior to their finalization. Specifically, the types of outcomes and measures we are proposing cluster into three broad domains: Child and Family, Programs, and Systems.

Child and Family Outcomes:

- Ratings of child and family needs and strengths from the CANS will be analyzed at both the overall composite level and at the Domain and selected item levels. CANS scores will be calculated for pre and post samples at the composite level and by specific domain. These domains include: Life Domain Functioning, Child Behavioral/Emotional Needs, Child Risk, Cultural, Child Strength, Transition to adulthood (as age appropriate), and Caregiver Resources and Needs. Item specific scores might include but not be limited to Delinquent Behavior, School

Achievement, Attendance; Resiliency, Community Connections, and others.⁷ Caregiver ratings will be used to assess parental capacity and other individual CANS measures will be used as proxies for positive youth development.

- Client level records of service utilization will be reviewed within DCF. Where possible, we will identify other agency service utilization.
- Child and family experience of care feedback will be obtained and reviewed (though this may not be systematically available for all youth prior to the waiver).
- Safety and health outcomes including hospitalization rates, incidents of restraint and seclusion, abuse and neglect reports and findings, and other safety measures such as incident reports will also be measured.
- Treatment goal attainment measures from DCF's SACWIS system, Family Net, will be analyzed.
- Permanency measures vary slightly for each of the three programs in Caring Together:
 - Follow Along seeks to improve satisfaction with and stability of family reunification or return to a foster family setting.
 - Stepping Out seeks to ensure a smooth and successful transition to independent living for the older adolescent, and
 - Continuum program seeks to maintain community tenure.

Data for each of these service levels will be collected, analyzed and included as stratified measurement units of analysis within the program effectiveness evaluation. Additionally, data will be stratified by age and race/ethnicity.

Program Measures and Outcomes: Measures of programmatic outcomes include measures of program structure, implementation status, and performance.

- Contract Fidelity – Has the program been implemented in a manner consistent with the contract and program design?
- Provider opinions about, and experience with, the waiver programs through structured surveys administered at 3 months, 6 months and every 6 months thereafter.
- Performance measures including utilization data, length of stay, recidivism rates, unplanned terminations, re-entry to placement, and success in achieving permanency goals, etc. These measures will be stratified by program type since the goals are slightly different for each program. They will also be reported by agency and program site.

Systems Measures and Outcomes: This will include:

- Assessment of the process and fidelity of implementation of the consolidated management teams for case review, training, case consultation, provider management and grand rounds.
- Provider, advocate and DCF Regional Team staff feedback through structured web-based surveys administered at 3 months, 6 months and every 6 months thereafter.
- Interagency collaboration levels and activities including evidence of interagency development in response to gap analyses.
- Utilization of services overall and stratified by region, agency and other criteria.
- Costs of care.

⁷ The team considered and reviewed other child well-being measures including the Behavioral and Emotional Rating Scale, the CBCL, Trauma Symptom Checklist, and others. The CANS was selected because it is in system-wide use already, the measures have been widely adopted nationally and have been selected as a result of an open and inclusive process with youth and families.

- Rates and incidence of multiple placements.

These measures will document program implementation and they will also measure the three core ACF and two supplemental goals. Table 1 below crosswalks ACF’s goals to the measures proposed by DCF.

Table 1

<i>ACF Goal</i>	<i>DCF Measures</i>
<i>Increase permanency</i>	Reduced length of stay; successful transition from placement (step-down); for youth with independent living permanency goal – successful transition to independent living; reduced levels of multiple placements (lateral moves or step-up to more intensive levels of care)
<i>Increase Positive Outcomes</i>	Improvements in well-being and safety measures in the CANS; reduced rates of hospitalization rates and ALOS, reduced restraint and seclusion, and abuse and neglect report rates; improved child and family experience of care ratings; increased levels of treatment goal attainment; reduced critical incidents.
<i>Prevent Child Abuse and Neglect</i>	Reductions in abuse and neglect reporting rates for youth in placement; reductions in re-entry rates; Lower overall rates for “stepped-up” levels of care.
<i>Strengthening Families</i>	Improvement in Caregiver resources from the CANS including items such as supervision, involvement, organization and natural supports, parent/child interaction.
<i>Positive Youth Development</i>	CANS items will include but not be limited to social functioning, recreation/play, self care, interpersonal, community connections, resiliency, school behavior, school achievement and school attendance, employment readiness, and civic engagement.

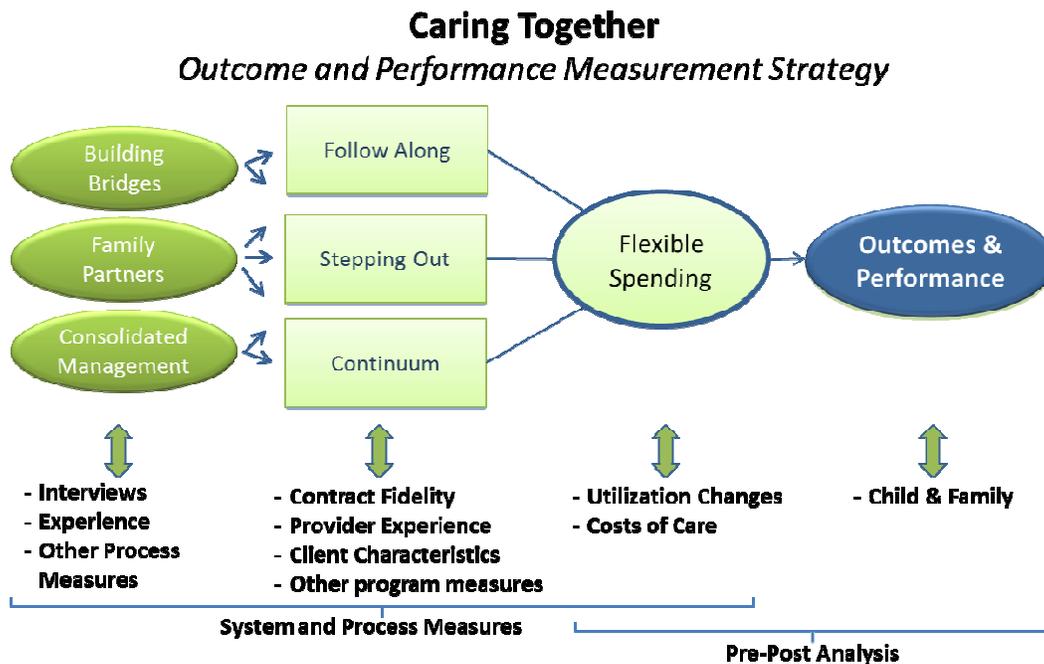
Where appropriate, these measures will be stratified by select demographic, program, or regional variables. Many will form a foundation for process based performance reporting that will be shared with providers on a quarterly basis. These quarterly process and performance measures will expand over time as the program is more fully implemented and as other data become available.

All of these measures will be reviewed closely with leaders from our Family Partners and with the Caring Together Governance Committee. The measures will be modified in response to their feedback. The evaluation team will include representatives of family members as advisors and the team will work closely with DCF Family Partner representatives.

8. Description of the proposed evaluation design

DCF plans a statewide implementation as a result of the joint interagency procurement. The goal of Caring Together is to achieve a complete system transformation to a more family-driven and youth-guided community-based system of services that improves safety, permanency and well-being through reduced lengths of stay in out-of-home placement, success in the community, and by providing more care within a child’s home community. Since it is statewide and implementation will not be staged (all regions and new contracts will be implemented simultaneously), it will not be possible to implement a model of random assignment or simultaneous comparison groups. As a result, we propose a pre-post comparison of program costs, utilization and service quality. A summary of the structure and logic of the program and the various measures that are proposed for each of the segments of the program is illustrated in Figure 3.

Figure 3



Caring Together involves the use of Building Bridges program principles and values, deployment of Family Partners, and the development of DCF/DMH Regional Clinical Support Teams. These principles and the clinical support teams will oversee the three new programs (Follow Along, Stepping Out and Continuum) that are being procured. Multiple providers will be selected in each of the regions. Each of the programs will have the charge of delivering services funded through new flexible community-based service spending authority under the waiver. These changes, taken together, are hypothesized to improve child and family outcomes in the DCF system. Our research task will be to measure the performance in each of these areas using a set of Process Measures and making comparisons in utilization, costs and outcomes between pre-waiver and post-waiver periods. As described above the outcomes and performance measures will be assessed across three levels – Child and Family, Program, and Systems.

Data for current fiscal year 2011 and fiscal year 2012 residential placements for youth in custody will be reviewed. CANS data are available for all youth referred for residential treatment for both years. All DCF utilization and cost data are available for the same period. The evaluation team will review child needs and strengths, service utilization, and costs of service for the pre and post waiver groups controlling for potentially different group composition using propensity scoring methods or through similar matched sample approaches. The post-waiver group will also have experience of care data for clients and family members.

DCF will implement a six month post-discharge follow-up study of a random sample of youth discharged from custody for the first two years of the program. The follow-up study will include telephone interviews with youth and their families where possible using a standard interview protocol. The results will be used to inform policy makers about the factors behind youth success on re-entry to the community.

In addition to this pre-post waiver comparison, the evaluation will focus on providing structured process evaluation feedback to DCF staff and Regional Teams. This will be accomplished through a series of interviews with state staff, analysis of key program data, web based surveys of providers (using Survey Monkey) and regional teams and evaluation meetings scheduled at 3, 6, 12, 18, and 24 months with the Regional Staff and also with providers. These meetings will provide structured feedback from the evaluation team about implementation, enrollment patterns, and utilization data summaries, CANS and demographic data and other preliminary outcomes.

The pre-post design is the most rigorous methodology possible given the transformative nature of the statewide changes being implemented. We believe that the follow-up protocols, the use of system wide CANS, utilization and cost data, the extensive use of process measurement and feedback and qualitative interviews will combine to sufficiently evaluate the demonstration project. .

All of the data will be made available to Family Partners and Youth and Family advocates in the state to get their input and to be as transparent as possible.

9. Estimate of the projected costs or savings

When the new services are fully operational, the Department estimates that they will cost approximately \$20 million per year. At the same time, the Department expects to reduce congregate care spending by approximately \$20 million, thereby creating both state and Title IV-E savings to support the new system.

The Department's budget and program personnel worked collaboratively with the Department's field managers to estimate the costs and savings associated with the new system of care. The Department commits to devote any Federal IV-E funds, as well as State and local resources, that are freed up under the demonstration to child welfare purposes.

10. Provide a reliable method for measuring and ensuring Federal cost-neutrality over the course of the demonstration

The Department wishes to cap the Title IV-E foster care maintenance and foster care administration payments received by the Commonwealth of Massachusetts at a mutually agreed upon level over the course of the demonstration project.

11. Describe impact on any similar projects already underway

The system reforms described herein are occurring within and are supported by a context of reform across human services and at the statewide level, although they are not contingent on any other State Plan Amendments or waivers. A brief summary of the most significant reforms is provided below.

The Children's Behavioral Health Initiative (CBHI) is an interagency initiative of the Commonwealth's Executive Office of Health and Human Services (EOHHS). Its executive team is made of members of EOHHS, MassHealth (the office of Medicaid), DMH, DCF, the Department of Youth Services, the Department of Public Health, and family representatives. The initiative aims to strengthen, expand, and integrate Massachusetts state child behavioral health services into a comprehensive, coordinated community-based system of care for all communities within the Commonwealth. Policies, financing, management, and delivery of publicly-funded behavioral health services will be integrated to make it easier for families to find and access effective services, and to ensure that families feel welcome, respected and receive services that meet their needs, as defined by the family.

At the same time, Chapter 257 of the Acts of 2008 in Massachusetts places authority for determination of reimbursement rates for human and social services with the Secretary of EOHHS. The law aims to streamline service classification systems across all sixteen EOHHS agencies, develop rational pricing, and reform current contracting mechanisms. The collaboration between DMH and DCF to jointly procure the Caring Together service system is consistent with both CBHI and Chapter 257 reforms.

In addition, the Department was recently awarded an Integrating Trauma-Informed & Trauma-Focused Practice in CPS Delivery grant from ACF. With this grant, the Department will train DCF staff and caretakers on trauma-informed approaches to child welfare practice and will train providers on evidence-based trauma treatment. Within a few years, these practices will be rolled out across the state. This work is well aligned with, and will support, the success of the demonstration project. Work associated with the Trauma grant is expected to conclude in 2016.

In addition to this waiver, DCF will also seek to use the Medicaid Rehabilitation Services option to support some of the services provided under the demonstration project. The Department will be working with DMH to identify allowable Rehabilitation services, assess whether any amendments are needed to the Medicaid State Plan, and develop processes and procedures for claiming them with the Massachusetts Executive Office of Health and Human Services. These funds will further support the system and allow the Department to serve as many children and youth as possible.

12. Accounting of any other sources of funding over the previous two years that have been used to provide the services that the agency now proposes to address under a waiver demonstration

The services that the Department proposes to include within the waiver demonstration are new; therefore, there have been no prior sources of funding for the services.

13. Provide an assurance that the Title IV-E agency will continue to provide an accounting of that same spending for each year of the approved demonstration project.

The services that the Department proposes to include within the waiver demonstration are new; therefore, there have been no prior sources of funding for the services. DCF will comply with all fiscal reporting requirements for a waiver demonstration project.

14. Identify the statutory and regulatory requirements under titles IV-B and IV-E of the Act for which waivers will be needed to permit the proposed project to be conducted

Massachusetts requests that ACF grant waivers to the following provisions of the Social Security Act and Program Regulations in order to implement the demonstration project:

- Section 472 (a) (b) (d) (e) (f) (g) and (i)
- Section 474(a)(1)
- Section 474(a)(3)(A) (B) (D) and (E)
- 45 CFR 1356.60(c)

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

DCF, DMH, and EOHHS are in the process of defining the vision and requirements for information technology functionality in the Massachusetts' SACWIS system, FamilyNet, to support the Caring Together procurement. DCF has recognized that the following changes may be required in the FamilyNet system at minimum:

- Access for DCF to authorize, manage, and pay for services procured as part of the Caring Together procurement.
 - Manage contracts for a variety of placement and non placement based services (e.g., Residential School, The Continuum, Group Home, Respite, Service Add-On, Teen Parenting, etc.).
 - Ability for DCF and/or Lead Agency staff to request, approve, and authorize a referral to a service provider for any of the service models under Caring Together.

- How users from the provider community are able view and/or update various clinical work products, such as CANS assessments, treatment plans, progress reviews, activity delivery reports, and/or incident reports.
- Provider census reporting functionality to support the planned service models.

16. Demonstration of readiness

DCF is highly ready to implement the new demonstration project. The Caring Together Request for Response (RFR) will be released very soon, and reflects planning efforts that have taken place over the past couple of years. In addition to DMH, the Department has worked with the Massachusetts Executive Office of Health and Human Services, and the Massachusetts Office of Medicaid where appropriate in the planning process. Families, providers, child advocates, and the public have been involved in the planning process as well.

DCF and DMH are jointly creating new monitoring and management systems to oversee the joint procurement. Service utilization, quality and network management functions will move from the local area to Regional Teams configured to match the DCF structure of four regions. New state positions have been developed that include clinical social workers and clinical social work supervisors, a family specialist, a statewide director, and a statewide assistant director. A matrix management reporting structure has been created wherein the Director will report to the assistant commissioners of DCF and DMH.

Internally, in order to implement changes to billing and reimbursement, DCF has had to change their service taxonomy. The new service taxonomy reflects the new way of defining residential treatment as a level of service, rather than a level of care.

DCF has already provided three day-long trainings in the Building Bridges Initiative framework for providers and agency staff, and we have provided a two day conference and training on restraint and seclusion prevention using a trauma informed framework. We will continue to provide these trainings on an annual basis. In addition the Regional Clinical Teams will be providing ongoing training, technical assistance, and coaching for agency and provider staff. The Family Specialist will work directly with providers who need assistance in meeting the expectations of family and youth driven care. And finally, with the exception of surveys and interviews, DCF already has the data necessary to track and report on outcomes related to the new system. DCF implemented the CANS assessment statewide several years ago, and has a robust SACWIS system which collects the administrative data necessary.

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

DCF has worked collaboratively with the Massachusetts Department of Mental health to develop this joint procurement and service framework. Attached please find a letter of support for this initiative from DMH.

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

The Massachusetts Department of Children and Families completed its PIP. The goals of the demonstration project are aligned with the CFSR and we expect it to positively impact permanency, placement stability, and rates of re-entry to care.

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

There are no court orders in effect in Massachusetts whereby a court has determined that the State's child welfare program failed to comply with the State's child welfare laws or with Title IV-B, Title IV-E, or the U.S. Constitution.

On April 15, 2010, Children's Rights, Inc. Attorneys of New York City, filed suit in the Federal District Court of Massachusetts on behalf of six named plaintiffs and seeking class certification. The law suit alleges, among other issues, that the Department of Children and Families was not fulfilling its requirements under Title IV-B and Title IV-E of the Social Security Act. The law suit is broad in nature and alleges failures in many aspects of the DCF system. The regional office of the Administration for Children and Families was made aware of this law suit at the time it was filed.

The Federal District Court has certified the law suit as a class action law suit on behalf of all children who have been (or will be) placed in the custody of the DCF as a result of abuse or neglect. The lawsuit is currently in the discovery phase of litigation. A trial date is scheduled for January 21, 2013. DCF is being represented by the Attorney General's office. DCF strongly denies the plaintiff's allegations and is confident that it will be successful at trial. This demonstration project is an example of DCF's commitment to continuous quality improvement of its child welfare system.

20. Summary of public input

DCF has worked collaboratively with families, providers, department personnel, and other stakeholders to design the new system of care. In June 2010, DMH and DCF issued a Request for Information (RFI) to inform the new system of care. Below is a summary of the principles derived from the RFI feedback:

- *Inclusive Process:* There is a thoughtful and planned approach to system change which includes input from providers and families.
- *Shared Vision:* There is a shared vision of philosophy, values and practice approaches between purchasers, providers, and families.
- *Appropriate Referrals:* Level of care decisions are based on presenting problem, complexity of family issues, and goal of placement.
- *Predictability:* There is a minimum obligation of adequate utilization and funding.
- *Authentic Dialogue:* There is a safe, honest and non-blaming culture of partnership between purchasers, providers and families fostered by authentic dialogue.
- *Collaboration:* There is a collaborative process in development of rates and performance measures.

DMH and DCF also conducted a number of public meetings for providers, families and other interested parties. Table 2 is a summary of those meetings.

Table 2

Meeting	Locations and Dates	Participants	Session Objectives
Commissioner Presentation	<ul style="list-style-type: none"> Shrewsbury, MA – May 2010 Marlboro, MA – October 2010 Four Regional meetings – March 2011 	<ul style="list-style-type: none"> Provider Agencies Board Presidents and executive directors of provider associations DCF 	<ul style="list-style-type: none"> Project introduction and vision Building Bridges forum Regional provider and Board President forums focused on systems change
EHS, HCFP, DCF, and DMH C257 Rate Setting Forums	<ul style="list-style-type: none"> Four Regional Provider Forums and DCF/DMH staff forums – Summer 2010 Three Provider Forums – November 2010 and June 2011 	<ul style="list-style-type: none"> Parent Advocacy League (PAL), DCF, DMH, and EHS personnel Provider Agencies DCF 	<ul style="list-style-type: none"> Initial presentation of project goals with subsequent session as program model consultative session Presentation and discussion of service models and factors under consideration
Family Forums	<ul style="list-style-type: none"> Over 350 families and youth participated in eight forums: <ul style="list-style-type: none"> Statewide (Shrewsbury, MA) – June 2010 Six Regional Forums – August 2010 Family Partner Forum – October 2010 Youth Advisory Board Survey 	<ul style="list-style-type: none"> PAL Families DCF DMH 	<ul style="list-style-type: none"> Obtain stakeholder guidance on final proposal design and priorities

The public meetings garnered the following feedback that has been incorporated in to the design the Caring Together program:

- Families expressed that they were tired of telling their story over and over again. They wanted consistency in services in service providers. This became the underpinning of the reform upon which all subsequent service specifications were ultimately built.
- Providers expressed support for the concept of integrated services, but expressed concerns that the system and its financing would change too quickly. As a result of this feedback, the Department will allow for subcontracting agreements between providers where individual providers do not have capacity to provide services across the array.

In addition, DCF conducted several public meetings to notify stakeholders and others that the Department plans to seek a waiver to support Caring Together. Table 3 includes a summary of those meetings.

Table 3

Meeting Type	Location and Dates	Participants	Session Objectives
Department’s Statewide Advisory Council	Marlboro, MA June 7, 2012	<ul style="list-style-type: none"> • Provider Agencies • Advocacy Groups • Foster Parent Representative • DCF 	<ul style="list-style-type: none"> • Title IV-E Waiver Background and Requirements • Child Welfare Program Improvement Polices
Children's League of Massachusetts	Natick, MA June 25, 2012	<ul style="list-style-type: none"> • Provider Agencies • Advocacy Groups • DCF 	<ul style="list-style-type: none"> • Overview of the Title IV-E Waiver
Massachusetts Coalition to Strengthen DCF Families	Boston, MA July 2, 2012	<ul style="list-style-type: none"> • Provider Agencies • Advocacy Groups • Parents • DCF 	<ul style="list-style-type: none"> • Obtain stakeholder guidance on final proposal design and priorities

DCF engaged stakeholders to help select the program improvement policies that DCF will pursue in conjunction with the demonstration project.

21. Assurance of health insurance coverage for all special needs children for whom the Title IV-E agency has entered into an adoption assistance agreement

The Commonwealth of Massachusetts provides health insurance coverage for all special needs children for whom the Massachusetts Department of Children and Families (the Title IV-E agency) has entered into an adoption assistance agreement, including those not supported by Title IV-E funds.

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

Attached please find a copy of the Massachusetts Department of Children and Families Foster Child Bill of Rights, implemented on August 27, 2009, which serves as the previously implemented child welfare improvement policy as required for this application. Also included is a copy of the recently enacted Siblings Bill of Rights.

Within three years of the date on which Massachusetts submits this application to conduct a Title IV-E waiver demonstration project or two years after the date on which the Secretary approves such demonstration project (whichever comes first) Massachusetts will have implemented procedures for:

- Ensuring that youth in foster care who have attained the age of 16 are engaged in discussions, including during the development of transition plans, that explore whether the youth wishes to reconnect with the youth’s biological family, including parents, grandparents, and siblings, and if so, what skills and strategies the youth will need to successfully and safely reconnect with those family members;
- Providing appropriate guidance and services to youth whom affirm an intent to reconnect with biological family members on how to successfully and safely manage such connections; and

- Making, when appropriate, efforts to include biological family members in such reconnection efforts.

The Department is working to develop this policy more fully and will ultimately incorporate it into policies regarding permanency or adolescent services.