



Rhode Island Department of Children, Youth & Families

## **Summit on Improving Outcomes: Procuring DCYF Services for Children and Families**

**On November 17-18, 2015, over 200 stakeholders** joined Rhode Island's Department of Children, Youth & Families at a public summit seeking input from service providers and other stakeholders on its strategy to procure a comprehensive array of services designed to improve long term outcomes for children and families. Participants generated thousands of responses to questions posed by the Department on service needs, referral and matching strategies, education and information sharing, contract and payment structures, and collaborations to continuously improve results.

This report outlines the key themes, observations and findings which emerged from the summit, including:

- Hope for enhanced collaboration and communications between all public and private stakeholders to achieve better outcomes for children and families in care.
- Potential to strengthen the array of services available by evaluating current practices, expanding programming where gaps exist, and innovating new solutions for populations whose needs are not effectively met today.
- Improvements to the service and placement matching process through more consistent and complete information sharing and faster, clinically-appropriate decision making.
- Enhanced education and data sharing to help caseworkers better align referrals with program strengths, and help providers adjust services based on child/family needs.
- Opportunities to work with different types of contracting and payment structures that reward providers for the achievement of positive outcomes for our kids.
- Focusing contract management on performance improvements over compliance alone, with more consistent uses of data and clearer expectations for outcomes.
- Operational and clinical practices on which providers would benefit from additional technical assistance.

I am grateful for the continued leadership of Rhode Island's service providers. While the summit was neither the first nor the last time we will come together, it marks an important point in our development as an outcomes-driven professional community. With your partnership, we are swiftly moving closer to achieving our collective vision of Healthy Children and Youth, Strong Families, and Diverse Caring Communities.

Warmest regards,

Jamia R. McDonald  
Chief Strategy Officer  
Executive Office of Health and Human Services

## **Summit on Improving Outcomes: Procuring DCYF Services for Children and Families**

The Department of Children, Youth and Families (DCYF) convened a public summit on November 17 and 18, 2015, to solicit input from service providers and other stakeholders on its strategy to procure a comprehensive array of services designed to improve long term outcomes for children and families. Through facilitated discussions and a web-based tool to collect feedback, the following key findings from attendees' responses are summarized below.

### **I. Summit objectives**

*What do you hope to get out of today's session?*

Participants articulated a desire to advance through the Summit a shared understanding of the elements necessary to build a successful and effective child welfare system in Rhode Island. Many hoped the summit would improve DCYF-service provider communications and enhance collaboration, partnership, and networking across public and private stakeholders. Participants highlighted the opportunity to foster mutual respect within the child welfare community, leverage providers' expertise in service delivery, and reinforce expectations for how stakeholders should operate. Participants hoped to learn about selecting, implementing, and funding evidence-based programs; gain clarity on overlooked sub-populations; understand where prevention fits; and set a foundation for receiving consistent data from DCYF.

### **II. What services and supports should DCYF purchase in order to improve outcomes for children and families?**

*Think about the 16 service categories (See Attachment 1) in relationship to your current programs. Please select one or more areas where there might be a gap or challenge in delivering services and outcomes.*

The most common three responses were Treating mental and behavioral needs of children (12%), Supporting successful transitions to adulthood (9%), and Serving the distinct needs of special populations (8%). Preventing unnecessary entry into out of home care (8%), Developing parenting capabilities and family resources required for reunification (8%), and Identifying and preventing at-risk families from DCYF involvement (7%) were also identified as top needs.

*What needs of children and families in the system appear to be missing from the array?*

The most popular response was support for youth aging out of DCYF care. Many of the needs identified related to strengthening linkages to non-DCYF services for families involved with multiple systems. Other common gaps identified included resource family recruitment; shared screening and assessment approaches between DCYF, medical/psychiatric providers, and the courts; culturally competent, ethnically diverse, and language accessible services and supports, especially for populations for whom English is not a first language; and resources to meet families' basic needs to help keep families together, including access to affordable housing, parental employment linkages, and parental mental health services.

*What additional resources and/or investments in infrastructure do you need to achieve these objectives?*

- Technical assistance – Learning from organizations that have successfully reinvented themselves; consultation with national professional organizations and academic centers around best practices, evidence-based programming, and special populations; and training on how to use data effectively for management and program evaluation.
- Increased capacity – Program funding that supports program-critical administrative oversight (program management, evaluation, quality assurance); investments in staff recruitment, compensation, training, and retention; and investment in technology for both frontline staff and sharing information across central systems).
- Increased collaboration – Increased used of team-based decision making; coordination with adult mental health and substance abuse systems; and coordination with schools.
- More and better information – More consistent collection, analysis, and reporting of data on services and outcomes for individual clients and provider organizations; shared performance benchmarks across DCYF, providers, and courts; regular communications with state personnel to address issues and recognize achievements; and regular and consistent provider meetings and other DCYF communications.
- DCYF capacity – Continued deepening of child welfare expertise on DCYF leadership team; speeding faster foster parent licensing; developing a level of care tool to standardize decision making; and more robustly coordinating recruitment, development, and support for kin and foster families.
- Travel and transportation resources for community-based programs.

*For which populations are there opportunities to innovate and test new solutions through home grown programs?*

Many participants highlighted opportunities to develop innovative programming to improve outcomes for youth aging out of DCYF care, including both youth transitioning to independence and youth with significant mental illness who will likely need ongoing support services as adults. Additional opportunities to find new ways to improve outcomes were identified for families and communities challenged by recurring or chronic homelessness, lack of employment, parental mental health, and/or lacking other basic needs which contribute to removal; post-adoption supports for families with adopted children at risk of re-entering DCYF care; cross-system identification and primary (upstream) prevention for families at risk DCYF involvement; and resources for parents with cognitive limitations, or experiencing substance abuse, domestic violence, or multi-generational trauma, abuse, or neglect.

*Which of the services categories would most benefit from the evaluation of practices?*

- New approaches for consistently assessing risk, safety, and level of care needs
- Targeting and delivery of specialized services to special populations (including youth identifying as LGBTQQI and sexually exploited or trafficked youth)
- Post-permanency services that support sustainability of reunification and adoption
- Community-based services offered in lieu of residential care
- Crisis intervention, respite, and placement stabilization services

*What are some innovative practices in place today that support DCYF's primary objectives and outcomes?*

Multilateral collaborations were the most frequently cited innovations. Highlighted practices included cross sector partnerships between providers, DCYF, and national expert organizations; those between community providers, psychiatric providers, and medical providers; and partnerships between schools, local police departments, and others that address truancy. Multi-agency partnerships that facilitate transitions between residential and community-based services were also identified, as well as consolidated Youth Services and Bridges to Hope for older youth, Together Forever for "hard to place" kids. Respondents also pointed to Wraparound and peer supports offered by the FCCP programs, and pre-/post-natal home visiting programs.

*What are the biggest obstacles to implementing evidenced-based programs in your area of expertise?*

Obstacles identified by participants included recruitment, training, and retention of qualified staff, access to matched data from DCYF and other state systems (including NHP), consistency and matching of data given mobile clients, and difficulty of determining appropriate metrics (especially those to quantify social and emotional skills). Eligibility restrictions limit enrollment (often due to lack of stable caretaker) and model inflexibility makes it hard to tailor services to meet distinct child or family needs. Providers also pointed to the high costs of fidelity monitoring and reporting, and the lack of referrals to programs already in place.

*What are some community-based alternatives to congregate care?*

Participants suggested programs to assist workers in individualized, rapid kinship searches for children at risk of removal, leveraging faith-based organizations, and offering access to respite and crisis intervention programs.

### **III. How and when should procurements take place?**

*How should future procurements be scoped?*

A majority of respondents voted to procure the entire service array simultaneously. Others preferred a plan that would begin with community-based services before bidding residential and foster care, as well as a mixed approach that would blend approved vendor lists, formal contracts, and service procured on a rolling basis.

*What other approaches to procuring outcomes-based services should DCYF consider?*

Participants suggested that DCYF ensure that providers who offer multiple programs or a service continuum can respond on a way that represents their strengths, and that DCYF be as transparent as possible regarding the scoring criteria, scoring process, and agency priorities, and procure in such a way that allows vendors of all sizes and technical capacities to respond effectively.

*What evaluation criteria should be used for scoring?*

Participants most commonly suggested considering alignment between mission and goals of the program with the work to be conducted, including: alignment with primary outcomes program(s) seek to address; prior experience and demonstrated success working with the target population; and track records of meaningful collaboration with other providers.

**IV. How should DCYF work to refer the right children and families to the right services and supports? What mechanisms should be in place to transition children and families out of DCYF care?**

*What aspects of the current or prior placement process have worked well from your perspective?*

Kinship placements were cited by many as an area that is working well. Respondents felt that DCYF's referral unit that was in place prior to the networks had a process that was faster, facilitated better information sharing with caseworkers, and was less burdened by bureaucracy than the networks'. Respondents felt that clinical expertise was strong in the network placement process, providers were often willing to respond with flexibility and collaboration to children and families' needs, and voice and choice of the children and families involved was typically valued.

*What are two improvements that could be made to the placement process?*

The most common theme was increased information upon referral, including complete and accurate referral packets, comprehensive clinical assessments to improve quality of service matches, and clear communication about the identified service goals. Participants also suggested prioritizing matching based on clinical fit rather than open program slots, and that increased supports for foster and kinship families would improve provider's ability to accept placements and maintain safe environments. Many respondents were skeptical that the process could significantly improve without changing DCYF's relationship with the Family Court. Structured transition planning that brings together youth, families, DCYF, and providers was recommended to smooth the process for children after their initial contact with DCYF. Many expressed hope that bringing placement matching back into DCYF (instead of with the networks) would enable swifter decisions more consistently made based on children's needs and program strengths.

*From your perspective what is the single most important thing that you need from DCYF during the placement process?*

The two most common answers were consistent, regular communication from the department and accurate information about the child and/or family upon referrals. Other common answers included collaboration, respect, cultural competency and population-specific competency (especially for youth identifying as LGBTQQI).

*How should we redesign the placement or referral process to best promote the goal of permanency?*

Participants suggested setting permanency goals in a structured way and increasing concurrent planning. The process should also allow for ongoing adjustments, prioritize sibling placement, and authentically engage youth and parents in decisions about service goals and referrals.

*What is the best way to match children to services?*

Participants commonly suggested that matching should occur through a comprehensive clinical assessment, that identifies the needs of the child (including level of care) *and* the family. There was disagreement as to whether CANS is the right tool. Many indicated that keeping children in their local communities - schools, extended families, friends, and natural supports - should be a priority, and suggested greater investment in community-based and home-based programs to ensure sufficient capacity exists to meet the demands of the entire system. Some participants expect all parties to be flexible in their approaches, making sure that services are fitting themselves to the needs of the child/family instead of the reverse.

*How do we ensure that children are placed with the most supportive services in the least restrictive setting?*

Participants voiced the desire to involve youth, parents, and extended family in the entire placement process. They suggested meetings between DCYF, providers, the child and family, and other stakeholders should take place at regular intervals to determine adjustments or update plans, and that all conversations and policies should be supported by meaningful assessments, screenings, and evaluations implemented by qualified staff.

Some suggested the juvenile justice referral and placement process might be a model to replicate. Participants also suggested that referral functions should look different for developmentally disabled children and families. Respondents pointing out that referrals and placements should be designed to meet the needs of the entire family, not an individual child.

**V. How should DCYF and providers work together on outreach and education around service availability and delivery?**

*What is the most effective way to communicate between caseworkers and providers about service availability?*

The most common answer was the development of a real-time dashboard that would inform service providers and DCYF staff about program availability, capacity, wait lists, and characteristics of services. For daily case-level communication, respondents report success with using a mix of email, phone, and face-to-face contact with DCYF staff and other stakeholders.

*What is the most effective way for providers to communicate with each other to improve outcomes for children and families?*

Many responses called for frequent in person meetings between providers and DCYF to solve problems, identify gaps, and ask for support. Respondents had diverse opinions about the right way to group providers - some suggested by geography, by families served, or by specialty. Others suggested a web-based collaboration platform for DCYF and providers to allow for exchange of ideas, requests for support, and problem solving. Many respondents also flagged existing mechanisms that fill this gap, including network monthly meetings and the Rhode Island Coalition for Children and Families.

*What are the key obstacles to effective collaboration for children/families served by multiple systems, for example behavioral health and developmentally disabled populations, or populations with Medicaid and privately funded healthcare?*

Siloed operations, divergent service goals, and that mixed (sometimes conflicting) funding streams hinder collaboration and occasionally put the interests of state agencies or providers against each other. They noted that families, providers, and DCYF staff are often overwhelmed by differences in eligibility criteria, policy structures, and multiple actors and priorities.

*Under what circumstances should DCYF allow providers to embed staff within agency facilities?*

There was a wide diversity of opinions among respondents. Some providers suggested that all providers should be equally allowed to co-locate to improve communication, although concerns were raised about where smaller providers would find the staff capacity to do this. Others suggested that providers should be allowed to co-locate if they fulfill an essential function, have a specific grant-related responsibility, or if it is in the best interest of children/families. Others recommended that no providers should be allowed co-locate, as it risks blurring responsibilities.

*What should be DCYF's role in educating stakeholders about eligibility criteria of target populations?*

Most respondents felt that DCYF and EOHHS should take the lead on educating stakeholders about available services and target populations, but many expressed concern about the agency's track record with doing this in a consistent and accurate way. Many respondents voiced a desire to be involved in crafting information circulated by DCYF. Participants also asked for an up-to-date service manual posted on the DCYF website.

*What should be the providers' role in educating stakeholders about eligibility criteria of target populations?*

Respondents identified many possible ways to educate stakeholders about their services including trainings, group presentation, brochures, posters, program profiles, videos, web-based portals, open houses/resource fairs. Suggestions for where to circulate this information included DCYF supervisor meetings, regional staff meetings, and one-on-one with case workers. Differences in understanding exist on whether providers or DCYF responsible for determining program eligibility.

*How can the department support you in the licensing process?*

Participants suggested the department maintain and communicate an updated version of policies and procedures as it relates to regulation; communicate clearly regarding timelines, expectations, and policy changes; and explore ways in which the licensing process can be streamlined or take into account licensing by other state agencies.

**VI. How should service providers be compensated for their work in a way that incentivizes strong performance?**

*What service types are most appropriate for cost reimbursed contracts?*

Responses covered a wide array of services, and there seemed to be concern about moving away from the cost-reimbursement for services where the volume of activity is unpredictable and/or unknown. There were also suggestions that programs with high facility costs should be cost-reimbursed. The most common service types identified for this type of contract included emergency and urgent medical and psychiatric services, including shelters, start-up of new programming, preventative services, residential services, and foster care recruitment.

*What service types are most appropriate for fee-for-service contracts?*

Many felt outpatient clinical services, as well as assessment and evaluations, should be contracted through fee-for service. Others suggested that this type of contract should be the most limited in use, as compensation is not linked with performance. The most common service types identified for this type of contract included foster care, outpatient therapy and skill development services for parents or youth, evaluations, other clinical services, and home-based treatment.

*What services types are most appropriate for incentive-based contracts?*

All services types were represented in the responses. Many participants were open to incentive-based contracts if outcomes were clearly defined, different services were allowed to be blended, and the contract model allowed incentive payments to be in place alongside other payment options. The most common service types identified for this type of contract included residential care, community-based services, and foster parent recruitment and support.

*What service types are most appropriate for pay-for-performance contracts?*

The responses to this question express heightened anxiety about this type of contract, with some feeling that Rhode Island's child welfare system is not ready for this type of contract. Some expressed a willingness to consider this for some types of services as the system matures in the future. The most common service types identified for this type of contract included, adoption and foster parent recruitment, advocacy and campaigns, and training and recruitment.

*How can DCYF encourage accountability while maintain capacity in the system?*

Many suggested that increased communication around data and expectations is the key to accountability. In addition, there were many comments that DCYF needs to more consistently hold its workers accountable for performance in addition to the provider community. Participants asked for shared data, clearer expectations, more consistent communications, and quarterly monitoring and comparative reports of performance outcomes and fiscal utilization.

*What technical assistance would be required by your agency to operationalize a pay for performance or incentive based contract?*

Participants indicated a need for a range of supports and technical assistance to move toward pay for performance or incentive based contracts. These supports include, but are not limited to,



aggregated data that is consistent for all providers to access, funding to support the transition toward these contract structures, and jointly developed outcome measures.

*How can contracts or payment rates be structured to encourage bundling of services?*

There were few responses to this open discussion question; they included individualized service plans that encourage bundling of services, and bundling community-based and residential services by population and by outcomes identified in the service array.

## **VII. How should DCYF work with providers to continuously monitor and improve performance?**

*What are appropriate types of metrics for informing weekly real-time service adjustments?*

Many asked for shared data and web-accessible dashboards that inform on services being used throughout the system and data associated with the various services and outcomes, and suggested as metrics census, capacity (available services and waitlists), and length of stay. In addition, respondents had varying views on the frequency of weekly meetings and many suggested monthly meeting were more appropriate.

*What are the best ways to communicate data between providers and DCYF?*

Participants suggested having clear points of contact at DCYF, more face-to-face meetings, webinars, or monthly web-based meetings; a clean, easy to use database with individualized logins that provide seamless data entry methods, data visualization, and real-time report generation; and access to RICHIST.

*What are some ways to connect contract management with daily practice management through data reporting?*

Respondents suggested consistent use of data, and standard data definitions that are understood by all; clear and established points for contract for contract management and data; a formal process of regular data sharing; clear expectations for outcomes, operational items and activities; and a common desire to focus on performance improvements over compliance alone.

*What resources would providers require to move toward a culture of continuous quality improvement?*

Participants noted the importance of clarity on evaluation metrics, clean and accurate data, clear expectations for quality improvement, defined roles and responsibilities for DCYF staff and activities, a shared-decision making model for improving knowledge and quality improvement, and more face-to-face meetings with DCYF to problem solve.

*How can contract management be improved at DCYF?*

Participants highlighted opportunities to standardize contract management policy and practice at the agency, ensure staff have the right skill set to manage contracts and providers, improve the

consistency of data sharing, both between DCYF and providers and across providers, and clarify how financial and program management fit with contract monitoring.

### **VIII. What technical assistance is available to providers? What additional technical assistance opportunities would be helpful?**

*What types of technical assistance would help you provide more effective services?*

- Assistance navigating the state procurement process (16%)
- Program Evaluation (14%)
- Targeted Research on trends specific to populations and programs (13%)
- Strategic and business planning (5%)
- Budgeting (4%)

*On what specific topics would you like to receive technical assistance and/or training?*

Participants reported a need for technical assistance and/or training on using data to drive decisions, developing clean data sets, and designing data collection tools. In addition, many respondents also expressed interest in assistance developing logic models, defining outcomes and performance metrics, preparing for performance contracting, and conducting program evaluation.

### **IX. Wrap up**

*What is one new thing you learned from the Summit? Is there anything else you wish you had the opportunity to share?*

Many respondents were appreciative of the opportunity to be part of the discussion, learn more about DCYF vision for change, and felt that the summit provided transparency into the process and created hope for doing better for Rhode Island's children and families. Participants reported learning about the steps DCYF is taking to increase transparency through the use of data, procure services differently, and consider new ways of collaborating with providers.

Participants hoped to maintain momentum in deepening partnership with DCYF and asked for additional opportunities to share input. Additional recommendations included having strategic conversations with other state agencies and system stakeholders, laying out concrete action steps on advancing the vision considered at the summit, and publically sharing a summary of the summit findings.