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Progress of the New Jersey Department of Children and Families

Monitoring Report for *Charlie and Nadine H. v. Corzine*

January 1– June 30, 2007

Center for the Study of Social Policy
1575 Eye Street, NW, Suite 500
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I. INTRODUCTION

Purpose of this Report

In July, 2006 the Center for the Study of Social Policy (CSSP) was appointed by the Honorable Stanley R. Chesler of the United States District Court for the Third Circuit as Monitor of *Charlie and Nadine H. v. Corzine*. As Monitor, CSSP is to assess independently the State's compliance with the goals, principles and outcomes of the Modified Settlement Agreement (MSA) of the class action litigation aimed at improving the State's child welfare system.[1] CSSP released its Period I Monitoring Report in February 2007 describing progress New Jersey had made towards compliance with the MSA as of December 31, 2006.[2] This is the second Monitoring report under the MSA and covers the period of January through June 2007.

The MSA structures the State's commitments into two phases of work. Phase I (through December 2008) is primarily directed to building a strong infrastructure within the Department of Children and Families (DCF) to ensure that children are healthy and safe, achieve permanency and stability, and that resource and service delivery systems meet children's health, mental health, educational and developmental needs. This second Monitoring report reflects the State's continued work in and commitment to these foundational elements of a successful reform, and also describes the State's efforts towards implementing its new Case Practice Model (CPM), which will ultimately guide New Jersey's practice change and is intended to yield improved results for children and families.

Methodology

The primary source of information for this Period II Report is the Department of Children and Families (DCF). DCF provides the Monitor with extensive aggregate and back up data as well as access to staff at all levels to enable the Monitor to verify DCF data and report on actions taken and progress made. During this Monitoring period, the Monitor also visited seven Division of Youth and Family Services (DYFS) offices across the State: Warren, Ocean South, Atlantic West, Salem, Camden North, Essex North, and Somerset. The Monitor spoke with all levels of

[1] *Charlie and Nadine H . et al. v. Corzine*, Modified Settlement Agreement, United States District Court for the District of New Jersey, Civ. Action No. 99-3678 (SRC), July 18, 2006. To see the full Agreement, go to http://www.state.nj.us/dcf/home/Modified_Settlement_Agreement_7_17_06.pdf.

[2] *Progress of the New Jersey Department of Children and Families: Period I Monitoring Report for Charlie and Nadine H . v. Corzine – July 2006 through December 31, 2006.* Washington, DC: Center for the Study of Social Policy. February 26, 2007.

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DYFS staff. The Monitor also spoke with various stakeholders of New Jersey's child welfare system, including foster and adoptive parents, relatives and birth parents, providers, advocacy organizations, attorneys and the Office of the Child Advocate.

Section II of the report provides overall conclusions and a summary of the State's progress in meeting the MSA through June 30, 2007.

Other sections of the report provide specific information on the requirements of the MSA as follows:

Section III:	Continuing to Build a High Quality Workforce and Management Infrastructure
Section IV:	Changing Practice to Support Children and Families
Section V:	Appropriate Placements and Services for Children
Section VI:	Meeting the Health and Mental Health Needs of Children

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II. SUMMARY OF PROGRESS AND CHALLENGES AHEAD

Summary of Accomplishments
The past six months have been demanding for the relatively new Department of Children and Families (DCF) as it has moved to expand the range, scope and pace of its reform initiatives. Despite the complexity of the challenges and demands of widespread growth and change, DCF has built considerably upon its accomplishments from the previous monitoring period. As shown in summary fashion in Table 1 on pages 8 to 12 and discussed in more detail in this report, DCF fulfilled and often exceeded the expectations of the MSA in each area in which the MSA called for activity.

This monitoring period covers additional Phase I commitments in which DCF continued to focus on the development of leadership throughout the organization and on the fundamental building blocks which are the foundation of the overall reform effort. While keeping that focus, DCF has thoughtfully planned and begun to implement several major initiatives in this monitoring period which have promise to move the Department beyond building infrastructure and toward lasting systemic change and better outcomes for children and families.

Highlights of the Monitor's assessment of progress include:

The Department has continued to make progress in developing the infrastructure necessary to create lasting reform. Examples include:

- DCF achieved or exceeded the June 2007 caseload targets set for Permanency, Intake and Adoption staff. In site visits in different parts of the State, staff consistently confirm that their caseloads have improved markedly and that this reduction, in turn, has improved their ability to perform their jobs.

- DCF exceeded the benchmark for the ratio of supervisors to workers. Eighty-seven percent (87%) of offices are in compliance with the requirement of a five to one supervisory ratio. Having an adequate cadre of skilled supervisors is absolutely essential to the work ahead to improve direct practice with children and families.

- DCF continued to improve its ability to use data to monitor performance and expanded the data provided to the public on its website.

- Following a pilot deployment in Ocean County beginning in April 2007, DCF initiated Phase II of New Jersey SPIRIT in August—launching statewide a comprehensive automated child welfare information system. In preparation for the deployment, DCF trained over 5000 employees on how to use the system. Since deployment, DCF has been operating an extensive help desk and support system to identify and trouble-shoot problems and to alleviate the steep learning curve that is typically associated with the introduction of these complex data systems.

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- The Institutional Abuse Investigations Unit (IAIU) achieved the June 2007 target for timely completion of investigations. By June 2007, IAIU was expected to complete 80 percent of its investigations within 60 days of referral. On June 30, 2007, the State reported that IAIU had 373 open investigations. Of those, 332 (89%) had been open less than 60 days. These open cases reflect investigations in-progress on referrals from May and June.

- The Department succeeded in reaching or exceeding all of the expectations in the MSA pertaining to training.
    - The Pre-Service training curriculum was modified to incorporate principles from the Case Practice Model (CPM);
    - Newly hired workers continue to be enrolled in Pre-Service training within two weeks of their start date;
    - All newly promoted supervisors have taken Supervisory Training;
    - All case carrying staff were trained in concurrent planning;
    - 5,025 staff were trained on New Jersey SPIRIT; and
    - All existing DYFS and IAIU staff were trained on Intake and Investigations, and new staff will now receive Intake training as part of the Pre-Service training curriculum

Simultaneously to focusing on fundamentals, the Department took important steps to fundamentally change the way it works with families in New Jersey. For example:

- DCF developed a thoughtful and ambitious Case Practice Model Implementation Plan to guide the Department's multi-year reform work.

- DCF developed a comprehensive plan to improve the health care delivery system for children in out-of-home placement. When fully implemented, this plan creates and resources Child Health Units in every DYFS office in order to coordinate care and provide information and supports to parents and Resource Parents so that children are healthy and able to thrive. The plan also expands access to medical and mental health providers to ensure that each child's developmental, health and mental health needs are appropriately assessed and met.

Finding appropriate placements for children, while still a major challenge, was a significant focus of the Department in the past six months and it achieved solid results.

- DCF exceeded its mandate to license 1030 non-kin Resource Family homes, licensing 1287 new non-kin families between July 2006 and June 2007.

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- At the same time, more children than ever before are placed permanently with appropriate relatives, allowing them to maintain important family connections. The number of children placed through subsidized kinship legal guardianship grew by 26 percent from 2,002 in 2006 to 2,515 by June 2007.

- DCF directed significant resources to new programs to support adolescents, funding a youth permanency demonstration project and adding 112 transitional living beds for older youth.

- DCF contracted for additional in-state capacity to meet the treatment needs of severely troubled children and youth that have in the past necessitated out-of-state placement by the Division of Child Behavioral Health Services (DCBHS). When all of the programs are functioning, an additional 86 "specialty" treatment beds will be available in the State of New Jersey.

While there is a long way to go, there are promising data on some outcomes as the Department matures and meets or exceeds expectations in the MSA.

- The number of children supported in permanent families through adoption subsidies or kinship guardianship arrangements (13,244) as of August, 2007 exceeds the number of children in state custody in out-of-home placement (9,978).

- The Department finalized 634 adoptions as of June 30, 2007 and is on target to meet its 2007 goal of 1400 adoptions.

- There is a consistent net increase in the number of Resource Families licensed each month, fueled by new resources and departmental improvements in the recruitment and licensing processes. In the first half of 2007, the net gain of Resource Families (a total of 667 families) tripled compared to FY 2006.

- As of July 2007, 92 percent of children entering out-of-home care received pre-placement assessments conducted in non-emergency room settings.

Challenges Ahead

In structuring Phase I and II of the MSA, the parties deliberately attempted to recognize that system reform is a long-term process. Pressures for a "quick fix" come from all fronts, and are felt acutely by leadership, management, and the front lines of the workforce as well as by children and families. Despite the many accomplishments cited above, the state's child welfare system does not consistently function well and the urgency of the reforms remains. At a number of site visits, the Monitor listened to staff's understandable difficulty with the rapid pace of change. Different offices are at different places in terms of readiness for system change depending on how swiftly they have added staff, how new the staff are to the work, the strength of local leadership, and whether they have benefited from being one of the demonstration sites of

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a new initiative. At the same time that some staff experience the changes as too much and too fast, some advocates and families wonder why problems remain and the reform is taking so long.

The Commissioner has made a conscious effort to expand and strengthen the leadership team in Trenton and at the Area and Local Office Manager level in this monitoring period, but this is still a work in progress. The leadership team is exceedingly strong in some areas, while there are other areas of weakness that continue to require attention as the Department's reform work continues and accelerates. There have been two major leadership changes during this period with the departure of the Director of the Child Welfare Training Academy (NJCWTA) and the Director of the Division of Child Behavioral Health Services (DCBHS). The Director of Administration has assumed responsibility for the management of the NJCWTA and an Acting Director has been appointed to DCBHS while the search for a permanent Director is completed.

A major challenge of the past year, which continues going forward, is completing the implementation and user acceptance of New Jersey SPIRIT. During the past six months, the daily demands to keep the project on track, respond to crises and ensure that the full deployment was as positive as possible for both workers in the field and the public occupied an enormous amount of leadership time and attention. The experience of most public child welfare systems implementing data systems like SPIRIT suggests that the months following deployment are typically as challenging as the months leading up to it. While it is true that staff have been trained and that the information system is functioning generally well in most areas of the State, realizing the intended benefits of SPIRIT will require consistent work over the next year or two. There are system bugs to be worked out, processes and reports to be modified, glitches to be unstuck, workers to be retrained and most importantly, consistent attention by managers at all levels on the need for proper data entry and on the use of the information for more effective case management and performance monitoring. Implementing a new data system is an enormous undertaking. Constant attention will be required over the next several months in order for SPIRIT's potential for management, data analysis and tracking to be fully realized.

As is clear from the Case Practice Model Implementation Plan discussed in detail in this report, implementing the new CPM is another formidable challenge, but a fundamentally necessary one in order to produce lasting change. In the Monitor's site visits, the inexperience of the workforce is readily apparent. Corroborated by the data on the number of new workers hired in the past year to 18 months, many offices are filled with workers who are either just completing training or have recently moved out of trainee status. The importance of their attachment to high quality Training Supervisors in their first few months was underscored by the workers who viewed the mentoring they received from those staff as essential for their successful transition to the job. As the Department moves forward to operationalize a practice model which demands new ways of working with families and with the community, training, support, coaching and mentoring will be necessary for not only the new and inexperienced workers but also for veteran workers. The demand for this kind of help is significant but it is hard to imagine the case practice transformations taking root and flourishing without such investments. Further, in implementing the Case Practice Model, the Department will need to consistently engage with and rely heavily on its partners in the community and across the State.

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Another challenge the Department will face in the coming months is implementing its newly created Health Care Plan—moving quickly to deploy the resources of the Health Care Units to the field, ensuring that the provider capacity for comprehensive assessments and follow-up treatment and care is developed, resourced and connected, and putting in place the data systems to track successful implementation. The shortage of willing providers for dental care must be addressed through both changed relationships and commitments and will also likely require a change in Medicaid reimbursement.

A significant challenge for the Department in implementing both the Health Care Plan and the Case Practice Model is space constraints. At each site visit, the Monitor heard from every level of staff that more space is necessary to carry out the Department's new initiatives. More space is needed for nurses, for health care visits, for parent/child visits, for family team meetings and the like. Further, as the Department has expanded so quickly, many of the newer local offices are located in places that are inaccessible by public transportation and sometimes far from the children and families the Department serves. The challenges of space (both the lack of appropriate space and the poor conditions of some offices sites) need to be approached with both short-term and longer term solutions. This is an issue which DCF cannot solve on its own; it will require assistance from other parts of state government.

An additional challenge is the Department's work with older adolescents. The Department has made notable progress in directing attention and resources to older youth in out-of-home care. However, this is a population that has been long neglected by system efforts. The Department has amended policies and procedures, but will need to move beyond plans to action to ensure real change for youth.

DCF has a lot of hard work ahead to realize the vision of an integrated agency that meets the needs of children and families in less categorical ways. While beginning steps have occurred to link the work of the Division of Youth and Family Services (DYFS), the Division of Child Behavioral Health Services (DCBHS) and the Division of Prevention and Community Partnerships (DPCP), much more will be required to move beyond artificial boundaries and distinctions to better serve children and families. Further, in every site visit and despite the fact that the Department has moved aggressively in this last year to increase contracted resources for community-based services for families and children, staff report the difficulties they experience in gaining access to the services that families need in their communities. These include such basic services as substance abuse treatment, help to secure safe housing, in-home counseling and family preservation services, mental health services and family support. The Governor and the Legislature should be commended for providing DCF sufficient resources to begin the work to expand necessary community services and supports. Developing and sustaining an appropriate and complete service array across the State is likely however to require consistent and additional resource commitments over the next several years.

In summary, the Department's work in this monitoring period has been focused and productive. Many promising strategies have been introduced, which will need to be consistently translated into new practices and accessible services on the ground for the Department to succeed in its mission of fundamentally changing how it works with children and families in New Jersey.

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Table 1:
Summary of State Progress on Modified Settlement Agreement Requirements
(January – June 2007)

Settlement Agreement Requirements	Due Date	Fulfilled (Yes/No)[3]	Comments
New Case Practice Model			
II.A.3 Begin implementation of the case model practice.	Development of CPM--December 2006 Ongoing implementation	Yes	Case Practice Model Implementation Plan completed in August 2007. Implementation underway.
Training			
Pre-Service Training			
II.B.1.a Institute Pre-Service Training program to include training on intakes and investigations and the new case practice model	January 2007	Yes	Pre-Service training modified to reflect case practice model and First Responder curriculum on intake and investigation.
II.B.1.b 100% of all new case carrying workers shall be enrolled in Pre-Service Training	September 2006	Yes	412 workers completed Pre-Service training 01/07 – 06/30/07. 94% were enrolled within two weeks of starting date
II.B.1.c No case carrying worker shall assume a full caseload until completing Pre-Service training and until after she has passed competency exams	September 2006	Yes	New protocols for competency assessment developed.
In-Service Training			
II.B.2.a Develop and institute In-Service Training program for case carrying staff, supervisors and case aides	April 2007	Yes	By agreement of parties, training on New Jersey SPIRIT and concurrent planning meet In-Service training requirements for this monitoring period.
II.B.2.d Implement in-service training on concurrent planning for all existing staff	September 2006	Yes	3,251 staff trained in Concurrent Planning. 729 staff trained between 01/07 - 06/30/07.

[3] "Yes" indicates that, in the Monitor's judgment based on presently available information, DCF has substantially fulfilled its obligations regarding the requirement under the Modified Settlement Agreement for the January-June 2007 monitoring period; or is substantially on track to fulfill an obligation expected to have begun during this period and be complete in a subsequent monitoring period. "No" indicates that, in the Monitor's judgment, DCF has not fulfilled its obligation regarding the requirement.

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Settlement Agreement Requirements	Due Date	Fulfilled (Yes/No)[3]	Comments
II.B.2.e 100% of caseworkers, supervisors and case aides not previously trained on the new case practice model shall have received this training.	Beginning April 2007 Continued through December 2007	Yes	By agreement of parties, training on New Jersey SPIRIT and concurrent planning meet training requirements for this period. Case practice model training commences 1/08 and continues through 12/08.
Investigations/Intake Training			
II.B.3.a All new staff responsible for conducting intake or investigations shall receive specific, quality training on intake and investigations process, policies and investigations techniques and pass competency exams before assuming responsibility for cases.	September 2006	Yes	Incorporated in Pre-Service training.
II.B.3.b All staff responsible for intake or investigation not previously trained shall receive specific training on intake and investigations process, policies, and investigation techniques.	June 2007	Yes	769 DYFS and 64 IAIU staff trained 01/01/07 – 06/30/07.
Supervisory Training			
II.B.4.b 100% of all staff newly promoted to supervisory positions shall complete their 40 hours of supervisory training and shall have passed competency exams within 3 months of assuming their supervisory positions	December 2006	Yes	114 new supervisors trained 01/01/07 – 06/30/07.
II.B.4.c 100% of supervisors promoted to supervisor before December 2006 shall receive their 40 hours of the supervisory training and have passed competency exams.	June 2007	Yes	138 previously hired supervisors trained 01/01/07 – 06/30/07.
Services for Children and Families			
II.C.2 Seek approval from federal government for Medicaid structure to support the use of community and evidence-based, informed or support practices for children and families.	June 2007	Not applicable	DCF was able to meet this requirement without needing to seek approval from the federal government.
II.C.3 Permit the utilization of flexible funds for birth families involved with DYFS to better promote family preservation and reunification.	June 2007	Yes	$1 million increase budgeted for FY08.
II.C.4 Develop and thereafter implement a plan for appropriate service delivery for gay, lesbian, bisexual, transgender and questioning (GLBTQ) youth.	June 2007	Yes	GLBTQ plan developed; implementation is ongoing. Monitor views plan as preliminary and to be refined as case practice model is implemented.

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Settlement Agreement Requirements	Due Date	Fulfilled (Yes/No)[3]	Comments
II.C.5 Promulgate and implement policies designed to ensure continuous services to youth between ages 18 and 21 similar to services previously available.	June 2007	Yes	Implementation is ongoing.
II.C.11 Add 18 transitional living program beds for youth between the ages of 16 and 21.	June 2008	Yes	DCF met this requirement early and far exceeded the number of beds, adding 112 transitional beds.
Finding Children Appropriate Placements			
II.D.3 Evaluate the needs of children in out-of state congregate placements to determine and develop action steps with timetables to serve children with these needs in-state.	June 2007	Yes	Evaluation has been completed. Conferences to develop strategies for children's return have been scheduled through October 2007 for 119 children involved with DYFS and placed out of state.
II.D.8 DYFS will eliminate the inappropriate use of shelters as an out-of-home placement for children in its custody.	June 2007	Yes	Policy has been issued.
Caseloads			
II.E.9 79% of offices shall have average caseloads at the standard of 15 families or less and 10 children in out-of-home care or less for the permanency staff.	June 2007	Yes	84% of offices met this requirement.
II.E.10 58% of offices shall have average caseloads for the intake staff at an interim caseload standard of 15 families or less and 10 new referrals or less.	June 2007	Yes	82% of offices met this requirement.
II.E.11 85% of offices shall have sufficient supervisory staff to maintain a 5 worker to 1 supervisor ratio.	June 2007	Yes	87% of offices met this requirement.
Provision of Health (Medical and Mental Health)			
II.F.5 and II.F.6 Set health care baselines and targets. Methodology for tracking compliance decided.	January 2007	Yes	Baselines have been set for June 2007 and the staging of targets agreed upon. The methodology for measuring all health care indicators is still under negotiation.
II.F.7 90% of children entering out-of-home custody shall have pre-placement assessments in a setting other than an emergency room.	June 2007	Yes	Requirement met as of July 2007 (92% in non-emergency settings).

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Settlement Agreement Requirements	Due Date	Fulfilled (Yes/No)[3]	Comments
II.F.8 Identify a statewide coordinated system of health care including a provision to develop a medical passport for children in out-of-home care.	June 2007	Yes	State has developed an ambitious plan which, among other things, expands the number of comprehensive medical exam providers and creates Child Health Units. Plan for Medical Passport developed.
Permanency Planning and Adoption			
II.G.12 Complete the adoption case transfer process across 100% of offices.	June 2007	Yes	
II.G.13 60% of offices for the adoption staff will have average caseloads consisting of 18 or fewer children.	June 2007	Yes	90% of offices have average caseloads at or below the standard.
II.G.14 Implementation of the adoption process tracking system.	June 2007	Yes	Tracking system is used in the 10 Concurrent Planning demonstration sites and is expected to be expanded statewide.
Resource Families			
II.H.9 Create an accurate and quality tracking and target setting system for ensuring there is a real time list of current and available Resource Families.	June 2007	Yes	Capacity developed in New Jersey SPIRIT
II.H.10 1,030 Non-kin Resource Family homes are licensed.	June 2007	Yes	1,287 non-kin family resource homes licensed.
II.H.15 Continue to further close by 25% the gap between current Resource Family support rates and the USDA's estimated cost of raising a child.	January 2007	Yes	New rates effective January 1, 2007.
Institutional Abuse Investigations Unit (IAIU)			
II.I.3 Completed 80% of IAIU investigations within 60 days.	June 2007	Yes	89% of investigations completed within 60 days.
II.I.4 All IAIU investigators provided with specific training on intake and investigations process, policies, and investigative techniques.	June 2007	Yes	64 IAIU workers trained 01/01/07 – 06/30/07.
Data			
II.J.5 Identify, ensure accuracy, and publish additional indicators.	February 2007	Yes	DCF continues to expand data published on website.
II.J.6 DCF agency performance reports produced with a set of measures approved by the Monitor.	February 2007	Yes	

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Settlement Agreement Requirements	Due Date	Fulfilled (Yes/No)[3]	Comments
II.J.7 New Jersey SPIRIT Release 2, Phase II	February 2007	Yes	State roll out beginning with Ocean County (pilot site) and full State deployment August 2007.
II.J.8 All case carrying workers trained on New Jersey SPIRIT.	May 2007	Yes	From April – August 2007, 5025 staff trained on New Jersey SPIRIT.

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III. CONTINUING TO BUILD A HIGH QUALITY WORKFORCE AND MANAGEMENT INFRASTRUCTURE

A. Caseloads

New Jersey's child welfare system cannot be expected to be successful unless and until it has a sufficient, stable and well-trained workforce. During this monitoring period, the Department continued to make exceptional progress toward achieving this goal. For years, excessively high caseloads in DYFS were a visible problem and source of controversy. While there was unanimity that caseloads were too high, the accuracy of data tracking and the high turnover of staff made it difficult to assess and tackle the problem. A high priority for the Modified Settlement Agreement (MSA) is the accuracy and transparency of caseload data and steady and rapid progress toward reducing worker caseloads across the State. The Department continued to demonstrate progress in both of these areas in the past six months. As discussed below, the State has met or exceeded each of the staffing commitments of the MSA for this monitoring period. The support from the Governor and the Legislature for the additional funds needed to hire the large number of case workers and supervisors required to reduce caseloads has been critical to DCF's success in this area. Continued support will be needed in subsequent monitoring periods to comply with additional caseload reductions before the end of Phase I in December 2008.

The Monitor took several steps to verify independently the reported caseload information. First, the Monitor and Department staff reviewed previous draft reports and the methodology used to compute the caseloads as well as the process put in place for verifying and refining the caseload reporting. This included reviewing examples of communication between central office and local managers regarding the exception reporting. This review identified an average of 10 corrections per office that were needed to improve the accuracy of the caseload data. Types of corrections needed included:

- Updating the appropriate program and personnel systems with worker leave information, updated trainee status, name spelling corrections, worker program area (i.e., intake, adoptions, permanency) Each of these corrections affect the "available pool" of workers by which the caseload averages are calculated.
- Correcting case assignments.

In addition to assessing the Department's internal quality assurance on the accuracy of caseload data, the Monitor collected information from the seven site visits and telephone interviews with local office managers in ten randomly selected offices. All personnel interviewed confirmed the accuracy of the Department's reporting on caseload and the vast majority of staff highlighted the positive effects of recently reduced caseloads. This independent review confirmed the accuracy of the State's caseload reporting for June 2007. The principal accomplishments regarding caseloads include:

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1. The State has continued to track and publicly report caseload information.

DCF can now accurately track and report on worker and supervisor caseloads. The tracking system allows the Department to provide accurate and increasingly more detailed caseload information quarterly on its website (www.state.nj.us/dcf). March 31, 2007 caseload data was posted on the website in May 2007 and June 30, 2007 caseload data was posted in September 2007. Additionally, caseloads for trainees in each unit are reported separately (MSA, Section II.E.2) and both levels of supervisory staff (SFSS1 and SFSS2) are separately counted and the website provides data on SFSS2 staff.

2. DCF exceeded the June 2007 caseload target for average caseloads of Permanency staff.

Permanency workers are assigned to provide case management of services to families whose children remain at home under the protective supervision of DYFS and those families whose children are removed from home due to safety concerns. To ensure staff has the time to devote to children and families with diverse needs and circumstances, the State agreed to achieve a caseload standard that has two intertwined components. One component is the number of families per worker and the other component is the number of children placed in out-of–home care per worker. This has been referred to as a "two prong" standard. Permanency workers are to serve no more than 15 families and 10 children in out-of-home care. If either of these standards is higher, the caseload is not compliant with the Modified Settlement Agreement standard (MSA, Section II.E).

During Phase I, caseload compliance is measured by *average* caseloads in an office. Ultimately, the Phase I goal is for 95 percent of all offices to have permanency workers that meet the two-pronged standard for average caseloads. This goal is to be achieved over a period of time with targets starting in 2006, and with the final target of 95 percent to be achieved by December 2008. As of June 2007, average caseloads in 79 percent of all local offices[4] are to meet the caseload standard. (MSA, Section II.E.9.)

As displayed in Figure 2, the State exceeded this target with 84 percent of the offices having average caseloads for available Permanency workers of 15 families or fewer and 10 or fewer children in placement. The State also reported to the Monitor that less than one percent of all case workers had caseloads of more than 30 families in June 2007. This data was independently verified by the Monitor as previously described. Appendix A contains a table with supporting detail on caseloads for each local office.

[4] On June 30, 2007, there were 46 local offices.

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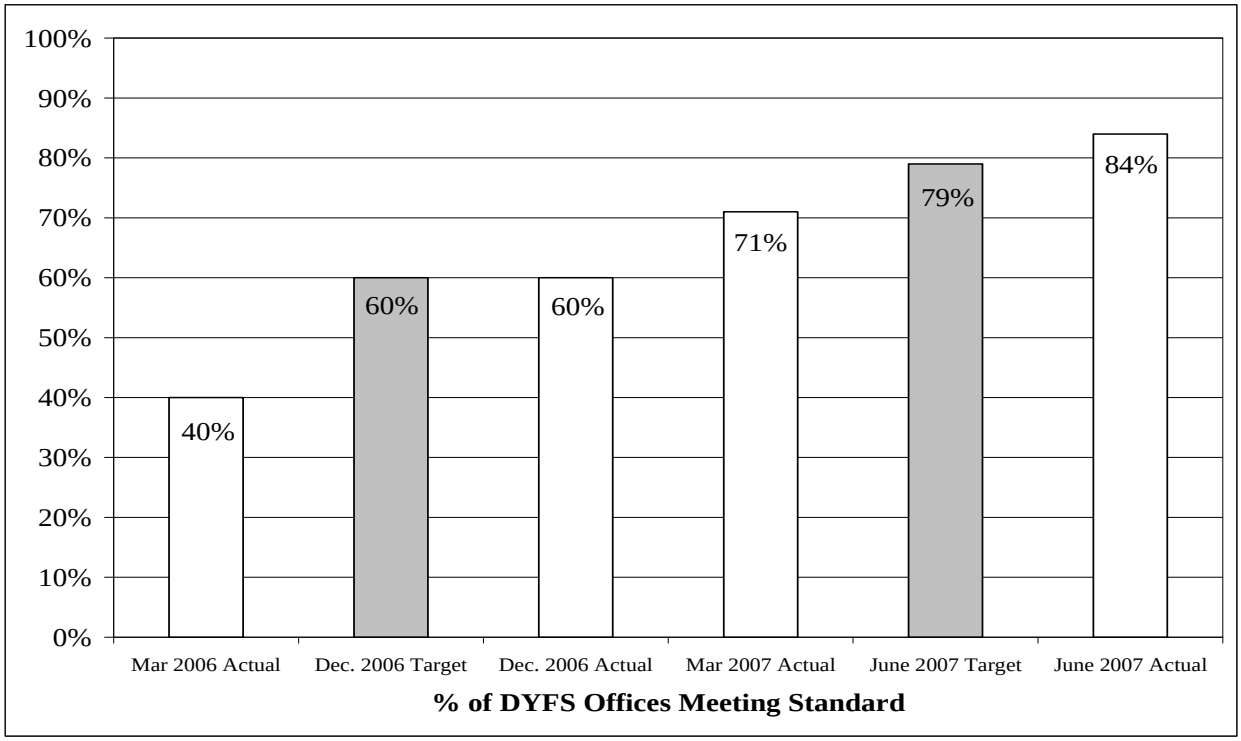
Figure 2:
NJ DCF DYFS Permanency Worker Caseloads* Compliance by Office



Source: New Jersey Department of Children and Families, Office of Policy and Planning
*Permanency caseload standard is 15 families and no more than 10 children in placement.
Note: DCF reports caseload data quarterly and the targets in the MSA were set at 6-month intervals (December and June).

3. DCF exceeded the June 2007 caseload target for average caseloads of Intake staff.

DYFS Intake staff is responsible for responding to community concerns regarding child safety and well-being. They take referrals from the State Central Registry and depending on the nature of the allegation, have 2 hours to 5 days to visit the home and begin their investigation and assessment under the MSA. They are to complete their investigation and assessment within 60 days. The caseload standard for Intake staff also has two components. One component is the number of families under investigation or assessment at any given time and the other component is the number of new referrals assigned to a worker each month. When fully implemented in Phase II, intake workers are to have caseloads of 12 families or less and 8 new referrals or less per month. (MSA, Section III.E). The interim standard in Phase I is caseloads of 15 families or less and 10 or fewer new referrals per month.

As with the Permanency caseloads, the Phase I standard for Intake staff is based on *average* caseloads in an office and by December 2008, the goal is for 74 percent of all offices to have average caseloads for intake workers that meet the two-pronged standard. As of June 2007, 58

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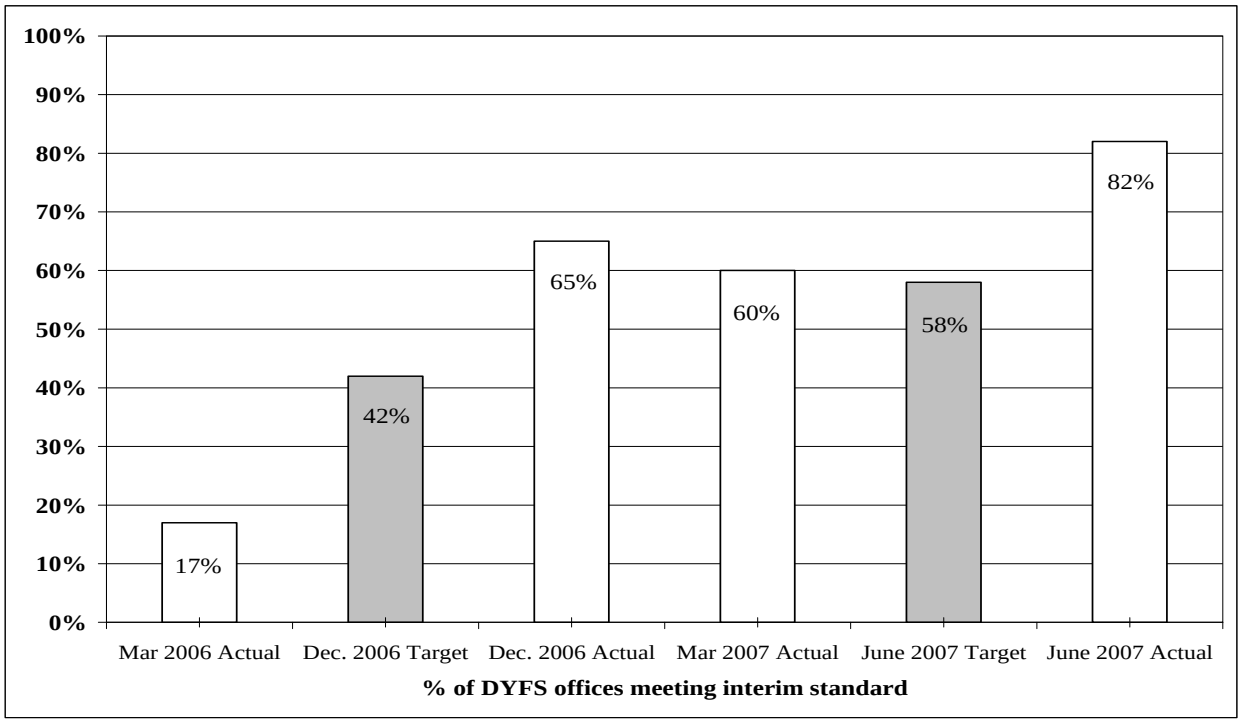
percent of all local offices were to have average caseloads for Intake staff of 15 families or less and 10 or fewer new referrals per month. (MSA, Section II.E.10)

As displayed in Figure 3, the State has exceeded this second target with Intake staff since December 2006. As of June 2007, 82 percent of the offices had average caseloads for Intake staff at or below the standard. This data was independently verified by the Monitor as part of the previously described process. Appendix A contains a table with supporting detail for each office.

Figure 3:
NJ DCF DYFS Intake Worker Caseloads*



Source: New Jersey Department of Children and Families, Office of Policy and Planning
*Interim Intake worker caseload standard is 15 families and 10 new referrals per month.

4. DCF exceeded the June 2007 caseload target for average caseloads of Adoption staff.

Adoption staff are responsible for moving children to permanency by developing adoptive resources and performing the work needed to finalize adoptions. The MSA requires the State to assign children with a goal of adoption to designated adoption workers (except in the small number of cases where there is a previously established relationship with a permanency caseworker or other acceptable reason) (MSA, Section II.G).

As with the Permanency caseloads, by June 2008, the goal is for 95 percent of offices to have average caseloads for Adoption staff of 18 or fewer children with a subset of 60 percent of the offices achieving average caseloads of 15 or fewer families (MSA, Section II.G.18). As of June

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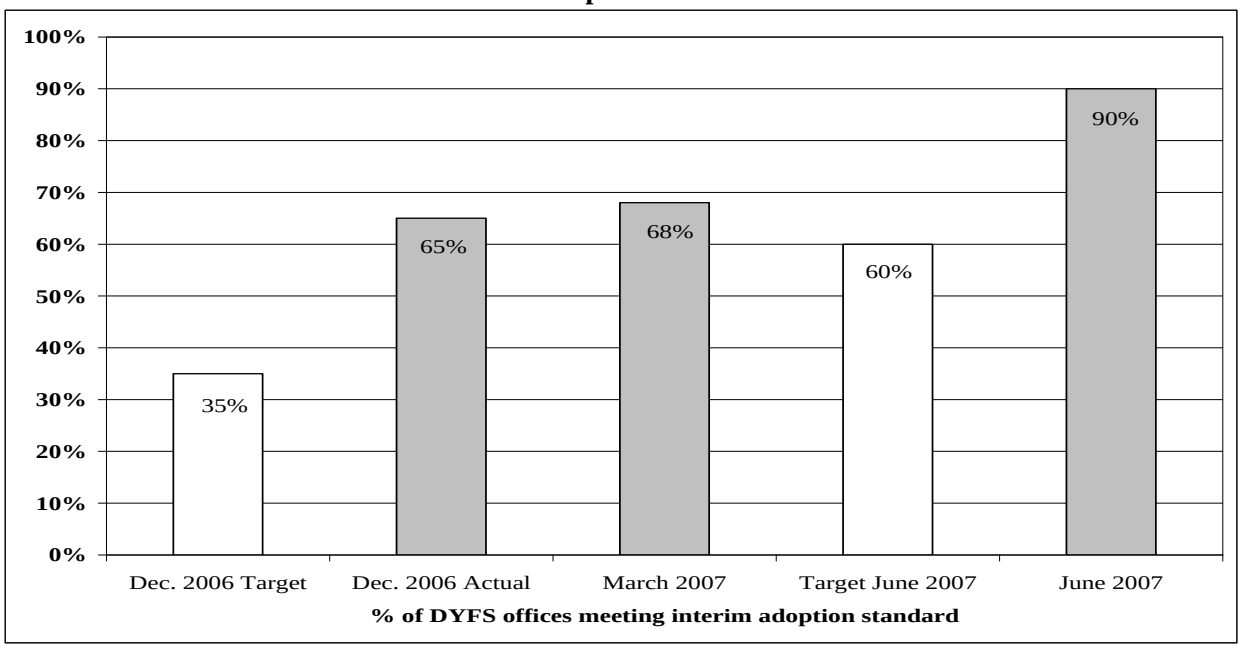
2007, 60 percent of local offices are to meet an interim standard of average caseloads for Adoption staff of 18 or fewer children (MSA, Section II.G.13).

As displayed in Figure 4, the State far exceeded the June 2007 target with 90 percent of the offices having average caseloads for Adoption staff at or below the interim standard. This information was verified by the Monitor using the previously described approach. Appendix A contains a table with supporting detail for each office.

Figure 4:
NJ DCF DYFS Adoption Worker Caseloads*



Source: New Jersey Department of Children and Families, Office of Policy and Planning
*Interim Adoption caseload standard is 18 or fewer children.
Note: Prior to December 2006, adoption staff and cases were included in permanency caseload data.

5. DCF exceeded the benchmark for ratio of supervisors to workers.

Supervision is a critical role in practice with children and families and the span of supervisor responsibility should be limited to allow more effective individual supervision of workers. Therefore the MSA established standards for supervisory ratios. By December 2008, 95 percent of all offices should be able to maintain a five worker to one supervisor ratio (MSA, Section II.E.17). Like the caseload standards, this standard was to be phased in starting in December 2006. As of June 2007, 85 percent of the offices were to have sufficient supervisory staff to maintain a five worker to one supervisor ratio. (MSA, Section II.E.11)

As displayed in Figure 5, the State exceeded the second target with 87 percent of the offices having 5 to 1 supervisory ratios. This ratio is calculated using only the SFSS2 staff.[5]

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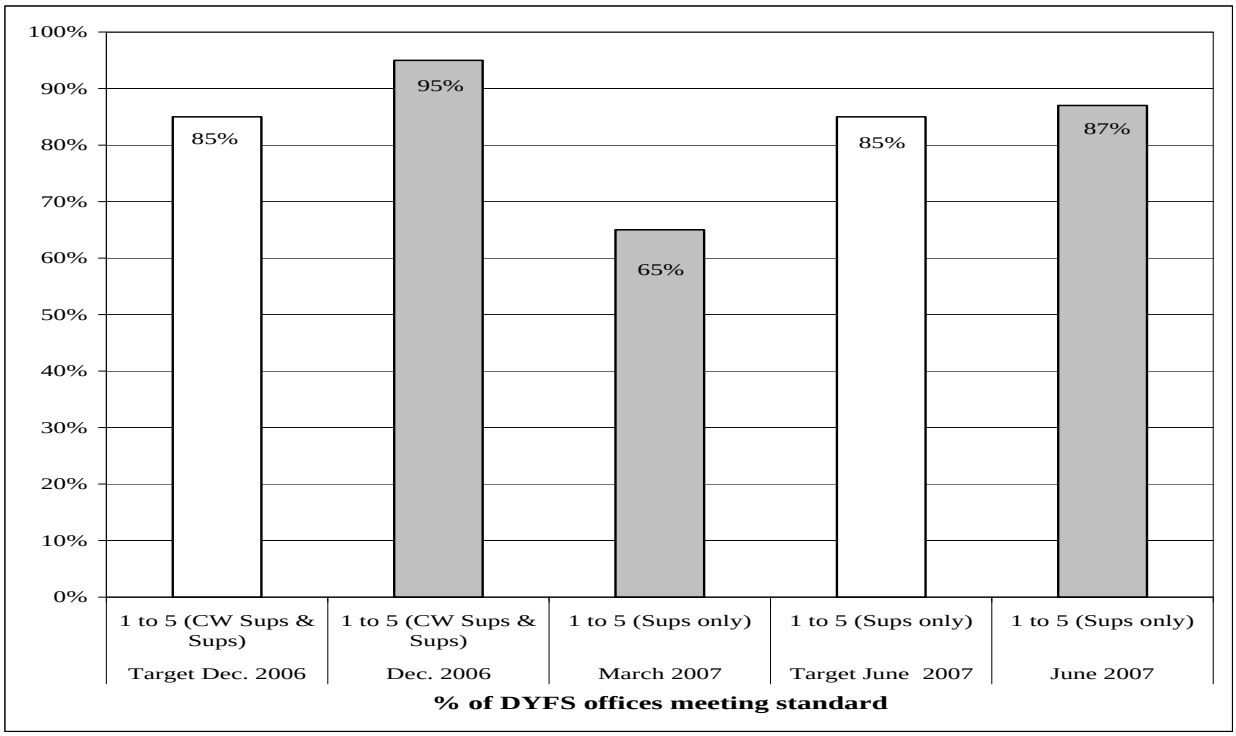
Appendix A contains a table with supporting detail for each office, including the number of supervisors in each level.

Figure 5:
NJ DCF DYFS Supervisor to Caseload Staff Ratios



Source: New Jersey Department of Children and Families, Office of Policy and Planning

[5] The Department has two supervisor levels. One level, Supervising Family Service Specialist 2 (SFSS2), is a direct frontline supervisor position responsible for supervising a casework unit. The field refers to this position as "supervisor" or "unit supervisor." The second level is Supervising Family Service Specialist 1 (SFSS1). In the field, this position is referred to as "Casework Supervisor." In general, five unit supervisors typically report to a Casework Supervisor. Prior to the March 31, 2007 reporting, DCF had combined both casework supervisors and frontline supervisors in the generic category of "supervisors" in the reported supervisor ratios. The web site posting now reflects the effect of disaggregating the supervisors. For purposes of meeting the Modified Settlement Agreement Standards of Supervisory ratios, only the number of unit supervisors (SFSS2) will be used going forward.

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6. Local Office Insights and Comments about Caseloads

In-person and telephone interviews with casework staff, supervisors and area and local office management confirm that caseload sizes have substantially improved since March 2006 and highlight caseload reduction as an area of significant progress. Even those offices that were not yet in compliance with all or some of the caseload standards have experienced notable reductions. When asked about the largest individual caseloads in June 2007, local office management indicated some Permanency and Intake workers might have had caseloads as high as 18 to 28 families. Some individual adoption caseloads were as high as 20 children in some offices. Local office personnel also cited individual caseloads as low as 13 families and adoption caseloads with no more than 9 or 14 children. Staff at many of the local offices visited commented on caseloads being more manageable, producing less stress and allowing more contact and better practice with children and families. Likewise, those workers who continue to have higher caseloads report that they don't have time "to do what we're supposed to do."

B. Training

As shown in Table 6, the State met each of its MSA obligations for training during this monitoring period. Given the large numbers of new staff added to the workforce, this has not been an easy accomplishment. The state's Director of the New Jersey Child Welfare Training Academy (NJCWTA) resigned during this period. Until a new permanent Director is selected, the NJCWTA is being managed by DCF's Director of Administration.

Highlights of the Department's work this monitoring period in training are:

- Modification of the Pre-Service training to incorporate principles from the Case Practice Model;
- All newly promoted supervisors have taken Supervisory Training;
- All staff were trained on concurrent planning;
- All case carrying staff, supervisors and others (5,025 staff) were trained on the State's new automated Child Welfare Information System, New Jersey SPIRIT; and
- Nearly all existing staff members were trained in Intake and Investigations; new staff members will henceforth receive Intake training as part of Pre-Service training.

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Table 6:
DCF Child Welfare Training Academy MSA Compliance Data
January 1, 2007 – June 30, 2007

Training	Settlement Commitment Description	# of Staff Trained in 2006	# of Staff Trained in 1st 6 months 2007	Total # of Staff Trained (Cumulative)
Pre-Service	Ongoing: New caseworkers shall have 160 class hours, including intake and investigations training; be enrolled within two weeks of start date; complete training and pass competency exams before assuming a full caseload.	711	412	1,123
In-Service	Ongoing: Training on concurrent planning; may be part of 20 hours in-service training by December 2007.	2,522	729	3,251
Investigations & Intake: New Staff	Ongoing: New staff conducting intake or investigations shall have investigations training and pass competency exams before assuming cases.	0	650	650
Investigations & Intake: Prior Staff	Between September 2006 and June 2007, staff currently responsible for intake and investigations who has not received investigations training shall have that training.	150	*DYFS* 769 *IAIU* 64	*DYFS* 919 *IAIU* 64
Supervisory: New Supervisors	As of December 2006 and ongoing, newly promoted supervisors to complete 40 hours of supervisory training; pass competency exams within 3 months of assuming position.	0	114	114
Supervisory: Prior Supervisors	By June 2007, supervisors promoted before December 2006 who had not previously received supervisory training shall have 40 hours of that training and pass competency exams.	44	138	182
Adoption Worker	As of December 2006, adoption training shall be provided for adoption workers.	91	140	231
New Jersey SPIRIT	New Jersey SPIRIT training for all case carrying workers by May 2007; may be part of 20 hours in-service training.	0	5,025	5,025

Source: DCF data, verified by Monitor August 2007.

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1. Pre-Service Training

a. DYFS revised its Pre-Service training to incorporate the new Case Practice Model and continues to provide a minimum of 160 hours of classroom training to newly hired staff.

The New Jersey Child Welfare Training Academy (NJCWTA) revised its Pre-Service training curriculum in this monitoring period to reflect the newly developed CPM. (MSA, II B.1.a) The new Pre-Service curriculum, entitled Family and Community Engagement Training, contains concepts, strategies and skills building exercises on engaging families and communities. The Department will be working with consultants to review these initial modifications to ensure they are consistent with changes to its In-Service and other training curricula and New Jersey's new CPM is the organizing principle of all training offerings. The Monitor will be involved in this change process, and will evaluate revisions to the Pre-Service and the In-Service training curricula in upcoming monitoring periods.

The Pre- Service curriculum as revised consists of 162 hours of training, 27 classroom days and 21 field instruction days. Figure 7 below shows the 11 modules that comprise the revised curriculum.

Figure 7:
New Jersey Pre-Service Training Curriculum

	Orientation – Welcome to DCF
Module 1	Understanding Child Welfare in New Jersey
Module 2	Taking Care of Yourself
Module 3	Computer Applications
Module 4	Self-Aware Practitioner
Module 5	Focusing on Families: From Screening to Closing
Module 6	Engagement and Interpersonal Helping Skills
Module 7	Child Development and Identification of Child Abuse and Neglect
Module 8	Assessing Strengths and Needs of Families
Module 9	Facilitating Change
Module 10	Structured Decision Making (SDM)
Module 11	Simulation

Source: NJCWTA as of June 2007

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b. All new case-carrying workers are enrolled in Pre-Service training within two weeks of their start date (MSA, II.B.1.b).

During the monitoring period, the Department hired 392 staff as Family Service Specialists. These 392 staff members as well as staff hired at the end of 2006[6] were required to take Pre-Service training. A total of 412 staff was enrolled in Pre-Service training between January and June 2007. The Monitor reviewed training logs of Pre-Service training participation for the months of January 2007 to June 2007 and cross-referenced human resource records with rosters of participants in Pre-Service training sessions conducted in the same period. This review established that 94 percent of Department trainees are enrolled in Pre-Service training within two weeks of their start date as required by the MSA. The Monitor's discussions with staff at various local offices throughout the State reveal that the Pre-Service training is generally well received.

c. DYFS revised and standardized its competency exams to better assess when new workers are ready to assume a full case load (MSA, II.B.1.c).

The MSA requires the Department to have standardized exams to assess worker competency before assuming a full caseload. Trainees take competency exams associated with each module of the Pre-Service training. In the first Monitoring Report, the Monitor recommended the Department revise its protocol for certifying when a trainee can assume a full case load. The NJCWTA developed a comprehensive tool to make this assessment, and has begun implementing it during this monitoring period. The new tool allows Field Training Unit Supervisors and others to more effectively evaluate a trainee's strengths and weaknesses, and make suggestions for areas of improvement. The Department will continue to evaluate whether the new assessment tool meets its need to effectively evaluate the competence of a new trainee.[7]

2. In-Service Training

a. The State has trained its staff on New Jersey SPIRIT as part of the requirement to begin an In Service training program (MSA, II.b.2.a).

At the conclusion of the last monitoring period, the parties agreed to permit the Department's training of staff in New Jersey SPIRIT to satisfy the MSA requirement to institute In-Service training by April 2007. As discussed on page 29 of this Report, the Division began training on New Jersey SPIRIT in April 2007 in Ocean County and with web-based training throughout the State. By the end of August 2007 the State had trained 5,025 staff on its new information technology system, including all of its 2,026 workers and 500 supervisors**.**

[6] 412 staff includes 20 staff hired at the end of 2006 who were required to take Pre-Service training within two weeks of their start so were trained in the current monitoring period.

[7] The Monitor recommended that this instrument include a scaled grade rather than a pass/fail assessment in order to assist in evaluating staff development needs. The Department agreed to re-evaluate this recommendation after gaining some initial experience with the assessment process.

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b. DYFS has provided in-service training on concurrent planning for existing staff (MSA, II.B.2.d).

The focus of concurrent planning is the development of permanency plans that incorporate reunification and long term planning in the event reunification is not possible. The Department has implemented In-Service training on concurrent planning through its contract with Rutgers University School of Social Work (Rutgers). In response to staff requests, the Department conducted the Concurrent Planning training in a variety of different locations and in local offices. As of June 30, 2007 the NJCWTA had recorded a total of 3,251 staff that Rutgers had trained. The Department reports all existing staff has now been trained on concurrent planning. The Monitor cross referenced a random sample of 37 staff transcripts with human resource data and found that all existing staff had taken Concurrent Planning training.

The Monitor attended the Department's Concurrent Planning training in Hunterdon, N.J. Staff were engaged and responded with enthusiasm to the training. Particularly useful to staff, as reported to the Monitor during site visits, was the consultant's use of case handlers' real cases (without names) as learning tools to construct permanency plans and tasks. Moving forward, the Department will need to ensure that the presentation and subject matter of the Concurrent Planning training conforms with more consistency and specificity to the new CPM.

3. Intake and Investigations

a. DYFS has trained nearly all existing staff members responsible for Intake and Investigations and has incorporated Intake into its Pre-Service training for new staff (MSA, II.B.3.a,b).

As indicated in Table 6 above, the NJCWTA reports that it trained 1483 DYFS staff on Intake and Investigations, including 64 IAIU investigators between January and June 2007. Now that training of existing Intake staff is complete, all staff newly responsible for Intake and Investigations will be trained in these skills as part of their Pre-Service training. The Monitor cross referenced a random sample of 84 staff transcripts with human resource data and concluded that the State has complied with the MSA.

b. DYFS developed and implemented a competency examination for all workers performing Intake and Investigations, and has incorporated that material into its Pre-Service testing (MSA, II.B.3.a).

Based on pilot testing of competency exams with Intake and Investigations staff, the NJCWTA developed a competency examination for staff that complete the 3-day Intake and Investigations course. The Monitor has taken and reviewed the exam. Starting in January 2007, the NJCWTA incorporated this exam into its testing of Modules 6, 9 and part of 8 of Pre-Service training, which cover Intake and Investigations. Supervisors

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review the results of the competency exams and are notified if a trainee fails the exam after taking it a second time. The Department reports that there have been no second failures of competency exams.

4. Supervisory Training

Table 8:
Supervisory Training: Total Number of Supervisors
Trained January 1, 2006 – June 30, 2007

Category	# Trained	Percent of Staff Needing Training*
Supervisors Appointed Pre- 12/06 • Trained in 2006 • Trained by 6/30/07 • Scheduled for Training	 44 138 5 187	 24% 74% 3% 100%**
Supervisors appointed 1/1/07 – 06/30/07	114	100%

Source: DCF, verified by Monitor
*Data excludes two supervisors on extended leave.
**Percentages add to greater than 100 due to rounding.

a. 100 percent of newly promoted supervisors have taken NJCWTA's Supervisory Training; 93 percent had taken 40 class hours within 3 months of their promotion.(MSA, B.II.4.b,c).

Newly-appointed supervisors

DYFS reports that 141 new supervisors were appointed during the monitoring period, 114 of whom required supervisory training. The remaining 27 appointments had prior experience and training as supervisors. To verify this data, the Monitor cross referenced a random sample of 15 staff transcripts with human resource data and concluded that the State has met the MSA requirement. It will be important for the Department to schedule those supervisors who took their supervisory training in 2004-2005 for training on the new CPM as soon as possible.[8]

[8] Based on the Monitor's random sample review of 15 staff, 4 staff took supervisory training in 2005 or earlier.

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Supervisors appointed before December 2006

As indicated in Tables 6 and 8, the Department reports that 138 supervisors appointed prior to December 2006 have taken supervisory training during this monitoring period; 5 supervisors have not yet completed supervisory training but have been scheduled. The Monitor cross referenced a random sample of 21staff transcripts with human resources data and concluded that the State has met the MSA requirement. It will be important for the Department to schedule those supervisors who took supervisory training in 2004-2005 for training on the new CPM.[9] Further, the Monitor's independent review of class rosters for supervisory training against human resources reports of newly appointed supervisors indicates that NJCWTA is providing supervisory training within 3 months of the supervisor's promotion.

At the conclusion of the training, supervisors are expected to pass competency examinations. During the last monitoring period, the Monitor reviewed samples of portions of supervisory competency examinations of varying quality and was not able to satisfactorily assess how the results were evaluated and used. The Monitor has recommended and is in discussion with DCF about the development of a more structured and standardized assessment of supervisory skills and the use of a more clearly defined protocol for how the results of the exam are used to develop individual staff competency. The Monitor will reevaluate this expectation in the next six-month period.

[9] Based on the Monitor's random sample review of 21 staff, 3 staff appear to have received supervisory training in January 2003.

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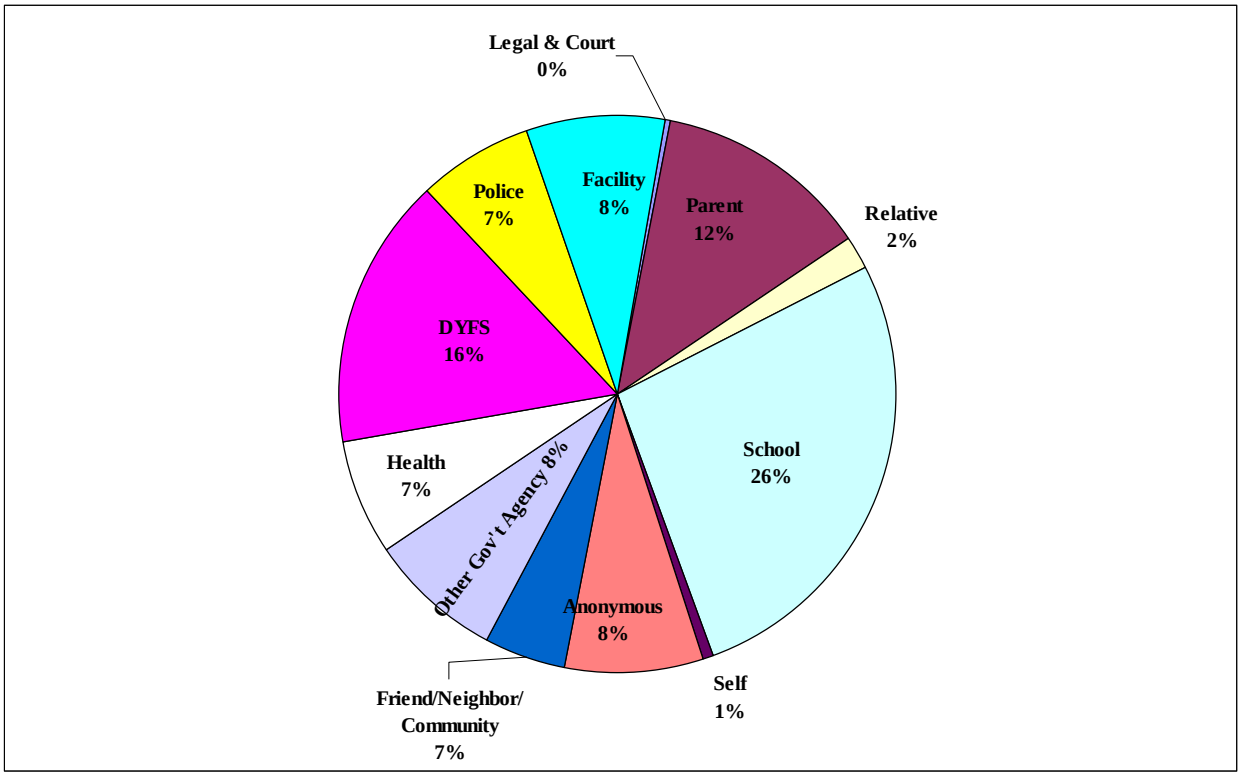
C. Institutional Abuse Investigations Unit ("IAIU")

The Institutional Abuse Investigations Unit (IAIU) is responsible for investigating allegations of abuse and neglect in any out-of-home care setting. This includes, but is not limited to foster care placement settings. It also includes correctional facilities, detention facilities, treatment facilities, schools (public or private), residential schools, shelters, hospitals, camps or day care centers that are licensed or should be licensed, Resource Family homes and registered family day care homes.[10] In the first half of 2007, IAIU received 1730 referrals. Figure 9 displays the source of these referrals.

Figure 9:
IAIU Source of Referrals
January – June 2007
Total = 1,730



Source: DCF September 2007

[10] DYFS (7-1-1992). IAIU Support Operations Manual, III E Institutional Abuse and Neglect, 302.

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1. The IAIU achieved the June 2007 target for timeliness of IAIU Investigations.

The purpose of IAIU's investigative effort is to determine whether children in out-of-home care settings have been abused or neglected[11] and to ensure their safety by requiring corrective actions to eliminate the risk of future harm. By June 2007, IAIU was expected to complete 80 percent of its investigations within 60 days of referral. (MSA, II.I.3)

On June 30, 2007, the State reported that IAIU had 373 open investigations, 332 (89%) of which had been open less than 60 days. These open cases reflect investigations still in process based on May and June referrals. The remaining 11 percent had been open for more than 60 days. According to the State, a significant number of the cases that were open more than 60 days involve criminal investigations and the IAIU investigations were on hold until staff are given clearance from law enforcement or prosecution to proceed.

In addition to the month-end report supplied by the State, the Monitor reviewed randomly selected IAIU daily work-flow reports for ten days between July 1 and August 31, 2007. The trend shown in these reports indicates that IAIU was able to maintain the performance achieved on June 30, 2007 throughout July and August for all open reports. The proportion of cases open less than 60 days ranged from 83 percent to 88 percent. During the next period, the Monitor will review a selection of investigation records to further validate the State's performance.

2. By June 30, 2007 all IAIU investigators had received appropriate training.

All IAIU investigators are to have had specific training on the Intake and Investigations process, policies, and investigative techniques. (MSA, III.I.4.)

Sixty-four IAIU staff statewide received the "First Responder" investigative training between January and July 2007. DCF reports that this includes all IAIU supervisors.

D. Accountability through the Production and Use of Accurate Data

One of the principal accomplishments of the Department in its first year is its progress in producing timely and accurate data, making that data available to the field and to the public and increasingly using the data for planning, management and accountability.The importance of data for planning and accountability has been consistently identified as a high leadership priority. The Department has begun to move from one which could not rely on or be relied on for accurate data to one which has steadily improved its internal capacity and external communication through performance and outcome data. This has been the result of diligent work by the DCF Office of Planning and Policy and the entire DCF leadership team.

During this monitoring period, the MSA required further development of data capacity in two major ways:

[11] As defined by statute at *N.J.S.A.* 30:40C-12 or 9:6-8.21.

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- The expansion of production and publication of accurate data on key indicators of system performance and
- The deployment of New Jersey SPIRIT, the State's Automated Child Welfare Information System (SACWIS).

Each of these is discussed separately below.

1. DCF continues to expand and refine its data on performance indicators and its presentation of data to the public through its website.

With the full deployment of New Jersey SPIRIT (discussed in more detail below), the State is poised to significantly expand the number and range of indicators on which it routinely collects and can report data. It is important to note that it will take time to achieve the expanded data reporting capacity of SPIRIT since producing accurate reports through a new data system require that staff learn to properly use the system to its full potential. Nevertheless, in this monitoring period and prior to full deployment of SPIRIT, DCF was able to continue to expand its data capacities and has made several modifications and additions that satisfy the MSA requirement to continue to expand performance reporting (MSA, II.J.5).

Important additions in DCF's Quarterly Data Update include:

- Demographic Data
  - Children in DYFS Placement by Placement Type (with separate delineation of treatment home placements)
  - Race/Ethnicity of Children Receiving DYFS Services (broken out by Placement and In-Home)
  - Age and Gender of Children Receiving DYFS Services (broken out by Placement and In-Home)
  - Age, Race/Ethnicity and Gender of Children Served by DCBHS (broken out by CMOs, and DCBHS placements
- Caseload Data
  - Staff with more than 30 Families
  - Caseload Data by Local Office
- Recruiting Foster and Adoptive Families
  - Data on Licensed Resource Homes (Kin and Non-Kin separately)
  - Net Gain on Resource Families (Kin and Non-Kin)
- Health Care for Children in Placement
  - Performance on Pre-Placement Assessments

Over the next year, it is the Monitor's expectation that the range of data elements that can be accurately collected and reported will substantially increase. Moreover, the monitoring requirements related to implementation of the CPM will require tracking of additional indicators and case processing functions that are not now captured. The Monitor will be working with DCF

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staff to identify a timetable and plan for additional data measurement and reporting. Discussions between the Monitor, Plaintiffs and State will occur by December 2007 to reach agreement on a plan for additional data rollout beginning in 2008.

2. Deployment of Phase II of New Jersey SPIRIT

The MSA required the deployment of Release 2, Phase II of New Jersey SPIRIT by February 2007 (MSA, II.J.7). In the last monitoring report, the release date for SPIRIT was modified to April 2007 in order to avoid possible disruptions in end of fiscal quarter and programmatic reporting. The State then wisely decided to implement SPIRIT by first piloting the deployment in Ocean County and using the experience there to identify and fix problems that would cause major disruption if the system was initially implemented statewide. Postponement of full deployment to the summer of 2007 also enabled the Department to have sufficient time to provide initial training for each of its staff.

The decision to pilot test the release in Ocean County was a good one. The Monitor visited Ocean County during the pilot phase and heard from staff about the promises, irritations, and challenges of SPIRIT. During the pilot phase, many, many case processing and system problems were identified by users and fixed. In addition, the Department gained critical insight into the level of on-site and on-line support that would be needed for full deployment. During the pilot period, data were double entered into the new SPIRIT system and into the old legacy system so as to avoid the possibility of lost data.

New Jersey SPIRIT was deployed statewide on August 22, 2007. Department leadership approached the deployment with both careful planning and some understandable trepidation. In advance of the deployment, all staff was trained in how to log onto and use SPIRIT for case processing functions, thus meeting the MSA requirement to train all case carrying workers (MSA, II.J.8). In addition, DCF established a centralized help desk consisting of 13 employees and put 176 “production support staff” in the field throughout all 46 local offices and in central office units. The need for this kind of intensive on-site help is well documented in other States’ experiences with information system deployment. In the period between August 22 and September 5, the Department reports that the Helpdesk responded to 1905 different requests for assistance, reflecting the ongoing challenge of acclimating staff to a new system, making sure that all system problems are identified and resolved and the need for continuous implementation monitoring and training. However, implementation problems still remain and significant on-site help will continue to be needed in some areas of the State for the foreseeable future.

A second hurdle for the new system was the processing of its first set of monthly payments. This task was also approached with trepidation but it appears that the payment processing parts of SPIRIT are functioning. DCF implemented back up systems to process manual payments when needed to supplement automatic payments through SPIRIT. A hotline was established for providers and Resource Parents in the event that payments were improperly made. In the first run of payments, 85% were made automatically. In the second run at the beginning of October, less than 1% of payments required manual processing.

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The deployment of New Jersey SPIRIT is a significant accomplishment. Diligent oversight and local office support will continue to be needed for the foreseeable future. Nevertheless, the implementation to date reflects the enormously hard work and attention of DCF managers and SPIRIT staff in the months leading up to and immediately upon deployment. The real test of the system's functionality will occur over the next six months to a year as workers get used to and are required to use the system and as managers learn to use SPIRIT and its data for tracking individual cases and for overall system and performance monitoring. The Monitor will more fully assess New Jersey SPIRIT implementation in the next six months.

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IV. CHANGING PRACTICE TO SUPPORT CHILDREN AND FAMILIES

A. Implementing the New Case Practice Model

The Department faced significant challenges in communicating and disseminating the new Case Practice Model (CPM) to the field, but has responded to this challenge with a detailed, thoughtful and ambitious CPM Implementation Plan. The Plan incorporates broad and deep strategies that seek to use the CPM as a dynamic tool to frame and guide future work. The conceptualization of this Plan took time to develop, and the Monitor has consistently taken the position that rather than rush through a truncated version of a CPM training to meet the MSA timeframes, the State should approach the execution of the CPM Implementation Plan as a longer term and intensive process. The parties have agreed, therefore, to extend the deadline to complete staff training and mentoring on the CPM until the end of 2008 with intensive work beginning in October 2007 and continuing over the next 15 months.

In this monitoring period, the MSA (II.A.3-4) required the State to:

- *Begin to implement the CPM*
- *Identify the methodology to track successful implementation of the CPM;*

In reporting on the CPM for Phase I of the MSA, the Monitor is charged with focusing "*primarily on the quality of the Case Practice Model and the actions taken to implement it.*" (MSA, II.A.5).

After its finalization in December 2006, the work of planning for implementation of the CPM began. With the Monitor's support, the Department took the necessary time to lay the foundation for a healthy and functioning department before it turned its attention to planning for implementation of the new CPM. These foundational steps included:

- Hiring large numbers of case-carrying staff to meet the needs of each office;
- Training staff, including Pre-Service, Investigatory, Supervisory, and New Jersey SPIRIT;
- Compliance with caseload standards to meet the MSA;
- Setting challenging adoption finalization targets;
- Reorganization of Resource Family licensing and recruitment units to meet aggressive new family recruitment targets.

Once these critical elements of a healthy system were underway, the Department began to focus on meeting its mandate to implement the CPM. Site visits reveal that some offices have begun to communicate and anticipate the change of practice envisioned in the CPM while others have not. In the Monitor's site visits, many staff however expressed excitement about a new vision for the agency and the new role the agency will be expected to take in the community and in partnership with families and community stakeholders. Other staff had little to no knowledge of the Department's CPM and its expectations for practice.

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As described in detail in the Department's CPM Implementation Plan dated September 2007 (Appendix B), the first formal step towards implementation of the CPM began with a series of focus groups of staff, stakeholders and families. Key Department leadership, including Area Directors and Assistant Area Directors, then met in a two day retreat devoted to CPM implementation. Each division and level of DCF had an opportunity to express what it needed in order to successfully implement the new CPM, and leadership had the opportunity to hear, analyze and reflect upon those needs. The Monitor attended this retreat as an observer.

The Department's CPM Implementation Plan articulates a six prong approach to system change:

1. Leadership Development
2. Statewide Readiness Strategy
3. Immersion
4. Service Development
5. Continued Focus on the Fundamentals
6. Enhanced Planning Between DYFS and DCBHS

Each prong is important and necessary for the overall reform effort.

1. Leadership Development

Sound reform requires a cultural change that begins with leadership engagement and development. Executive leadership made a critical determination early on to involve Area Directors, Assistant Area Directors—and later office managers—in the decision-making and leadership of the reform effort. This is not easy to do given the size of New Jersey's child welfare system, and DCF should be commended in taking this step even before it could reap any direct benefits. In addition to regular meetings and better communication strategies generally, Central Office made critical data available to each director and manager for the first time and supported and encouraged directors and managers to make management decisions based on this data. A Leadership Summit was held in October 2007 with key staff from DYFS, DCBHS, Prevention and Central Operations, DCF Executive Management and the Child Welfare Policy and Practice Group (CWPPG), a consultant group which was an important innovator and leader in Alabama and Utah's model child welfare reform efforts.

2. Statewide Readiness Strategy

By December 2007, the Department will have developed training curricula consistent with the CPM and will begin to intensively provide additional training to existing staff. Concurrently, DCF will again review and modify its Pre-Service curriculum to ensure consistency and to enhance necessary skill development. This work will be shared with the New Jersey Partnership for Child Welfare Program, a partnership of four regionally diverse schools of social work facilitated by Rutgers University School of Social Work. The chosen curricula will cover the principles of family engagement, while giving the staff practical tools for beginning to practice key principles.

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Training staff on the CPM is a formidable task. DCF estimates that in 2008 at least 4000 case carrying staff will need to be trained for a minimum of 40 hours. Over 1,100 days of training—assuming a class size of 25—will need to be scheduled and delivered. To accomplish this task, the Department has developed a matrix relying on regional training teams that will include:

- the DCF Child Welfare Training Academy (NJCWTA);
- the University Training Consortium, facilitated by Rutgers University School of Social Work;
- a DYFS central office CPM technical assistance group;
- local providers, such as local CMOs who have experience and proven track records of family engagement and family centered practice; and
- consultant team members (CWPPG).

The regional teams will be deployed sequentially across the State as explained below and in depth in the Implementation Plan. The Department will utilize a train the trainer model so that, at the conclusion of the consultant's work with the State, the regional teams can seamlessly continue training the workforce as needed.

3. Immersion

At the same time the regional teams are training the statewide workforce, the Department will work more intensively with staff at carefully chosen sites to more fully develop new skills and practices. As discussed in detail in the Implementation Plan, beginning in January 2008, DCF will launch this intensive immersion process in four pilot counties. This process will provide intensive training, mentoring, and coaching for staff conducted by CWPPG and DCF technical assistance partners. It will also involve an examination of services available to families and, equally important, the development of an infrastructure to schedule and facilitate family team meetings. The Monitor heard from all levels of staff at all sites that a lack of appropriate space hindered their ability to provide families with proper, dignified team meetings and visits. This issue will have to be addressed in the immersion sites and hopefully will yield creative solutions including community-based options for these sites and for other parts of the State.

The intensive coaching and mentoring of staff envisioned by the Implementation Plan takes time to implement correctly and to seed the foundation for lasting change. The process of developing immersion sites is expected to take approximately seven months to complete. DCF has committed to an evaluation process to determine efficacy and the Monitor will be a partner in that process.

As the immersion sites develop, local office leadership will conduct training and focused coaching to ready the rest of the workforce. Advanced case practice training and advanced intensive coaching will be made available to staff across the state as local training capacity and technical assistance are developed by the second half of 2008. The Department will then stagger advanced training and coaching as needed.

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4. Service Delivery and Budget Transparency

During site visits, the Monitor heard from staff about the need for more services that better align with the needs of children and families and with the vision of the CPM. Without a sufficient quantity and quality of services, a case practice model will fail; staff cannot successfully engage with families if they cannot offer them the services they need. Family teams cannot successfully assist families unless willing, trained and capable partners are members of the team.

Over this past year, DCF has begun investing in service capacity and as discussed later in the report, has been using contracts with private providers as a means to expand local capacity for services to children and families. These include investments in three pilot sites implementing new differential response systems as well as resources for flexible funds to support family services, visitation support services, family success centers, substance abuse treatment, domestic violence treatment services and other service enhancements.[12] The State is also actively implementing a Strengthening Families child abuse prevention initiative which seeks to build services and supports around families through early care and education programs.

For the first time in the history of the Department, DCF is implementing a strategy of child and family-based budgeting of investments and services *by immersion site*. In order to create such a budget, the Department will first inventory, across all its divisions, the public and private investments it makes in each of the sites where the CPM immersion is underway. This is an innovative undertaking that will likely deliver critical information to the State to assist in developing more family centered service delivery models and for future resource planning and development.

5. Continued Focus on Fundamentals

In its CPM Implementation Plan, the Department stresses the importance of continuing to keep its attention on the fundamentals of the reform, while simultaneously rolling out major new initiatives such as the CPM. By a continued and simultaneous focus on the fundamentals, DCF will continue to devote attention and resources to actions including reducing caseloads, retaining qualified staff, improving recruitment and licensing of resource homes. Continued progress on fundamentals will require recognition, cooperation, and support from stakeholders to ensure that core elements of the reform remain center stage as the CPM implementation is underway.

6. Enhancing Planning and Coordination between DYFS and DCBHS

In 2006, the Division of Child Behavioral Health Services (DCBHS) held a series of focus groups with system partners, including Family Court judges, Mobile Response and Stabilization Services, Family Support Organizations, Youth Case Management (YCM), and Care Management Organizations (CMO) to discuss how to better serve families with the behavioral health system. A consistent message was that children's behavioral health needs must be better integrated into the daily work of the Department.

[12] The monitor intends to review the use of flexible funds in future monitoring reports.

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In response, DCF will pilot reforms to unify case practice in DYFS and DCBHS in up to three counties in Spring 2008. The purpose of the pilots will be to test the elimination of dual case management within DCBHS, between YCMs and CMOs, and between DCBHS and DYFS by transitioning youth to the most appropriate entity. DYFS will be the lead on all cases that involve safety and permanency, but will continue to be supported by DCBHS.

Another component of the plan is DCBHS case management entities will deploy clinical staff into DYFS local offices to provide technical and other assistance to DYFS staff. DCBHS will also assign staff to DYFS Area Offices to become part of the team that works to return youth from out-of-home care. Taken together, these innovations are designed to improve the coordination of services within the Department and to better serve children with behavioral health needs. The Monitor will be looking closely at these improvements and the progress the Department anticipates as a result of them in the next monitoring period.

7. Implementation Plan Evaluation

The MSA requires the Department and the Monitor to track the implementation of the CPM going forward. Specifically, during Phase I the Monitor must evaluate and report "*primarily on the quality of the Case Practice Model and the actions taken to implement it."* (MSA, II.A.5). The Monitor strongly supports the Department's decision to track the implementation of the CPM through Quality Service Reviews (QSRs). The Department will also be collecting longitudinal outcome data such as the data developed for DCF by the Chapin Hall Center for Children. Quality Service Reviews will be phased in over time according to a schedule to be developed by DCF and the Monitor. The schedule will phase in QSRs throughout the State, beginning with the immersion sites. DCF offered suggestions for monitoring the State's CPM implementation in its CPM Implementation Plan. The Monitor will take these suggestions into consideration in developing, with DCF and Plaintiffs, a comprehensive method of measuring whether the CPM has successfully taken hold in New Jersey.

B. Improving Results for Permanency and Adoption

Over the last several months, DCF has dramatically increased its efforts to move more children out of foster care, whether through safe reunification, placement with an adoptive family or placement in the permanent legal custody of an appropriate kinship family. The MSA requires DYFS to engage in several activities to promote permanency. Adoption units have been reconstituted and appropriate cases have been assigned to these units. Specific targets were set for each local office to ensure that DYFS meets the MSA requirement of 1400 adoption finalizations. Further, in an effort to change practice at the front end of the child welfare system, DYFS developed and implemented the Concurrent Planning "Enhanced Review" Model in ten demonstration sites. Concurrent planning is a concept employed by jurisdictions throughout the country in which workers assist children who come into out-of-home placement to reunify with their family of origin safely and quickly, while simultaneously pursuing alternative permanent placements for these children should reunification efforts fail. DCF describes concurrent planning as "a child-focused practice meant to minimize placement trauma and repetitive moves

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for children entering care."[13] As DCF prepares to implement the CPM statewide, much planning and coordination will be necessary to help offices and workers understand that concurrent planning is a critical part of the CPM. Concurrent planning practice will "roll out" statewide with the implementation of the CPM.

It is also noteworthy that DCF has organized its policies and practices to heighten attention to identifying permanent homes for older adolescents in its care. Specifically, in accordance with the MSA, DCF targeted its efforts to find permanent homes for 100 youth in care who have been waiting the longest for a permanent family. DCF also launched a Youth Permanency Project to identify permanent, life-long connections for youth who are transitioning out of the foster care system.

1. Through adoption units, DCF continues to finalize adoptions at a steady pace.

As required by the MSA (Section II.G.12), DCF reports that all local offices have transferred appropriate cases to the adoption units. Reportedly, 95 percent of all adoption cases are now with adoption workers while 5 percent of cases remain in permanency units (due to an acceptable exception such as a previously established relationship with a caseworker). From January 2007 to June 30, 2007, DCF finalized 634 adoptions.[14] The MSA requires 1400 adoptions to be finalized by December 2007. (Section II.G.17). Although DCF was less than halfway to this target, the State is operating at a steady pace to reach this goal. By comparison, in 2006 DCF had finalized 586 adoptions by June and ultimately finalized 1402 adoptions by December.[15]

Specific adoption finalization goals now have been set for each local office based on their current placement rates.[16] Currently, eight Adoption Expeditors are working in counties with high numbers of legally free children (Essex, Union, and Ocean counties) to help those offices meet these targets. Two other counties (Middlesex and Bergen) have permission to hire Expeditors should they require assistance.

[13] DCF, Concurrent Planning, Enhanced Review Model, update prepared 1/3/2007.
[14] New Jersey Department of Children and Families, Quarterly Update, September 5, 2007.
[15] The monitor previously reported 1,387 children had finalized adoptions. Because adoption data takes time to verify, a few more adoptions were finalized in 2006 but not reported before the monitoring report was issued. The final number of finalized adoptions in 2006 was 1402. The Monitor believes DCF can meet the MSA requirement of 1400 cases because, according to DCF, the second half of the year is strongest for finalizing adoptions as a result of activities during National Adoption Month in November.
[16] The formula for adoption finalizations each office was: 90% of children already in adoptive placements + 80% of children in foster homes with an adoptive interest + 70% of children in kin homes with an adoptive interest. Additionally, 30% of children for who termination of parental rights process is underway will achieve the completion of litigation and finalization of adoption.

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2. DCF launched 10 Concurrent Planning Enhanced Review demonstration sites and has begun to assess their progress through the use of the Adoption Process Tracking System.

The MSA requires DCF to improve concurrent permanency planning and adoption practice (Section II G.1 and 2). DCF began implementation of the concurrent planning process in ten demonstration sites this year. DYFS staff in these sites have received specific training on this new model and follow-up coaching focusing on developing appropriate case plans for families. In June 2007, a concurrent planning handbook for DYFS staff was completed. This handbook describes the concurrent planning process and provides checklists and other documents that help guide a worker's decision-making process. Additionally, the Deputy Attorney Generals who handle DYFS cases in these demonstration sites have received training and have begun to participate in the 10-month review hearings where a decision is made to provide more time for reunification with parent(s) or to recommend the termination of parental rights (TPR).

Currently, DCF is relying on the Adoption Process Tracking System to evaluate compliance with the concurrent planning model. The tracking system records 5 and 10 month reviews, the timeliness of case transfers to adoption workers, and the termination of parental rights. It is the responsibility of the Area Concurrent Planning Specialists to ensure that case information is entered promptly into the tracking system. As concurrent planning expands statewide, the measurements currently captured by the adoption process tracking system will be captured by NJ SPIRIT and/or Safe Measures.

In the first six months of implementing the concurrent planning process, the demonstration sites have experienced a not unexpected variety of successes and challenges. In most offices, staff were able to complete the majority (90% or higher) of 5 month reviews within the necessary time frame. However, offices varied more dramatically in their ability to successfully complete the 10-month reviews. Seven offices had timely 10 month reviews for 75 percent of their cases or higher, while two offices held timely reviews in less than 40 percent of their cases. The prompt transfer of cases (within 5 days) to an adoption worker also varied by office. Five offices achieved the timely transfer 100 percent of the time, while 4 offices had rates that ranged from 11 to 50 percent. Finally, a total of 45 cases were supposed to have TPR petitions filed within 45 calendar days, but this goal was only achieved in 14 cases (31%).

3. Services to support reunification have been expanded.

Recognizing the importance of providing services to parents whose children are in out-of-home care, DCF awarded $6 million in contracted services for family engagement and therapeutic visitation across the State—$575,000 of this award was dedicated to private agencies to work with the 10 demonstration sites to facilitate family engagement meetings. Additionally, as required by the MSA, the State amended its policies and procedures to allow for the use of flexible funds to support family preservation and reunification efforts, increasing the amount of expenditures on each parent annually and extending the time period for the use of these funds (Section II.C.3). The FY 2008 budget includes an additional $1 million for flexible funds. Given the heightened effort to work with families, the Monitor recommends that DCF continue to track

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and report on reunification rates as part of the concurrent planning process and on the use of flexible funds to support family reunification.

4. DCF has begun implementing permanency strategies for older youth in care.

a. DCF is making progress to identify permanency options for youth who are legally free for adoption and have been in care for long periods of time ("100 Longest Waiting Teens").

Specific attention has been paid over the last six months to finding permanent homes for youth in the foster care system who are legally free with adoption as their permanency goal. The total number of legally free youth awaiting adoption has declined from 2278 in January 2006 to 1939 in January 2007 and was 1740 in August 2007. Slightly more than 400 legally free children require DYFS to locate a permanent home for them—through the work of "Impact" Recruiters and select home adoption staff. In January 2007, five Adoption Impact Recruiters were hired and trained to find permanent connections for youth who have been identified as part of the "100 Longest Waiting Teens." These workers, skilled in working with adolescents, are supervised by the Statewide Adoption Recruitment Specialist in the Office of Adoption Operations. Over the last six months, they have received specific training on working with adolescents who have been in care for extended periods of time and on strategies for recruiting appropriate families for these youth[17].

According to DCF, the 100 youth who have been waiting the longest for permanent homes and are being targeted by the Adoption Impact teams are primarily African American (89 youth), with a little over half of them boys (59 boys and 41 girls). Most of the youth are between the ages of 14-16 (72 youth)[18], and 70 percent of them live in highly structured group homes, treatment homes, or residential settings. The median length of stay for youth in out-of-home care is eight years (with the length of time ranging from 3 years to 16 years). These youth have many educational and mental health challenges related to being in care for so long and experiencing multiple placement moves.

Adoption Impact Recruiters have employed many strategies for finding potential permanent placements for these youth. Recruiters have "mined" the case files of youth in care and had conversations with the youth about individuals to whom they feel connected. Workers have tracked down family members or family friends to assess them as possible permanent caregivers. Some youth have chosen to participate in the Heart Gallery, a recruitment strategy where professional photographers take pictures of children in need of adoptive homes. 115 youth were featured in the Heart Gallery this year; 29 are teens who are part of the "100 Longest Waiting" group. Eight other children have had other media exposure including newspaper articles and television appearances on

[17] This training was also offered to local office recruitment and adoption staff.
[18] There are some latency age youth who are part of a sibling group that includes an adolescent.

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Wednesday's Child. DCF is also in the process of developing a Speaker's Bureau of teens who can talk to other youth and potential adoptive parents about the need for homes for older youth in care.

DCF is adapting policy and practice to be flexible and responsive to meeting the needs of youth. For example, DCF recognizes that many foster parents might be willing to serve as a permanent resource for older youth. However, foster parents currently receive a foster care board rate until the child is 21, but if they were to adopt the child, the adoption subsidy only continues until the child is 18. As a result, DCF is working to identify and eliminate barriers to extending adoption subsidies to age 21 for youth who are adopted after the age of 14.

Table 10 summarizes the progress made by the Adoption Impact Teams in finding permanent homes for the "100 Longest Waiting Teens."

Table 10:
Progress on Permanency for "100 Longest Waiting Teens"

Permanency activity	Number of youth benefited
Finalized Adoption	1
Selected Home Adoption Placements	2
Foster Home Adoption Plan	7
Relative Adoption Placement	2
Relative Adoption Placements Pending	9
Kinship Legal Guardianship Plan	2
Adoption Home study in progress	2
Reconnecting with Birth Parents	2
Visiting (possible placement)	2
Other possible placement identified[19]	10
Match Party Matches	5

Source: DCF, Longest Waiting Teens Report, Updated 9-6-07
Children are counted in one category only.

[19] "Other possible placements" is a category that encompasses viable adults who are being assessed as a possible placement for a youth.

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b. DCF is launching a Youth Permanency Demonstration Project.

DCF began a Youth Permanency Demonstration Project to address the problem of too many youth leaving the foster care system without permanent connections to caring adults. This project is "designed to combine independent living and youth development skills with extensive permanency planning." Beginning July 1, 2007, DCF will work with three agencies to support permanency planning for approximately 60-75 youth. Youth referred to these agencies will be between the ages of 14 and 21. Some youth will be "legally free" and some "not-legally free" for adoption. The agencies' success will be measured by the number of connections established for youth. Additional outcomes to be measured include: youth-adult connections still existing one year later, 80 percent of youth with some viable means of support (employment skills), and improvements in the youth's sense of well being.

DCF will also begin working with youth who are at risk of aging out of the child welfare system without any permanent connection, and whose goal is neither adoption nor legal guardianship. DCF has begun using the Wendy's Wonderful Kids model to assist with youth-specific recruitment to find permanency for these youth. This model has been used on a smaller scale in a few offices and will be expanding as services to adolescents expand. Both of these projects demonstrate the State's commitment to finding permanent homes and/or adult connections for older youth in its custody. Further, these projects are part of a larger effort to improve practice with adolescents in DCF's care.

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V. APPROPRIATE PLACEMENTS AND SERVICES FOR CHILDREN

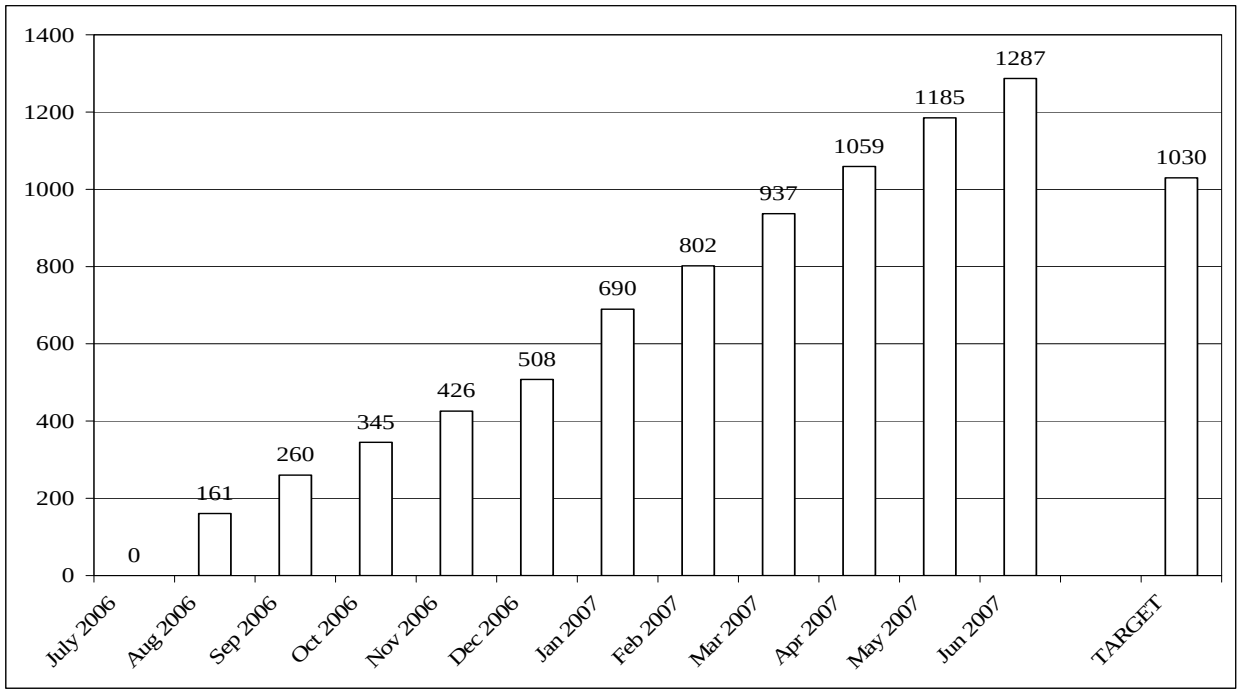
A. Resource Families

Recruitment and licensure of Resource Families has improved in the past year. Many changes have been made both structurally and substantively that have begun to bear fruit in this monitoring period. Impact Teams deployed statewide have been successful in reducing the backlog of waiting applications and the Department has licensed a record number of new homes. The Department licensed 1287 new non-kin Resource Family homes, significantly exceeding the MSA requirement to have licensed 1030 non-kin Resource Family homes by June 2007. Further, the Department now routinely achieves a net gain of Resource Homes each month, demonstrating the increasing success of recruitment and licensing efforts.

1. DCF recruited and licensed 1287 new non-kin Resource Families between July 2006 and June 2007 exceeding its mandate to license 1030 non-kin Resource Family homes in this period. (MSA, II.H.10.)

The State licensed a total of 643 non-kin Resource Family homes from July 2006 through January 2007. This put the Department in very good stead to exceed its goal of licensing 1030 non-kin Resource Family homes by June 2007. Indeed, as early as April 2007, the goal of 1030 homes was met and by June 2007, a total of 1287 homes were recruited and licensed (see Figure 11).

Figure 11: NJ DCF Resource Families
Number of New Non-Kin Families Licensed



Source: New Jersey DCF, DYFS, verified by Monitor

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The Department continues to collect and analyze data that distinguish the number of kinship and non-kinship homes licensed each month. Table 12 provides data for July 2006 through June 2007 on the total number of kin and non-kin homes newly licensed.

Table 12:
New Licensed Family Resource Homes
July 2006 – June 2007

	Kin	**Non-Kin**	**Total**
July 2006	18	60	78
August 2006	33	101	134
September 2006	35	99	134
October 2006	27	85	112
November 2006	21	81	102
December 2006	28	82	110
January 2007	59	182	241
February 2007	29	112	141
March 2007	61	135	196
April 2007	44	122	166
May 2007	37	126	163
June 2007	32	102	134
TOTALS	**424**	**1287**	**1711**

Source: New Jersey DCF, DYFS, verified by Monitor.

The Monitor reviewed a random sample of approximately 20 percent of licensing case files from January 2006 or before to verify data supporting that the Department reached its goal of licensing 1030 non-kinship Resource Families. The Resource Family Support and the Resource Family Licensing units of DCF are to be applauded for this tremendously successful effort. First, the Impact Teams established at the end of the last monitoring period moved into high gear beginning in January 2007. Working jointly with Resource Family Units first in Middlesex, Passaic and Atlantic counties, and then moving on to Union and Burlington counties, the teams vastly reduced the backlog of waiting applications and licensed a record number of homes so that there has been a consistent monthly net increase in the number of new homes. Figure 13 provides data on the net gain of licensed homes by month from July 2006 to June 2007.

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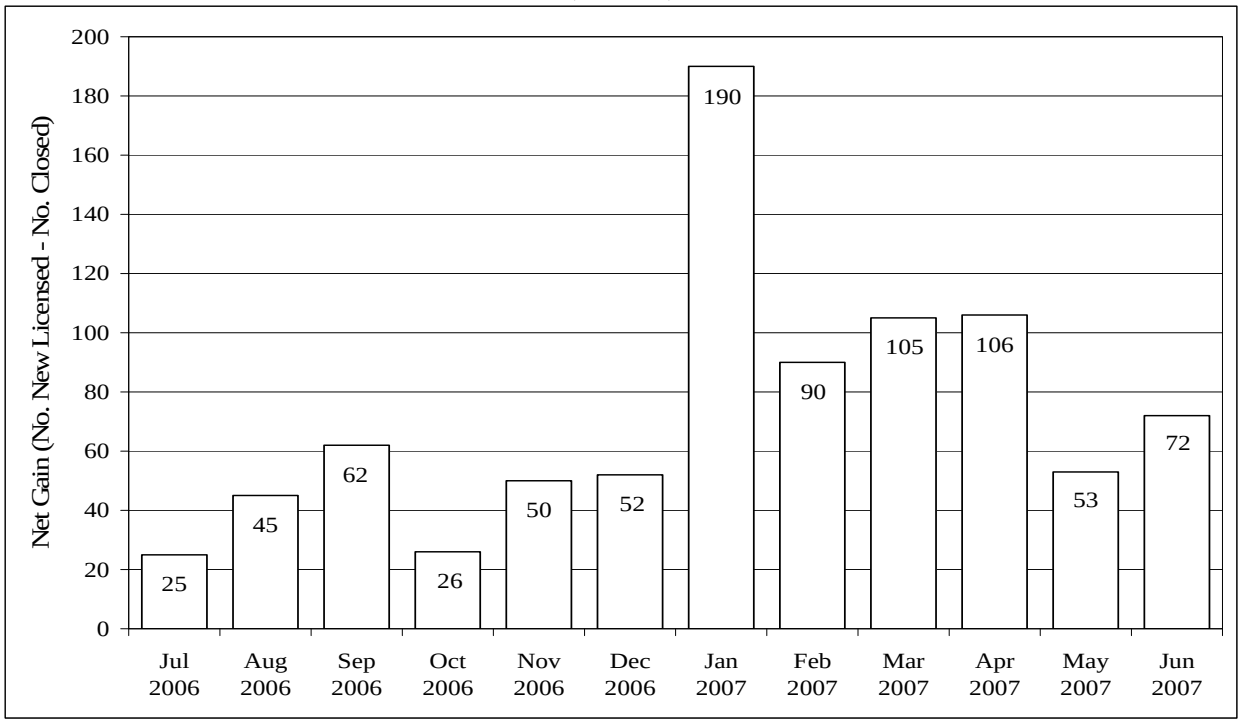
Figure 13:
NJ DCF Resource Families – Net Gain by Month
(n = 876)



Source: DCF, DYFS, verified by Monitor

The Impact Teams also established new protocols and began to standardize procedures to facilitate licensing within 150 days of a Resource Family's application. Figure 14 on the following page is a pictorial representation of the process a Resource Family application takes to become licensed within 150 days.

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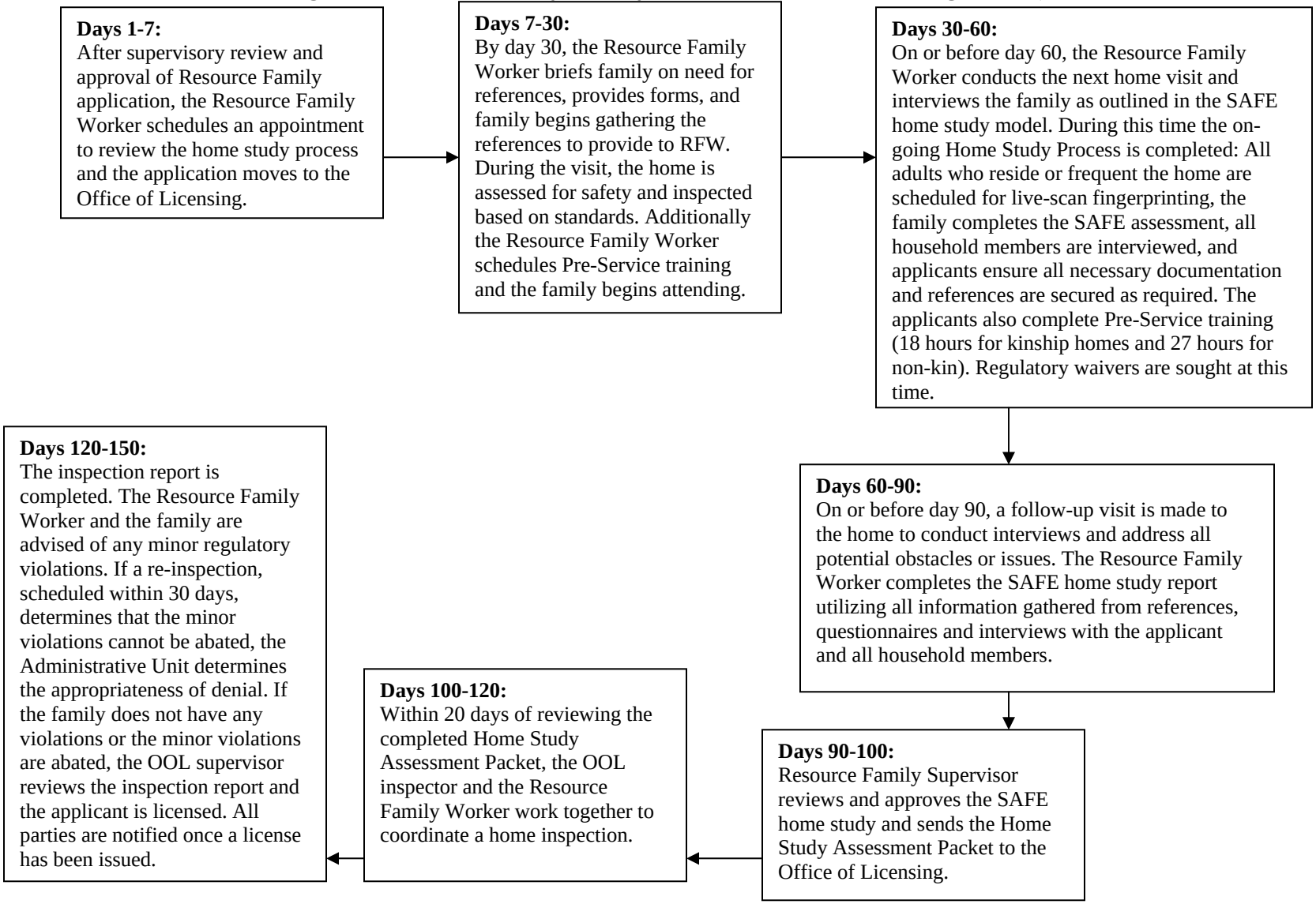
Figure 14: Resource Family 150 Day Flow Chart (Revised as of August 2007)



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Resource Family Impact Teams developed a protocol for Resource Family Licensing staff to join Resource Family Workers in the inspection of homes. Monthly meetings between the two units are now an expectation. At the monthly meetings, outstanding licensing issues are discussed and are moved toward resolution. Resource Family Licensing staff are now routinely assigned to geographic areas and therefore have relationships with Resource Family Workers that did not exist with the prior organizational structure. These relationships have created an expectation of cooperation and a sense of mutual accountability for the work. The Monitor saw evidence of improved communication between Resource Family Licensing and Resource Family Workers in many, though not all, of the local DYFS offices visited.

The Impact Teams will continue to be deployed to the remaining Area Offices until the majority of Resource Family applications can be resolved in 150 days.

The Impact Teams also identified areas of training for both Licensing and Resource Family staff. The Department responded to this finding by assigning high level staff to develop cross-training curricula for the two units so that Licensing and Resource Family staff will better understand their corresponding roles. The training as currently constructed begins with training on New Jersey's new CPM and its role in work with Resource Families. Other components under consideration for intensive training are:

- Customer Service – A Brief Overview of Applicants Rights
- Job Responsibilities of Office of Licensing
- Job Responsibilities of Resource Family Worker
- Office Structure – How local offices and Licensing are structured and the general flow of work of each office
- Foster Parent Role – What is a SAFE home evaluation?
- What is an Office of Licensing Home Inspection?
- One day field experience – Licensing workers spend a day with Resource Family worker and Resource Family worker spends a day in Licensing.

The Department continues to rely on the Impact Teams to raise systemic and structural problems to leadership's attention. For example, during site visits, staff in several offices identified some structural licensing standards as a barrier for licensing families and kin in urban areas. The Department is now reviewing these barriers to determine how modifications can be made. The Monitor looks forward to more closely examining the results of the Impact Team's work in the next monitoring period.

The MSA requires the State to facilitate the process for potential Resource Families so that they can achieve licensure within 150 of their application (MSA, II.H.4). The Department is implementing the process and timeframes as outlined in Figure 16. However, the Department continues to evaluate, review and improve the process, and considers it a work in progress.

As evidence of its own self-evaluation, the State provided the Monitor with a breakdown of applications approved in January 2007, a month in which it received 311 applications. In

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January, a total of 48 percent of applications were licensed within the 150-day period, and another 19 percent had issues resolved and were awaiting final licensing. The Monitor is satisfied that, given the complexity of the licensing process, the State is making significant progress towards its goal of a 150-day timeframe between application and licensure of Resource Families.

2. DCF created a tracking and target setting system for ensuring there is an accurate real time list of current and available Resource Family Homes (MSA, Section II.H.9).

In the previous monitoring period, DCF worked hard to produce an accurate baseline of available Resource Family Homes. The MSA requires the State to use this baseline information to create an accurate tracking system to determine in real time which Resource Family homes are available to staff seeking placement for a child. (MSA, II. H.9). The State has chosen to include this system as part of its New Jersey SPIRIT program, and has demonstrated to the Monitor its significant capabilities. When fully operational, a worker will have available online up-to-date and accurate information on the homes available as placement options: homes open, homes closed, family members in the homes, ages, active services available to the home, whether it is open to sibling groups, etc. The approval process for placements is clear and accessible. While this process does not supplant the need for quality case conferencing, it is a valuable tool that will greatly enhance the work of Resource Family staff, management, and leadership.

3. DCF further closed the gap by 25 percent between current Resource Family support rates and the USDA's estimated cost of raising a child.

The MSA requires the State to close the gap between current Resource Family support rates (foster care, kinship care, and adoption subsidy) and the United States Department of Agriculture's estimated cost of raising a child. (MSA, II. H.15). New rates sufficient to close the gap by 25 percent became effective January 1, 2007 (see Table 15).

Table 15:
DYFS Approved Resource Family Rates, Effective January 1, 2007

Age of Child	DYFS Rate 12/31/06 (STEP 0)	Revised USDA Rate CY 2005 (published April 2006)	Difference between USDA 2005 Rate and DYFS Rate 12/31/06	Percentage of increase required to close gap 25% by 1/1/07	Approved Increase to Monthly Rate	Approved DYFS Rate 1/1/07
0-5	$497	$667	$170	33%	$56	**$553**
6-9	$534	$718	$184	33%	$61	**$595**
10-12	$557	$741	$184	33%	$61	**$618**
13-17	$609	$786	$177	33%	$58	**$667**

Source: DCF, DYFS, January 1, 2007

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B. Division of Child Behavioral Health Services (DCBHS)

DCF, through its Division of Child Behavioral Health Services (DCBHS) is responsible for finding appropriate community-based services and/or out-of-home placements for children and youth in New Jersey who experience significant emotional and behavioral challenges. Some of these youth are also involved with DYFS and the Division of Developmental Disabilities (DDD). Under the MSA, DCF, through DCBHS, is required to minimize the number of children in DYFS custody placed in out-of-state congregate care settings and work to bring these children placed out-of-state back to New Jersey as soon as they are ready to be "stepped down."

DCBHS has experienced several leadership changes in this monitoring period. An interim director has been appointed with the expectation of selecting and appointing a permanent Director in the coming months. Despite the changes in Division leadership, the MSA requirements related to DCBHS' work have been achieved for this reporting period.

1. DCF took concrete actions to minimize the number of out-of-state placements and return children placed out-of-state to New Jersey.

DCF continues to place children out-of-state. The majority of these children have significant mental health problems and are placed out-of-state following attempts to find an appropriate placement within the State. A few of the placements made out-of-state are in locations closer to the child's community than alternative in-state placements. As of June 2007, there were 306 children placed out-of-state.[20] Table 16 depicts the number of new out-of-state placements made during this reporting period.

Table 16:
Out-of-State Authorizations
January – June 2007

Month	Number of authorizations for youth in DYFS custody (total number of authorizations)
January	8 (28)
February	8 (20)
March	6 (12)
April	3 (7)
May	2 (9)
June	9 (15)
TOTAL	36 (91)

Source: New Jersey Department of Children and Family Services, DCBHS

[20] New Jersey Department of Children and Families, Quarterly Update, September 5, 2007. The number of authorized placements has subsequently decreased in July and August 2007 (290 children and 287 children respectively).

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For the most part, the number of authorizations is significantly lower than the three months tracked in the last monitoring report.[21] Much work, including the development of additional appropriate in-state resources, remains in order to significantly minimize out-of-state placements.

Based on the State's analysis of the reasons youth were being placed out-of-state, DCF and DCBHS contracted with providers throughout New Jersey to add 86 "specialty beds." These beds will serve youth with complex behavioral and mental health issues. Several of the beds are specifically for teenage girls. Currently, 34 beds are operational and filled, 22 beds will be available by the end of October 2007, 15 are scheduled to be available in January 2008, and 15 are still under negotiation.

In addition to employing strategies to prevent out-of-state placement, DCBHS in partnership with DYFS has begun to examine each child placed out-of-state and implement an individualized plan for their return to New Jersey and their specific community. DCBHS and DYFS identified 119 children under the custody of DYFS for case planning conferences. These conferences will be held with DCF partners, including the Division of Developmental Disabilities (DDD), and will assess each child's current progress, feasibility of returning to the State, and appropriate programs and/or community services necessary to return the child to the State and/or step the child down to a lower level of placement. These conferences began in September 2007 and will continue through the early November 2007. In the first week, of 14 children reviewed, 7 have been identified as ready to leave their out-of-state placement and return to placement in New Jersey.

2. DCF is able to find placements within 30 days for almost all of DYFS youth who are in juvenile detention awaiting placement.

As described in the last monitoring report, DCF created a systematic process to identify and track youth in juvenile detention facilities who remain in these facilities solely because they are awaiting appropriate placement. Under the MSA, no youth in DYFS custody should wait longer than 30 days for placement (Section II.D.5). According to DCF, 18 youth in DYFS custody and in detention were awaiting placement from December 2006 to July 2007. Of these 18 youth awaiting placement post-disposition, 10 were male, 8 female.

Table 17 on the following page provides information on the length of time each of these youth waited for placement. All but two youth were placed within the 30-day time period.

[21] In the last monitoring report the number of authorizations for out-of-state placements were as follows: 24 children in October 2006, 54 children in November 2006, and 39 children in December 2006.

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Table 17:
Youth under DYFS custody in juvenile detention post-disposition awaiting placement

Length of waiting time	Number of Youth
0-15 days	3
16-30 days	13
Over 30 days	2

Source: DCF, August 1, 2007 placement report

The two youth who were not placed in 30 days were both female—one waited 33 days, the other 37 days. Both of these teenage girls were characterized as assaultive, with severe emotional problems. DCBHS made significant efforts to find in-state placements, but after multiple rejections the girls were both placed out-of-state.

3. DCF continues to find avenues to support new services for children and their families that are "evidence-based practices."

Under the MSA, the State was required to seek approval from the federal government for a Medicaid rate structure "to support the use of new services for children and families, including community-based and evidence-based informed, or support practices, such as Functional Family Therapy and Multi-Systemic Therapy" (Section II.C.2).

The State examined different avenues for funding this evidence-based practice. Based on the analysis, DCF decided that these services could best be supported by the Intensive In-Community service line within the existing New Jersey Medicaid State Plan. Approval was sought from the Division of Medical Assistance and Health Services (DMAHS) and DMAHS determined this expenditure was appropriate and that approval from the federal government was not required. Thus, the MSA requirement is not helpful or necessary to the State in accomplishing the ultimate requirement of supporting these new services for children and families.

The State intends to issue an RFP for Evidence-Based Services by December 2007. The RFP will identify targeted populations and a menu of evidence-based practices approved by DCBHS. The goal is to select four evidence-based practice sites in FY 2008 and then expand services based on lessons learned.

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4. DCF has amended its policies to prevent the inappropriate use of shelters for children coming into out-of-home care.

The MSA requires the State to eliminate the inappropriate use of shelters as an option for youth who need to be placed out of their homes. The only appropriate use of shelters will be: "(i) as an alternative to detention, or (ii) a short-term placement of an adolescent in crisis which shall not extend beyond 45 days; or (iii) a basic center for homeless youth." (Section II.D.8) Further, beginning in July 2007, shelters shall not be used as a placement option for children under the age of 13 (MSA, II.D.7). DCF developed the policy to support these new placement restrictions.

C. Services and Supports for Youth

Unfortunately, in jurisdictions throughout the country, the specific needs of adolescents in foster care are too often neglected. Over the last several years, child welfare agencies and foundations have brought heightened attention to adolescents' need for permanency and well-being, especially for youth growing up in and transitioning out of the foster care system. This report has highlighted some of New Jersey's permanency activities for older youth in Section IV.B. Additional activities DCF has taken to support youth are described below.

During this monitoring period, the State was required to report on changes to its policies and practices for youth aged 18 to 21 and for youth who identify as gay, lesbian, bisexual, transgender, questioning or intersex (GLBTQI). DCF spent much of this year assessing its data about youth in care, understanding where they are placed, and the current state of practice supporting them. The State has taken some preliminary steps to focus on the specific needs of this population, and the Monitor hopes that in the upcoming months, additional progress will be made in providing for the permanence and well being of adolescents.

DCF is focusing on expanding the number of youth aged 18 to 21 who receive services if they have not achieved permanency by age 18, and the range of supports available and provided to older youth. As of June 2007, DCF reported the following:

- 1250 youth ages 18-21 were receiving in home services;
- 471 youth ages 18-21 were receiving out-of-home services;
- 323 youth were enrolled in Chaffee Medicaid; and
- 418 youth received tuition assistance, room, board and books through the New Jersey Scholars program (an 86% increase over the previous year at a cost of $2.5 million).

1. DCF significantly revised existing policies in order to continue to provide supportive services to youth aged 18 to 21.

Upon reviewing the policies regarding the provision of support to older youth, DCF leadership discovered that there was an operating presumption in policy and practice of closing the DYFS case when youth turned 18. The information system presumptively closed a youth's case on his/her 18th birthday unless there was a *proactive* request by the worker and youth to keep the case open. DCF worked with the Office of Information services to amend the SIS computer

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system to correct the presumption of case closure. Further, DCF changed its written policies to create a presumption in *favor* of keeping the youth's case open. Now, according to DYFS policy, a youth's case is closed only upon written request of the youth or no later than his/her 21st birthday. Further, Resource Homes will continue to receive a daily board rate for youth aged 18 to 21 who have left their homes, but return for college breaks or unexpected or prolonged illness. DCF will need to continue to work with case workers and Judges to help them understand this change in policy and practice. These actions by DCF meet the MSA requirement (Section II.C.5). The Monitor will continue to investigate the State's efforts to implement these policy changes.

2. DCF added 112 transitional living beds.

In April 2007, DCF far exceeded the MSA June 2008 requirement to establish 18 beds available to youth transitioning out of the foster care system. (Section II.C. 11). DCF established 112 transitional living beds, and dedicated a handful of these beds to youth who identify as gay, lesbian, bisexual, transgender, and intersexual (GLBTI).[22] According to DCF, "the investment by DCF of $2.7 million to support these transitional housing services will be leveraged to gain additional federal and state dollars, primarily in capital acquisition and rehabilitation funds, through New Jersey's Department of Community Affairs, who partnered with DCF on the request for proposal (RFP) process."[23]

3. DCF created a preliminary GLBTQI Plan.

DCF's GLBTQI Plan represents its "first statement of how it intends to meet the needs of this most vulnerable population."[24] According to DCF, the plan was designed with consultation from three different workgroups looking at issues faced by GLBTQI youth. This plan is to be part of the general enhancement of services to adolescents and is an initial document that will grow as the CPM is implemented. Most of the plan will be implemented by June 2008 (meeting the MSA requirement Section II.C.4).

Highlights of the GLBTQI Plan include:

- Examining screening procedures for youth and reviewing in-service training;
- Providing additional training in "adolescent development, including adolescent sexual development, integrating the issues associated with GLBTQI youth"[25];
- Recruiting appropriate Resource Families, counseling and health services that can be sensitive to needs of GLBTQI youth; and
- Analyzing policies and practices to assess the impact on GLBTQI youth.

[22] These are 4 beds at Anchor House according to the New Jersey Department of Children and Families Plan for Service Delivery for Youth who Identify as Gay, Lesbian, Bisexual, Transgender, Questioning, or Intersexual, State Fiscal Year 2007. (New Jersey DCF, GLBTQI plan).
[23] New Jersey Department of Children and Families, Transitional Living Beds report, 2007.
[24] New Jersey DCF, GLBTQI plan.
[25] Ibid.

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4. DCF directed significant resources to new programs to support adolescents.

As stated previously, DCF has committed many new dollars to supporting services specifically to address the needs of adolescents under their care and supervision. Tables 18 and 19 below describe how these resources are distributed.

Table 18: Youth Transitional and Supported Housing Grants

Name	No. of Beds	Award	Counties Served
Anchor House	4	$88,740	Mercer County
Cape Counseling	4	$137,440	Cape May
Catholic Charities, Diocese of Newark	8	$435,000	Hudson County
Catholic Charities, Diocese of Trenton	8	$129,299	Monmouth County
Collier Services	5	$283,274	Monmouth County
Corinthian Homes	18	$248,900	Essex County
Covenant House	15	$212,314	Essex County
Garden State Home of New Brunswick	5	$273,943	Middlesex County
Middlesex Interfaith Partners with the Homeless (MIPH)	6	$209,666	Middlesex County
NJ Community Development Corporation	9	$198,000	Passaic County
Robin's Nest, Inc	10	$150,000	Gloucester County
Tri-City People Corporation	6	$97,145	Essex County
Union Association Children's Home	4	$80,000	Burlington County
Volunteers of America	10	$200,000	Hudson/Essex Counties
Total:	**112**	**$2,743,721**	**9 different counties**

Source: DCF, 2007

Table 19: Youth Permanency Demonstration Project*

Provider	Award	Counties Served
Robin's Nest	$83,333	Atlantic/Burlington/Camden/Cape May/ Cumberland/Gloucester/Salem Counties
Family Services	$83,333	Burlington/Camden/Mercer Counties
Children's Aid and Family Services	$83,333	Bergen/Essex/Passaic Counties
Total:	**$249,999**	**11 different counties**

Source: DCF/DYFS

*See description of Youth Permanency Demonstration Project on page 46 of this Monitoring report.

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VI. MEETING THE HEALTH AND MENTAL HEALTH NEEDS OF CHILDREN

A. Building a new system for the provision of health care to children in out-of-home placements

Redesigning the delivery of quality health care services to children and youth in out-of-home placement is a key obligation under the MSA (Section II.F.8). Like other MSA reform efforts, the improvement of health care service delivery requires a thoughtful and staged process. Numerous studies in the past several years, including two reports by the Office of the Child Advocate have highlighted the need for reform of the health care delivery system for children in out-of-home placement. As reported in the first monitoring report, the State fulfilled its requirement to gather and analyze health care data regarding the frequency of pre-placement assessments, Comprehensive Health Evaluations for Children (CHECs), and the provision of dental care. Based on this information, the State was required to establish baselines and targets for the delivery of health care services to children in out-of-home placement and to develop a comprehensive health care plan for these children and youth. Over the next year, DCF will be aggressively implementing this new plan and modifying it as necessary to ensure quality health care services are appropriately developed and delivered to all children and youth in an accessible and timely manner. Both DCF and the Monitor will be evaluating the effectiveness of this new model.

DCF undertook a deliberative process to build a new comprehensive health care model. DCF contacted many external partners to obtain feedback and information—including the Regional Diagnostic and Treatment Centers (RDTC), existing Comprehensive Health Evaluation for Children (CHEC) providers, the Office of the Child Advocate (OCA), and the Monitor. The Plan that emerged is both comprehensive and ambitious.

As the result of deliberate work over several months to analyze data, track progress, and develop creative solutions, nearly all children entering out-of-home care received pre-placement assessments, with the majority receiving these assessments in a non-emergency room setting. DCF met the MSA requirement (Section II.F.7) in July 2007 by having 90 percent of these exams occur in a setting other than an emergency room. Additionally, DCF reached agreement with the Monitor on health care targets to be measured over the next several years.

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1. DCF designed a comprehensive, coordinated health care plan for children in out-of home placement.

On May 22, 2007, DCF released their vision for providing comprehensive coordinated health care to children and youth who are placed out of their homes.[26] Specifically, this plan outlines a health care model which "emphasizes:

- Care should be provided in a manner sensitive to the child.
- Continuity of care is critical and will be managed by child health units providing health care case coordination in each of the DYFS local offices.
- Children's access to care requires expansion of existing providers statewide and flexibility in the service delivery model which will be addressed through contracting via a public Request for Qualifications Process (RFQ) in June 2007.
- Health care planning must be integrated into permanency planning for children in out-of-home care.
- Success requires real partnership between state agencies, with and among providers, and with the child and family team."[27]

Noteworthy changes provided for in the new "coordinated" health care plan include:

- Modification of the manner in which comprehensive medical examinations can be delivered;
- Building of children's medical health units and significantly expanding the number of nurses in local DYFS offices;
- Redefining the referral protocols to Regional Diagnostic and Treatment Centers (RDTC); and
- Refining the definition of pre-placement assessments.

a. Rethinking Comprehensive Medical Examinations

Under the MSA, the State is required to provide all children entering out-of-home care with comprehensive medical care. Services the State has committed to providing include pre-placement assessments, a comprehensive medical examination within the first 60 days of placement, yearly medical exams in accordance with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines, semi-annual dental exams, mental health assessments for children with suspected mental health needs, and any follow-up care needed by a child (MSA, II.F.2). Previously the State relied on the Comprehensive Health Evaluation for Children (CHEC) model as the intended vehicle to comprehensively assess the health care needs of all children and youth entering out-of-home placement. CHEC examinations require a three part examination—medical, neuro-developmental, and mental health assessments—and in most instances took place on a single day for four to six hours. These services, which were to be completed within the

[26] New Jersey Department of Children and Families, Coordinated Health Care Plan for Children in Out-of-Home Placement, May 22, 2007. http://www.nj.gov/dcf/DCFHealthCarePlan_5.22.07.pdf
[27] Ibid, Executive Summary, p.2.

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first 60 days of placement, were provided once a year primarily by a limited number of medical facilities who contracted with DCF.

After careful analysis, DCF determined there were many challenges to the CHEC approach. Many regions of the State had no facilities available to provide CHEC examinations and as a result children were either exempt from this examination or traveled a great distance to be seen by a CHEC provider. Further, case workers experienced great frustration because these exams were difficult to schedule due to the limited number of CHEC examination slots available and CHEC providers were frustrated by the high rates of cancellations or "no shows" of children. Because the existing structure prevented efficient coordination of CHEC schedules, children experienced long waits to be seen by CHEC providers and CHEC providers were not providing services at their full capacity. A final concern was that the CHEC model was developed with essentially no provisions for follow-up care or for linking children and their families with a "medical home."

A CHEC audit in 2005, lead by the Office of the Child Advocate, similarly found that CHEC examinations were not occurring on a timely basis, children were attending CHEC appointments with individuals that had little or no knowledge of their health history or current needs, and follow-up care was insufficient.[28] On October 3, 2007, the current Child Advocate released another CHEC audit that re-examined this service and found similar challenges.[29] Specifically, the report found that the CHEC program provided an invaluable service, but only to a select number of children. Less than one-third of children entering care received a CHEC evaluation, and those that received these evaluations did not receive them within the 30 day recommended time period. Few children received the identified follow-up care and vital medical information was not always shared with caregivers and other medical providers.[30]

Obviously, thoughtful health care reform is necessary and crucial for children entering out-of-home care. In developing its reform plan, DCF set to accomplish two goals; to ensure: 1) that more children in the State of New Jersey who are placed out of their homes receive timely comprehensive medical examinations upon coming into out-of-home care and 2) that providers of these exams have the ability to serve as an ongoing medical home for the children they see. This model is promoted by the American Academy of Pediatrics. The comprehensive medical examinations the State has proposed for implementation differ from the current CHEC model. These health examinations require a comprehensive physical examination as well as an initial mental health screening. Should a child be found to have a mental health need, a full mental health evaluation will then be conducted.

[28] Office of the Child Advocate, Needs and Assets Assessment of the Comprehensive Health Evaluation for Children (CHEC) Program, December 19, 2005.
[29] Office of the Child Advocate, Health Matters: A Study of the Comprehensive Health Evaluation for Children (CHEC) Program, October 3, 2007.
[30] Ibid.

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DCF leadership met with some federally qualified health centers (FQHCs) and other qualified providers in areas of New Jersey where children were not receiving CHEC exams due to a lack of a CHEC provider to determine their interest and availability to become "medical homes" for children in out-of-home placement and what, if any, impediments they might face in meeting the comprehensive medical examination requirements. Based on these conversations, it was determined that some FQHCs and other providers had the capacity to serve these children, but that the comprehensive medical exam may require them to partner with additional providers for particular parts of the exam (such as mental health assessments). Thus, the Request for Proposal that DCF published in June 2007 provided for this flexibility. A bidders' conference was held on July 25, 2007 and additional questions emailed to DCF were answered publicly on the DCF website. DCF is now reviewing provider responses to the health care RFP. When new contracts are in place, all children in DYFS custody in New Jersey will receive a comprehensive medical examination from a FQHC, CHEC, or other qualified medical provider.

Under the MSA requirement, DCF is required to provide comprehensive medical exams within the first 60 days of a child entering out-of-home placement. DCF is working with staff and providers to meet the more rigorous American Academy of Pediatrics standard of comprehensive exams being conducted within 30 days of placement. The Monitor supports this goal, but in keeping with the MSA requirement, will measure the completion of comprehensive medical exams within 60 days of placement. Over the next few months, the Monitor will be working with DCF and other partners in the State to design an effective means of measuring the timeliness and quality of health care services provided to children in out-of-home placement.

b. Building Child Health Units

After examining different States' models of coordinating health care service delivery for children in foster care, DCF leadership decided that the responsibility for coordinating the health care of children in out-of-home placement must lie with DCF. Therefore, each local DYFS office will have a Child Health Unit (CHU) consisting of at least a nurse and a scheduler. Eventually, each office will have one nurse for every 50 children in out-of-home placement, with appropriate administrative supports. These units will be responsible for medical case management—compiling medical records and documentation and providing key information and documentation to appropriate service providers. Schedulers will be responsible for coordinating all comprehensive medical exam appointments for the local office and assuring the maximum use of these health care facilities by filling cancellations with other eligible children. Nurses will provide medical consultation to workers and pre-placement assessments as necessary.[31]

[31] A flow chart delineating the responsibilities of the Child Health Unit is included in DCF's Coordinated Health Plan. New Jersey Department of Children and Families, Coordinated Health Care Plan for Children in Out-of-Home Placement, p. 16.

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DCF identified the University of Medicine and Dentistry of New Jersey(UMDMJ)'s Francois-Xavier Bagnoud Center (FXB) to provide appropriate nursing support to local DYFS offices throughout the State. With a Memorandum of Understanding beginning July 1, 2007, DCF is working with FXB on a phased roll-out of the CHU throughout fiscal year 2008. The first phase begins December 2007 in Sussex, Hunterdon, Bergen, and Passaic counties (there will be one unit in each area except for Bergen which will begin with two CHUs). DCF intends to evaluate the roll-out with FXB on a regular basis to adjust the roles and responsibilities of the CHU.

Table 20 below identifies the care coordination functions of the proposed CHUs.

Table 20:
Health Care Coordination Functions of Child Health Unit

- Performing Pre-placement assessments
- Initial full health examinations scheduled
- Children received CHEC or initial full health examination
- Children received annual EPSDT examination
- Children ages 3 and older receive semi-annual dental exams
- Children receive appropriate follow-up care
- Creation of Health Care Plan for children in out-of-home placement
- Participation in Case Review conferences
- Participation in Family Team Meetings (or equivalent)
- Participation in the Case plan implementation in the pilot local offices and ongoing as new local offices come on-line

Source: DCF, The Child Health Program, Francois-Xavier Bagnoud Center, University of Medicine and Dentistry of New Jersey, Fiscal Year 2008.

Local office workers are enthusiastic about the creation of Child Health Units and the expanded services of nurses and schedulers. Site visits revealed that space will be a constraint in the planned roll-out but the pressure to make these units available and operational in every office as soon as possible is significant. Integrating this comprehensive health model into the developing CPM will be another challenge which the Monitor will continue to follow over the next several months. Several of the targets DCF will be tracking will also be incorporated into monitoring of the CPM and of the delivery of quality health care to children in out-of-home placement. Over the next several months, as the CHUs are established, DCF must balance a rapid roll-out plan with ensuring quality medical care for children in their custody.

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c. Clarifying the use of Regional Diagnostic Treatment Centers (RDTCs)

Currently, DCF works with four Regional Diagnostic and Treatment Centers (RDTCs) and one satellite office to assist in the evaluation of severe cases of child abuse and neglect. This is a specialized service that requires highly trained physicians (who are a limited resource in New Jersey). DCF spent several months meeting with the staff at the RDTCs to discuss their current capacity to meet the needs of children who have experienced severe abuse and neglect. According to DCF, many children who require this service are not able to be seen by RDTCs. DCF believes that the reason for this gap in service is due to inappropriate referrals of children to RDTCs and, similar to the CHEC exams, high cancellation and "no show" rate for appointments. As a result of these discussions, DCF and the RDTCs agreed that new protocols were necessary to prioritize and target their services to youth most in need of their services. On May 3, 2007,DCF issued new referral protocols to address these concerns. DCF will assess the effectiveness of the dual strategies of clarifying the protocol for referrals to RDTCs and using schedulers at the local office Child Health Units to coordinate filling spots for cancelled appointments and reducing no show rates. The combination of these strategies will be assessed to determine if the RDTCs as currently resourced are capable of fully meeting the needs of children requiring this service, or if the capacity of RDTCs will ultimately need to increase.

d. Refining the definition of pre-placement assessments

Over the last year, DCF has worked with local offices to assess their ability to provide pre-placement assessments in a non-emergency room setting for all children entering out-of-home care. Under the MSA, all children entering out of home care are required to have this assessment and beginning in June 2007, 90 percent of children entering out-of-home placements must have pre-placement assessments in a setting that is not an emergency room (Section II.F.7). DCF is to be commended for achieving nearly 100 percent of pre-placement exams, with 92 percent of all children in out-of-home care in July 2007 receiving their pre-placement health assessments in a non-emergency room setting (see Table 21).

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Table 21:
Completion of Pre-Placement Health Assessments (PPA)
and Use of Emergency Rooms for Assessments
January – July 2007

Month	No. of children Entering care	No. PPA Completed	Percent PPA Completed	Percent completed in Non-ER Setting
Jan-07	420	420	100%	66%
Feb-07	380	379	100%	59%
Mar-07	419	418	100%	63%
Apr-07	301	301	100%	58%
May-07	442	442	100%	70%
June-07	328	328	100%	78%
July-07	377	377	100%	92%
TOTAL	2667	2665	100%	

Source: DCF, Healthcare Pre-placement Assessment Update, August 2007 and September 5, 2007 NJ Department of Children and Families Quarterly Data Update

DCF worked with local offices to identify barriers to receiving pre-placement assessments outside of an emergency room and tailored strategies to achieve this goal. For example, in both Camden and Essex counties, new after-hours pre-placement assessment resources were created. Additionally, nurses in local offices had their job responsibilities reorganized to prioritize providing pre-placement assessments. Some local offices staggered the hours nurses worked so that pre-placement assessments could be provided outside of traditional office hours. Further, DYFS caseworkers were encouraged by leadership to prioritize pre-placement assessments when they recognized the need to remove a child. Workers were urged to contact a child's current primary care provider to determine if a pre-placement assessment could be conducted; if that was not possible, the local office nurse, or medical provider partner were to be contacted for an appointment. [32] Finally, DYFS still requires a pre-placement assessment to be conducted before a child is placed out of his/her home, but has added the caveat that under exceptional circumstances a child may receive a pre-placement assessment within 24 hours of placement if it is determined that it is in the child's best interest (For example, a child is removed late at night and has no noticeable and immediate health concerns. The worker would be responsible for ensuring that child be seen the next day, rather than take the child to an emergency room and wait that night.)[33]

[32] See New Jersey Department of Children and Families, Coordinated Health Care Plan for Children in Out-of-Home Placement, p. 8. for pre-placement assessment flow chart.
[33] Exceptional circumstances are detailed in the policy guidelines.

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As a result of these strategies, DCF reports that it was able to decrease the use of emergency rooms, particularly during evening hours. DCF increased the percentage of pre-placement assessments completed during the day and reduced the number completed in the evenings. Pre-placement assessment data will continue to be monitored moving forward, especially in light of the proposed coordinated health care delivery system.

e. Creating a Medical Passport for all children in out-of-home placement

Under the MSA, all children entering out-of-home placement are to have a Medical Passport created for them. This passport will gather all relevant medical information in a single place and be made available to parents, children (if old enough), and any other caregivers. The CHU nurses will be responsible for ensuring that the passports are created, given to children, families, and providers, and updated regularly. The information for the passport will be entered into New Jersey SPIRIT by the nurses, and then exported to a "passport" form. Items included in the passport are: medication of child, immunizations, hospitalizations, chronic health issues, practitioners and contact information, key mental health and developmental milestones, last EPSDT, dental information, and any special transportation needs. These passports will be tested in Hunterdon and Sussex counties first, adjusted as needed, and then rolled out to other CHUs.

DCF decided to launch this Passport Plan now rather than wait for the Medicaid project, eMedic, to be finalized. The Medicaid project will pull together all existing medical information from electronic records from Medicaid and Health databases.[34] When Medicaid has created eMedic, DCF will revisit the current Medical passports for compatibility and/or merger with the Medicaid documents.

2. DCF set health care baseline and targets to be measured over the next several years.

The DCF Child Health Unit staff conducted two studies of DYFS and Medicaid data to assess current status of health care delivery and inform the setting of health care baselines and targets. The studies were of a small, but significant sample size. Based on this information and after discussion with the Monitor, the following health care baselines and targets were agreed upon in August and September 2007 (MSA, II.F.5-6).

[34] Medicaid is in the process of developing this integrated medical information database. DCF is involved in the planning and will use that database to populate the Medical Passport system once it becomes available. (Target date is Fall 2008).

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Table 22: Health Care Baseline and Targets
(June 2007 – December 2011)

	Baseline as of 6/30/07	June 2008	Dec. 2008	June 2009	Dec. 2009	June 2010	Dec. 2010	June 2011	Dec. 2011
Indicator 1: Pre-Placement Exam Completed; 90% of which shall be in a non-emergency room setting.	90%	95%	95%	98%	98%	98%	98%	98%	98%
Indicator 2: Comprehensive medical exams completed in 60 days of child entry into care	75%	75%	80%	85%	95%	98%	98%	98%	98%
Indicator 3: Annual medical examinations in compliance with EPSDT guidelines for children in care for one year or more	75%	75%	80%	90%	95%	98%	98%	98%	98%
Indicator 4: Children ages 3 and older in care 6 months or more receive semi annual dental examinations.*	Annual 60% Semi-Annual 33%	Annual 60%	Annual 65% Semi-Annual 50%	Semi-annual 70% Annual 90%	Semi-annual 75% Annual 95%	Semi-annual 80% Annual 95%	Semi-annual 85% Annual 98%	Semi-annual 90% Annual 98%	Semi-annual 98% Annual 98%
Indicator 5: Mental health assessments for children with a suspected mental health need.	TBD	75%	80%	85%	95%	98%	98%	98%	98%
Indicator 6: Children receive timely accessible and appropriate follow-up care and treatment to meet health care and mental health needs.	TBD	60%	65%	70%	75%	80%	85%	90%	98%

*Due to need to ramp up dental service capacity, this standard is phased in, beginning with requirements for annual dental examinations.

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The Monitor has proposed that DCF add two additional health care targets:

- Children are current with immunizations; and
- Children's caregivers receive up-to-date health passport upon placement or following completion of the 72-hour Family Team Meeting.

DCF and the Monitor have agreed to review these indicators by December 2007, determine how and when data can be collected to measure them and make a decision about their inclusion in the health care targets to be monitored.

3. DCF is pursuing other health-related strategies

Psychiatrist

Many children and youth who come into contact with DCF have significant behavioral and mental health challenges. DCF recognized the need to have the help of a child/adolescent psychiatrist as they implement the new health care plan, begin reforming the children's behavioral health system, and develop prevention services for children and families. Further, DCF staff require clinical consultation on the use of psychotropic medications and understanding psychiatric diagnoses of children in their care. Thus, DCF has entered into a Memorandum of Understanding to obtain the assistance of a qualified psychiatrist to help meet these needs. While not required by the Modified Settlement Agreement, using the expertise of a psychiatrist at a senior leadership level should help DCF with its reform efforts.

Dental Care Provider Capacity

New Jersey still faces significant challenges in building capacity for dental care for children in its custody. The lack of dentists willing to accept Medicaid patients is one of the resounding themes identified by the seven sites visited by the Monitor in the spring 2007. Workers described spending significant time transporting children across the State in order to receive dental care. In upcoming months, DCF leadership will meet with dentists across the State to discuss the gap of services and will work with the Child Health Units to identify additional providers. Adequate and timely dental care is an area that requires new state partnerships with the dental community. The State must also consider raising Medicaid reimbursement rates so that more dentists are willing to see children and youth involved with DYFS.

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APPENDIX A

Caseload and Supervisory Level Detail for Local Offices

Table A-1:
Permanency Caseloads by Local Office
June 2007

Local Office	Perm Children in Care	Perm Families	Perm Avg Children in Care	Perm Avg Families	Perm (Jun 07)
Atlantic East	90	186	6	12	Yes
Atlantic West	63	188	5	16	No
Bergen Central	77	220	5	15	Yes
Bergen South	144	409	5	15	Yes
Burlington East	160	378	6	14	Yes
Burlington West	113	309	4	12	Yes
Camden Central	146	329	4	9	Yes
Camden East	160	511	5	16	No
Camden North	137	369	3	9	Yes
Camden South	128	433	4	14	Yes
Cape May	88	207	6	14	Yes
Cumberland East	70	100	8	11	Yes
Cumberland West	115	243	5	12	Yes
Essex Central	268	489	7	13	Yes
Essex North	108	399	4	13	Yes
Essex South	94	308	3	11	Yes
Newark Center City	283	589	7	15	Yes
Newark Northeast	275	432	6	10	Yes
Newark South	262	487	7	14	Yes
Newark West/Adoption					
Gloucester East	63	215	4	13	Yes
Gloucester West	52	170	4	13	Yes
Hudson Central	109	331	5	16	No
Hudson North	91	335	6	21	No
Hudson South	99	237	7	16	No
Hudson West	80	194	5	11	Yes
Hunterdon	16	43	3	9	Yes
Mercer North	191	353	6	11	Yes
Mercer South	118	331	3	10	Yes
Middlesex Central	53	148	4	11	Yes
Middlesex Coastal	168	541	3	9	Yes
Middlesex West	155	381	4	11	Yes
Monmouth North	216	366	7	11	Yes

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Table A-1:
Permanency Caseloads by Local Office (continued)
June 2007

Local Office	Perm Children in Care	Perm Families	Perm Avg Children in Care	Perm Avg Families	Perm (Jun 07)
Monmouth South	177	289	6	10	Yes
Morris	111	345	4	12	Yes
Ocean North	235	458	7	13	Yes
Ocean South	136	331	4	10	Yes
Passaic Central	188	312	5	9	Yes
Passaic North	117	299	6	14	Yes
Salem	68	199	3	10	Yes
Somerset	92	242	6	16	No
Sussex	57	162	5	15	Yes
Union Central	113	307	4	11	Yes
Union East	113	305	4	10	Yes
Union West	165	290	6	10	Yes
Warren	61	175	6	18	No
Totals	*5,825*	*13,945*	*5*	*12*	*84%*

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Table A-2:
Intake Caseloads by Local Office
June 2007

Office	Intake Assignments	Intake Families	Intake Avg Assignments	Intake Avg Families	Intake (Jun 07)
Atlantic East	96	171	6	11	Yes
Atlantic West	77	155	8	16	No
Bergen Central	91	163	6	11	Yes
Bergen South	137	195	7	10	Yes
Burlington East	94	181	7	13	Yes
Burlington West	103	142	8	11	Yes
Camden Central	78	89	5	6	Yes
Camden East	109	216	6	12	Yes
Camden North	54	103	5	9	Yes
Camden South	116	171	6	10	Yes
Cape May	66	146	7	15	Yes
Cumberland East	57	71	6	8	Yes
Cumberland West	79	207	6	15	Yes
Essex Central	109	116	7	7	Yes
Essex North	69	73	6	6	Yes
Essex South	71	102	5	7	Yes
Newark Center City	58	201	3	12	Yes
Newark Northeast	100	176	6	10	Yes
Newark South	51	106	6	13	Yes
Newark West/Adoption					
Gloucester East	79	135	7	12	Yes
Gloucester West	90	138	6	9	Yes
Hudson Central	52	188	5	19	No
Hudson North	75	176	6	14	Yes
Hudson South	76	248	8	25	No
Hudson West	63	145	5	12	Yes
Hunterdon	32	71	5	10	Yes
Mercer North	90	139	7	11	Yes
Mercer South	97	116	7	9	Yes
Middlesex Central	77	153	7	14	Yes
Middlesex Coastal	91	148	5	8	Yes
Middlesex West	101	118	4	5	Yes
Monmouth North	131	278	7	15	Yes
Monmouth South	110	276	7	18	No
Morris	154	307	6	11	Yes
Ocean North	156	233	7	11	Yes
Ocean South	118	233	6	12	Yes

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Table A-2:
Intake Caseloads by Local Office (continued)
June 2007

Office	Intake Assignments	Intake Families	Intake Avg Assignments	Intake Avg Families	Intake (Jun 07)
Passaic Central	159	352	8	19	No
Passaic North	155	246	9	14	Yes
Salem	56	95	5	9	Yes
Somerset	105	375	8	29	No
Sussex	59	114	8	16	No
Union Central	70	170	6	14	Yes
Union East	75	141	5	9	Yes
Union West	76	114	5	8	Yes
Warren	82	220	6	16	No
Totals	*4044*	*7713*	*6*	*12*	*82%*

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Table A-3:
Adoption Caseloads by Local Office
June 2007

Office	Adoption Children	Adoption Avg Children	Adoption (Jun 07)
Atlantic East	71	14	Yes
Atlantic West	23	12	Yes
Bergen Central	64	13	Yes
Bergen South	130	19	No
Burlington East	67	17	Yes
Burlington West	70	18	Yes
Camden Central	81	14	Yes
Camden East	57	14	Yes
Camden North	71	14	Yes
Camden South	71	24	No
Cape May	48	24	No
Cumberland East	93	16	Yes
Cumberland West			
Essex Central	135	17	Yes
Essex North	86	17	Yes
Essex South	53	11	Yes
Newark Center City			
Newark Northeast			
Newark South			
Newark West/Adoption	568	18	Yes
Gloucester East	31	16	Yes
Gloucester West	34	17	Yes
Hudson Central	70	12	Yes
Hudson North	59	15	Yes
Hudson South	42	14	Yes
Hudson West	46	12	Yes
Hunterdon	22	11	Yes
Mercer North	93	16	Yes
Mercer South	67	13	Yes
Middlesex Central	51	13	Yes
Middlesex Coastal	106	18	Yes
Middlesex West	40	13	Yes
Monmouth North	83	17	Yes
Monmouth South	50	10	Yes
Morris	71	14	Yes
Ocean North	117	17	Yes
Ocean South	88	15	Yes

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Table A-3:
Adoption Caseloads by Local Office (continued)
2007

Office	Adoption Children	Adoption Avg Children	Adoption (Jun 07)
Passaic Central	78	16	Yes
Passaic North	59	20	No
Salem	115	16	Yes
Somerset	42	14	Yes
Sussex	42	14	Yes
Union Central	65	13	Yes
Union East	128	13	Yes
Union West	128	16	Yes
Warren	46	15	Yes
Totals	3,461	15	90%

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Table A-4: June 2007				
Local Office	**Total Number of Workers**	**Total Number of Supervisors**	**Ratio 5 to 1**	**Supervisory Ratio (June 07)**
Atlantic East	44	9	5	Yes
Atlantic West	27	6	4	Yes
Bergen Central	44	10	4	Yes
Bergen South	60	12	5	Yes
Burlington East	52	11	5	Yes
Burlington West	54	9	6	No
Camden Central	63	14	4	Yes
Camden East	62	11	6	No
Camden North	59	14	4	Yes
Camden South	62	13	5	Yes
Cape May	39	8	5	Yes
Cumberland East	27	6	4	Yes
Cumberland West	49	9	5	Yes
Essex Central	73	14	5	Yes
Essex North	53	11	5	Yes
Essex South	50	11	5	Yes
Newark Center City	67	13	5	Yes
Newark Northeast	75	18	4	Yes
Newark South	64	15	4	Yes
Newark Adoption	40	9	4	Yes
Gloucester East	35	8	4	Yes
Gloucester West	36	7	5	Yes
Hudson Central	51	11	5	Yes
Hudson North	41	9	5	Yes
Hudson South	39	11	4	Yes
Hudson West	34	8	4	Yes
Hunterdon	16	4	4	Yes
Mercer North	54	13	4	Yes
Mercer South	57	11	5	Yes
Middlesex Central	34	7	5	Yes
Middlesex Coastal	88	17	5	Yes
Middlesex West	71	12	6	No
Monmouth North	67	13	5	Yes
Monmouth South	55	11	5	Yes
Morris	75	15	5	Yes
Ocean North	72	13	6	No
Ocean South	72	13	6	No
Passaic Central	62	13	5	Yes

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Table A-4 :
June 2007 (continued)

Local Office	Total Number of Workers	Total Number of Supervisors	Ratio 5 to 1	Supervisory Ratio (June 07)
Passaic North	59	11	5	Yes
Salem	47	9	5	Yes
Somerset	43	10	4	Yes
Sussex	25	6	4	Yes
Union Central	52	12	4	Yes
Union East	67	12	6	No
Union West	59	12	5	Yes
Warren	36	9	4	Yes
TOTAL	2411	500	87%	

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APPENDIX B

New Jersey
Department of Children and Families

Implementing the Case Practice Model

September 2007

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> *The family engagement model of service delivery is not just a defined process with a set of policies, procedures and skills for staff to be taught and implement. It is more of a philosophy and a mindset that affects our thoughts and behaviors in our relationships with the families we serve. DYFS has historically been perceived by some of our families, service providers and the general public as a powerful agency who determines who, what, where, when, why and how families will respond to our intervention…[The challenge] as we implement the new Case Practice Model [is to] move from a case management manner of service delivery to a strengths-based, family-centered, child focused approach [and] the critical shift from power over our families to power sharing with them.*
>
> DYFS Atlantic-Cape May Staff

The heart of the reform of the New Jersey child welfare system lies in implementing the Case Practice Model (CPM) and making it come alive on the ground in the daily experience of the children and families who depend on the Department of Children and Families' (DCF) Division of Youth and Family Services (DYFS) for safety and services.

Case Practice Model Development

Implementation of the CPM requires both broad and deep strategies. DCF will utilize a six prong approach:

1) Leadership Development

2) Statewide Readiness Strategy

3) Immersion

4) Service Development

5) Continued Focus on the Fundamentals

6) Enhanced Planning and Coordination between DYFS and Division of Child Behavioral Health Services (DCBHS)

Methodology

In December 2007, after a process seeking broad public input through a series of regional stakeholder forums, the DCF finalized its written CPM for the child welfare work that is the mission of DYFS. DCF then worked with DYFS leadership to disseminate the model throughout DYFS' 47 local offices and began a planning process for implementation – spearheaded by the 12 area directors; their assistant regional administrators, designated as the point people in each area for implementation of the CPM; the directors of adoption, resource families, child health and adolescents; and community agencies, using quality analysis and information. Throughout the spring, the directors, managers and staff worked intensively to achieve the goals set forth in

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Focusing on the Fundamentals in order to lay the groundwork for beginning implementation of the CPM. Those goals included:

- Hiring sufficient caseload carrying and supervisory staff to meet the needs of each office.
- Facilitating the training of staff, including pre-service, investigatory, and supervisory (as applicable) as well as concurrent planning and New Jersey Spirit training for all staff.
- Intensive caseload management to ensure progress in meeting the caseload standards set forth in the Modified Settlement Agreement (MSA).
- Focus on improving permanency practice including the roll out of 10 concurrent planning sites each with important new process steps.
- Continued focus on adoption practice including realignment of children with adoption goals with the newly established adoption staff and work towards challenging adoption finalization targets.
- Increased focus on resource family recruitment, particularly the home study application process and the need for coordination with licensing, in order to meet aggressive new family recruitment targets.

The directors, managers, and their staff made measurable progress with respect to these goals by June 2007. The basics are beginning to be addressed successfully, while much more work in each of these areas remains. The leadership has expanded its attention to address the need for a CPM implementation plan that balances the continued focus on fundamentals and real capacity constraints with the hunger in the field for embracing a new way of doing business, as well as the desire of DCF leadership to move forward the work that is the heart of the reform – and holds the most promise for changing the experience of children and families.

Learning from the successes and mistakes made by other jurisdictions and New Jersey's own history, DCF knew the process had to begin with concerted outreach to the field. The area directors (ADs) and their assistant regional administrators spearheaded an intensive process that began with a series of focus groups of staff, stakeholders and families to discuss the CPM. They selected a typical case in each area to frame their discussions and keep it concrete. As delegates from their areas, they came together for a two-day retreat devoted to CPM implementation. They were joined by the directors of resource families, adoption, child health and adolescents, quality analysis and information, and the Division of Children's Behavioral Health Services (DCBHS) – who had also done intensive work with staff to understand their role in implementing the CPM. That group spent the first day with the DCF Commissioner, DYFS executive management and the Policy and Planning staff. The remainder of the DCF executive management team joined on the second day. The delegation from DCBHS included System of Care community agencies well versed in child and family-centered practice. The end result was a rich assessment of the existing state of practice, including identification of opportunities for innovation, pockets of promising practice, and barriers to implementation. They all agreed to return to their areas, divisions and units and think hard with their staff and stakeholders about how to implement the CPM, which has resulted ultimately in this statewide plan.

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The Six Prongs of CPM Implementation

1) Leadership Development

The launch into the case practice implementation process will begin with a Leadership Summit in fall 2007, building on the work of the previous months to broaden and develop the reform leadership team and engage that team in planning the implementation of the CPM.

In examining reform efforts in New Jersey and elsewhere, it is clear that it is critical to engage leadership at the start, immerse them in the principles of the new practice, and secure their buy-in. As previously seen in New Jersey, it has been a common mistake to attempt to seed reform only in pre-service training for new DYFS workers, or the equivalent. The result is a wave of new staff who have been trained using different principles and practices than their supervisors, as well as their supervisors' supervisors, managers, and so on. Because the new staff training does not fit the culture in the offices, it quickly becomes subverted when the new staff begins to practice – they cannot carry the reform on their own. Sound reform requires a cultural change in an office, and that starts with leadership.

To that end, New Jersey began its process of engaging leadership early. Throughout the first year, DCF has cultivated the role of its DYFS ADs. DYFS' statewide operations are divided into 12 areas, each led by an AD. There are also directors of practice for resource families, adoption, child health and adolescents, and quality analysis and information. Previously, these roles were largely administrative – they did not develop policy or strategy and they were expected only to implement what came from central office leadership. As part of its *Focusing on the Fundamentals* approach, the DCF executive management team made a commitment to the directors to engage them in the decision-making and leadership of the reform. DCF leadership also set up an aggressive meeting schedule where directors came together with central office leadership every other week for at least half a day. Central office leadership also made critical data available to each director with supports to ensure they knew how to use it. Central office also worked hard on team building with the directors, first on achieving clarity around their role development and then on the need to roll out supports to make their leadership effective. To that end, over the past year, DCF built a team in each area office, led by the AD, which includes an assistant regional administrator and a team of experienced technical assistance staff: point people in critical areas of practice including concurrent planning, resource families, adoption, and continuous quality improvement. DCF made similar investments with the directors of DCBHS, Prevention, adoption, resource families, child health and adolescents, and quality analysis and information. The directors participated in the strategy development which resulted both in the *Focusing on the Fundamentals* and the Modified Settlement Agreement (MSA), and they were responsible for driving out the initial fundamental reforms, which in the first 18 months consisted predominantly of: hiring new staff; effectuating training and re-training of all of their staff; balancing caseloads; recruiting new resource families; and achieving aggressive targets for adoption finalization.

Leadership in a public system this large extends beyond the directors to each local manager in the public agency and to their natural partners in the community across the state. While the number of local offices in New Jersey has continued to fluctuate with changing demographics, at the time of this writing, DYFS has 47 local offices. As part of its leadership development strategy, the DCF executive management worked hard not only to incorporate the directors into the leadership group but then to extend that ownership to the local office managers. That process has necessarily taken longer and is continuing. Intensive work with the local office

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managers began in the second half of 2006 as DCF leadership began to meet with the office managers in smaller groups in series of four regional meetings. Those proved to be productive forums for the exchange of information, strategies and challenges – and resulted in a strong level of ownership around the goals set forth in both *Focusing on the Fundamentals* and the MSA. As local DYFS managers began to consider their recommendations for effectively embedding the CPM in their work with children and families, many drew upon the experiences of community agencies and DCBHS System of Care providers whose commitment to family engagement has been modeled in many instances over many years.

Building on the intensive CPM planning work completed by the DYFS leadership in the first six months of 2007, the next step is to engage that leadership – and the leadership of DCBHS, Prevention and Central Operations – in a Leadership Summit to take place in fall 2007. The Leadership Summit will be jointly led by DCF executive management and a team from the Child Welfare Policy and Practice Group (CWPPG), which led Alabama's model child welfare reform effort and monitored Utah's successful implementation of its reform commitments over the past seven years. Also joining the Leadership Summit will be representatives from DCF's University Training Consortium, who will play a critical role in statewide training delivery. The summit will provide both an opportunity to mark the "kick-off" moment for the implementation of the CPM and the opportunity to begin to embed common language and principles across the state with a sense of shared mission across divisions within DCF.

2) Statewide Readiness Strategy

New Jersey commits to pursue a broad strategy to seed family engagement training and practices throughout the state as an essential step in CPM implementation. Even as DCF begins to develop its own model sites where the CPM can be embraced in its entirety through an immersion strategy (see below), the remainder of DYFS' statewide operations will begin to refine the core skills of teaming and engaging at the heart of the CPM. The intensive planning work with the DYFS areas during the first six months of 2007 surfaced unanimous demand for training related to the CPM, beginning with very fundamental information related to engaging families and the basics of developing a practice driven by family meetings. New Jersey's review of previous work by the CWPPG suggests that their training curriculum developed for Utah, *Developing Strength Based, Individualized Child and Family Practice*, contains a module on *Developing Trusting Relationships with Children and Families*. That module includes:

- Overview of the skill for building a trusting relationship
  Understanding the cycle of need, challenge model and the five stages of change
- Working through resistance
- Use of solution focused questions
- Assessing your relationship with a family
- Developing and using a plan to build a trusting relationship

CWPPG has also developed a rich curriculum entitled *Making Visits Matter*, which takes the important and necessary practice of child and family visits and reframes them in an intensive family engagement, family meeting model of practice. That curriculum includes the following:

- Identification of the purposes in visiting and the value of partnership in worker visits with children and families
- Development of strategies to support effective working agreements for visiting

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- Identification of and practice in safety assessment during visits, including observation and interviewing information
- Individualization of visiting techniques and observations based on developmental considerations, case progress and key decision points in work with children and families
- Tracking and adaptation of case plan goals, tasks and accomplishments
- Development of worker engagement strategies with children, families, and caregivers
- Development of strategies to support team building during visits to promote progress and stability for children and families

These two courses together meet the need to engage staff both conceptually in the principles of family engagement while giving them a concrete set of tools for beginning to practice those principles in the context of a very important area of practice. Through December 2007, DCF leadership will work closely with CWPPG to revise these curricula to make them consonant with New Jersey practice and to ensure they form a holistic whole.

Concurrently, DCF proposes to build the infrastructure necessary to deliver this training statewide. The challenges on this front are formidable. DCF estimates that approximately 4000 staff will need to be trained and each will need to receive a minimum of 40 hours of training in 2008. This training will be delivered by the University Training Consortium and the DCF Training Academy, beginning in January 2008, after trainers are certified by CWPPG and DCF through the fall. Those trainers will be members of regional training teams which will include representatives from the:

- DCF Training Academy;
  University Training Consortium (which will also include trainers who have a proven track record in delivering DYFS training with a family-centered focus, including concurrent planning trainers, adoption trainers, etc.);
- A DYFS central office CPM technical assistance group;
- Local providers with philosophically similar training capacity (examples include some of the local CMOs who have strong family engagement practices and training capacity and some providers who have demonstrated commitment to family centered practice and experience with family engagement training); and
- CWPPG team member(s).

One of these groups, the central office CPM technical assistance group, is currently under development and will focus on providing central office support to the field on the difficult work of embedding the new CPM in our work. That group will be led by the DYFS deputy director.

The broad membership in the regional training teams serves several purposes. First, there is the very practical necessity of developing sufficient training capacity to meet the needs of thousands of staff, and that means there will need to be a large number of trainers. No one source can deliver all of those trainings – but these five sources together will provide a rich group with varied experiences and backgrounds. Over the past several years, New Jersey has invested in a wide variety of trainers and trainings – the next step is to build that capacity into a consonant whole. Second, seeding each group with CWPPG trainers leverages their expertise while ensuring New Jersey develops its own capacity to train on the CPM going forward.

Beginning in fall 2007, CWPPG trainers will work in a “train the trainer” model to develop each regional training team. The first step will be to identify the members of the training teams. Each regional training team will train as a group together so that they develop into a team. That training will be intensive but could take as many as 15 to 25 full days as it will need to cover

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both the substance of the training and training in training. It is critically important to engage community providers in this process; therefore the schedule may need to be adjusted to accommodate their needs. It will be important not to skimp in the development of these regional training teams. On the ground, they will be one of the most important deliverers of the CPM – they need to know it, own it and have the skills to deliver it. The expectation is that there will be approximately four regional training teams, but that number is still in development. The end number will depend on the assessment of capacity balanced against the need. DCF anticipates that the training of the regional training groups will need to be sequenced – in other words, that there is not sufficient capacity to launch all four at the same time and do that well (the groups would be too large to do them all together and there are strong advantages to training each team as a group). In prioritizing, CWPPG and DCF executive management will think through the need to support the immersion areas and the statewide training. The expectation is that the regional training teams will be trained and ready to go by the end of December 2007.

In parallel, the CWPPG, DCF leadership and identified leadership from the other training groups (including the Consortium) will be working on the logistics of the training delivery system for 2008. This group will develop the statewide training schedule which will balance the needs of each area in the context of ensuring staff coverage to continue the important work in the field. They will also identify training sites throughout the state which minimize travel strains for staff. The training consortium is ideally positioned to facilitate both location identification and enrollment. The partners in the Consortium are strategically located throughout the state and each has excellent training facilities available. DCF has an existing Web-based enrollment tool that will facilitate statewide enrollment. DCF utilized a tool to facilitate New Jersey Spirit training and found it worked well.

Statewide training on the CPM implementation (*Family Engagement* and *Making Visits* Matter) is planned to begin in January 2008 and roll out statewide over the course of 2008. Over 1,100 days of training (assuming a class size of 25) will need to be scheduled and delivered. This training estimate is conservative – and additional training demands are likely to be identified during the planning process. For example, depending on the timing of the development of potential provider partnerships, community provider staff will also need to receive training. DCF and CWPPG will work closely together to strategize the grouping of trainings. The first three regional training teams developed will need to focus on supporting the development of the Immersion Sites (see below). Training will be staggered as follows:

- Meeting the immediate needs of the Immersion Sites
- Training field leadership – the managers and casework supervisors responsible for bringing the change in practice to each of their offices
- Prioritizing training for the staff in the unit in each office designated as the lead unit for that office in beginning the practice change
- Balancing the need to leverage capacity geographically to ensure the most efficient use of trainer time; and
- Ensuring the least level of disruption in service delivery.

While areas will be prioritized, the goal is to ensure all designated DYFS staff will have completed this CPM training in 2008.

Selecting sites as part of the statewide readiness strategy will also require attention to the following areas:

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- Alignment of investments and efforts in the development of DYFS concurrent planning sites with the CPM.
- Alignment and incorporation of existing tools, including structured decision-making (SDM) and safety and risk assessments into the full CPM practice.
- Continued reflection and iterative revisions of existing training to ensure consonance with the CPM training (including pre-service, investigator, and supervisor training).
- Launching of DYFS-DCBHS reform pilot areas, which will feature unified care coordination among DCBHS providers, the establishment of primary case management for youth involved with both divisions, and the deployment of clinical staff from the local DCBHS care coordination agency into DYFS offices to support coordinated planning.
- The implementation of Differential Response.
- On-going contract assessment and re-assessment to align services and deliverables with the CPM and the continued development of business infrastructure to better support the field in delivering on the promise of the CPM.
- Continued development of quantitative and qualitative tools available to the field to further support the CPM.
- The pace and progress of establishing child abuse prevention and family support services in a given area under the auspices of the Division of Prevention and Community Partnerships, including Family Success Centers, School-Based Youth Services and Home Visitation programs.
- Recognition of the challenges associated with the rollout of New Jersey Spirit and tempering demands on staff depending on absorption of the impacts of the new system.
- Concurrent development of the Child Health Units in order to provide local capacity to integrate robust health planning into the CPM. We will build Child Health Units in all DYFS local offices. Staffing levels vary within each Child Health Unit and are based on the number of children in out of home placement served by an office. DCF firmly commits to the establishment of five fully operational Child Health Units by December 2007, and plans to do so in Sussex (1 office); Hunterdon (1 office); Bergen (2 offices); Passaic (1 office). By June 2008, we plan to have Child Health Units established in: Sussex (1 office); Hunterdon (1 office); Passaic (1 office); Hudson (3 offices); Cumberland (2 offices); Warren (1 office); Somerset (1 office); Middlesex (3 offices); Union (1office); Mercer (1 office); Monmouth (1 office). And we plan to have Child health Units established in the remaining DYFS local offices by December 2008.
- Expansion of health care services to ensure children's access throughout the state.
- Continued development of resource family recruitment and retention strategies.
- Integration and attention to other key stakeholder demands, most notably, the Federal Child and Family Service Reviews.

This list is not exhaustive but it is intimidating. All of these areas of practice are important. Several are underway but will need continued support and on-going work to ensure alignment with CPM implementation. And in each area, the work will need to be triaged as it cannot all be undertaken efficiently and effectively concurrently.

This statewide readiness strategy will continue to grow and evolve to meet the needs of the children and families of New Jersey. In January 2008, beyond the first four DYFS Immersion Sites, all other local DYFS offices will pilot the implementation of the CPM in an aspect of their work. Some will begin that work at the start of 2008 – but a few offices will first need to continue focusing on the fundamentals of lowering caseloads and tackling their targets for improved performance before they begin. Flexibility will be critical in order to identify organizational development needs and redirect resources and support as needed.

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3) Immersion

Even as New Jersey pursues a broad strategy to seed family engagement training and practices throughout the state, DCF needs to begin to develop its own model sites where the CPM can be embraced in its entirety. To that end, beginning in January 2008, DCF will launch an intensive CPM immersion process in four DYFS offices – Bergen Central, Burlington East, Gloucester West and Mercer North. Immersion will be an intensive process which will include:

- Training for all staff members in those sites
- On-site coaching provided by CWPPG staff with DCF technical assistance partners
- Concurrent development of the local provider partners
- Service inventory and expansion
- Development of the infrastructure including the capacity to schedule and facilitate family team meetings

Coaching and training at the Immersion Sites will be time intensive. DCF leadership will work with CWPPG to adapt the full Utah curriculum, *Developing Strength Based, Individualized Child and Family Practice*, for New Jersey. The expectation is that adaptation will be completed so that training can begin in January 2008. That training will cover the following topic areas:

Developing trusting relationships with children and families

- Overview of the skill for building a trusting relationship
- Understanding the cycle of need, challenge model and the five stages of change
- Working through resistance
- Use of solution focused questions
- Assessing your relationship with a family
- Developing and using a plan to build a trusting relationship

The basics of creating and supporting family teams

- Identifying the characteristics of a successful team
- Assessing team
- Conflict management, consensus building and conflict resolution
- Introduction to family systems
- Family focused interviewing
- Family and social network mapping
- Identifying and assembling the team
- Prepping for the team
- Facilitation
- Building trust and agreement among team members
- Leadership style, validation, cooperation
- Five stages of creating a team
- Team skills building

Assessment

- Functional assessment
- Self assessment
- Helping families self-discover
- Strengths and needs
- Timeline tools
- Safety/CPS assessment
- Genograms, eco mapping, and family systems mapping

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- Dual track – assessment and investigation
- Quality service reviews and assessing documentation
- On-going assessment
- Strength and resiliency

Using assessment to craft individual plans

- Effective planning
- Gathering assessments
- Practice crafting plans

This training includes both the basic CPM training offered statewide as well as advanced training.

Even as the training is being adapted, CWPPG staff, in conjunction with identified central office technical assistance staff, will meet with the selected Immersion Sites, identify provider partners, and set up a coaching schedule which will be integrated with the training schedule. The early coaching sessions will allow CWPPG to learn the existing culture of the offices and adapt their coaching and training strategies to meet the strengths and needs of each of those offices.

As discussed below in the section on *Focusing on the Fundamentals*, while New Jersey's DYFS offices have made strides in the last 18 months, they are at different places in their organizational development based on the history of previous investment, local demographic changes, access to services, opportunity to hire necessary staff and office culture. The Immersion Sites were selected based on an intensive evaluation process which took into account the factors identified earlier for statewide readiness, as well as the following factors:

- Assessment of readiness as measured by the goals set forth in *Focusing on the Fundamentals*:
  - Staffing meets targeted fill levels
  - Majority of staff have moved beyond trainee status
  - Caseloads balanced
  - Stable referral patterns that could be managed with existing investigatory staff
  - Stable management, a stabilized supervisory workforce, and low staff turnover rate
  - Progress in developing resource family practice
  - Progress in developing adoption practice
- Leadership with a demonstrated interest in family centered practice and some existing demonstrated commitment to family centered practice
- Geographic distribution (one each in north, central, and south) to provide ready access to serve as a peer to peer site and to demonstrate efficacy of model in different geographic areas
- Demographic variation that is representative of the range of challenges across New Jersey
- Referral rates and placement rates that are representative (which required excluding outliers in practice)
- Assessment of other pilot efforts to ensure no office is overloaded and any existing pilot efforts can be incorporated into the model

It is important to focus on fully developing these Immersion Sites so that they can flourish and develop into peer-to-peer demonstration sites. That will take time. Approximately 400 staff will need to be fully trained, and the training delivery will have to be calibrated over time to ensure

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sufficient coverage of the existing workload. Coaching and training will be interspersed to allow staff to learn, practice what they learn, reflect on their practice, and incorporate improvements into their practice. There will be regular meetings with leadership to assess progress, identify challenges, problem solve, and engage in mutual learning. This process will take at least 7 months and the fruits of that process will take even longer to realize. If this process begins as anticipated in January 2008, the peer to peer sites will be through the first level of development by July. But it is important to recognize that it will take much longer to see the full flowering of the CPM in practice. Examination of other jurisdictions suggests this is a multi-year process that cannot be truncated – and that there has to be the expectation of setbacks in organizational development along the way. In short, this process is not for the faint of heart – DCF and its stakeholders will have to commit for the long haul to realize return on this investment to achieve a stronger practice with children and families.

These first Immersion Sites will develop more slowly than later sites because they are the pioneers. While there is pride in being the first, they will have to find their way. DCF will take maximum advantage of telescoping that process by leaning heavily on the experience of the CWPPG, but the learning process itself on the ground requires time to absorb and mature. DCF will have to work closely with CWPPG, the federal monitor and other important stakeholders to protect the development of these sites to ensure their development is not rushed nor resources and focus diverted under the pressure of expansion, and to evaluate the efficacy of the immersion approach beginning in July 2008.

Staggering Expansion Beyond Immersion

Even as the Immersion Sites develop, statewide training in conjunction with focused coaching lead by the local office leadership will help develop readiness throughout the state. Advanced case practice training and advanced intensive coaching will become available to the rest of the offices in the state as local training capacity and technical assistance develop by the second half of 2008. Advanced training and coaching will then be staggered as needed throughout the state taking into account critical measures of readiness:

1) Staffing Levels: Staffing must be at or near target staffing levels for caseload carrying and supervisory staff. Ideally, staffing levels for other critical staff, including resource family staff, will also be at or near target level. Most offices are close to achieving these criteria. DCF anticipates, barring unexpected demographic shifts (a spike in referrals, for example), all will meet this criteria by December 2007.

2) Staffing Maturity: Given the necessary and welcomed influx of new staff into the local offices, the system staffing maturity level is necessarily low. The threshold here is not high but does require that 80 percent of staff be beyond the six month initial trainee period. Given the high current retention rate, DCF can anticipate that all offices should meet these criteria by January 2008.

3) Stable staffing: Offices with a new manager, substantial turnover or changes in supervisory or caseload carrying staff will not meet these criteria. Executive staff are monitoring these areas closely and will be able to effectively evaluate this set of criteria each quarter to determine when an office is ready for advanced training and targeted coaching.

4) Caseload targets: Offices must have achieved the caseload targets by office as articulated in Phase I of the MSA. Currently, New Jersey has achieved compliance in excess of 80 percent on all four prongs of the caseload standard. However, two of those prongs grow

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more stringent over time. Again, executive leadership has the tools to monitor compliance quarterly and so effectively identify offices meeting these criteria.

5) Caseload distribution: Offices must have the capacity and the ability to distribute caseloads evenly among staff so that individual staff are not burdened with excessive caseloads. ADs and managers made considerable progress towards this goal in June 2007 but it will take an additional six to nine months for all offices to have the staff maturity levels necessary followed by measured redistribution practices to affect this goal. Note that barring an unexpected demographic shift (such as a surge in referrals), this projection places New Jersey ahead of the schedule anticipated in the MSA. Nonetheless, DCF needs to proceed cautiously here with close managerial attention and support. Executive leadership does have the tools to effectively monitor these criteria.

6) Service development: Service development has been uneven throughout the state for historical reasons. In the past 18 months, DCF began the process of developing resources in some of the most service poor areas of the state and the service development process described in this plan will provide further support in those areas. Nonetheless, those efforts will take time to mature. Previous experience in other jurisdictions suggests the need to develop provider partners in order to effectuate the CPM. So the quarterly readiness assessments will monitor service development to ensure a matched level of service development and identify challenges that will need to be addressed at each stage of the implementation process.

7) Training capacity: DCF is frontloading development of the pool of trainers necessary to deliver the basic training statewide. Once that basic training is underway, DCF will then need to develop training capacity to deliver the advanced CPM training and may need to add to the pool of initial trainers. Again, DCF leadership will evaluate its training needs quarterly and adjust as needed.

Proposed Schedule (subject to change depending on need and capacity)

January 2008	Training begins in both the Immersion Sites and statewide
February 2008	Intensive coaching begins in Immersion Sites
July 2008	Immersion Sites complete training Managers and casework supervisors statewide will have completed their training Leadership units from each office will have completed training and will be receiving coaching from their leadership on the CPM Evaluate immersion strategy and deploy targeted coaching resources statewide Chart expansion from leadership units to entire offices
November 2008	Initial statewide training complete Training plan completed which charts delivery of advanced CPM training statewide
January 2008	Advanced CPM training begins Coaching expands to every office statewide

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June 2009 Advanced CPM training complete
Evaluate coaching and training statewide

4) Service Development and Budget Transparency

One of the powerful lessons of reform from other jurisdictions is the need to develop and nurture provider partnerships poised to deliver the continuum of services necessary to support a robust family centered child welfare practice. The CPM articulated by New Jersey has a profound effect not only on existing state staff, it may also require changes in practice by provider partners. Those changes include:

- Embracing the principles of family centered, strengths based practice
- Commitment and capacity to participate in family meetings
- Flexibility in service delivery (in substance, in timing, and in methodology)
- Willingness and capacity to experiment and test new methods of service delivery and types of services
- Willingness and capacity to make agency staff available for training
- Development of service continuums rather than single service delivery models

The development of provider partnerships must begin on the same timeframe as the development of the other prongs of the reform so as to be ready when called upon to participate as full partners throughout the planning process, during the training and coaching phases, as members of the developing family teams, and to respond to service requests as the service needs are identified through robust family engagement.

As a core component of the Immersion process, DCF will inventory, across all its divisions, the public and private investments it makes in the county within which the CPM immersion is underway. In these initial four counties – Bergen, Burlington, Gloucester and Mercer – DCF will strive to publish a transparent child and family-based budget of investments and services by May 2008, including an index of children and families served within that county.

The pilot development of a child and family based budget in these four counties will include an accounting of the increased investment in services over the past 20 months of the reform. That increased investment across the state includes:

- Expansion of flex funds
- Expansion of visitation support services
- Expansion of concurrent planning services
- Investments in developing a new differential response model
- Investments in-home visitation services
- Expansion of school-based services
- Development of pilot family success centers
- Expansion of specialty beds to meet the needs of previously unmet populations
- Investments in new resource family recruitment partnerships
- Expansion of health care services for children in out-of-home placement
- Expansion of domestic violence services
- Expansion of transitional living services for youth ages 18-21
- Expansion in tuition assistance for DYFS involved youth attending college and technical schools

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The CPM planning work by each of the areas also revealed that New Jersey has existing provider partners with a history of delivering family-focused, strengths-based services who are eager to partner – both to assist in training delivery and to work hand in hand in the development of the necessary service continuum to support the full CPM. While distribution of these providers is not equal throughout the state, some areas will have the benefit of an existing pool of potential provider partners.

Nonetheless, the ADs also surfaced some continuing areas of significant need beyond training and coaching:

- Welcoming, accessible and neutral space for family meetings and visitation
- Intensive in home services
- Flex funds for refreshments, child care, and other costs associated with family meetings
- Transportation supports
- Expansion of existing contracts with partner providers with a demonstrated capacity for family engagement
- Expansion of substance abuse, counseling, and other child and family services
- Family friendly publications (in English and Spanish) to explain family meetings and the CPM

DCF has set aside resources to support this necessary service expansion and will build on the experience of CWPPG in the design of the service delivery models. But there is still important and substantial work to be done in drafting and then executing the necessary Requests for Proposal (RFPs). While in the last 18 months, DCF has honed its ability and capacity to generate, review and award grants for services pursuant to RFPs, even the most streamlined process will take four to six months to effect, and depending on provider readiness, a provider could take several months to grow the capacity to serve as a full provider partner.

The process of drafting the initial necessary RFPs will drive to a target issuance date of spring 2008. In the interim, New Jersey will analyze its existing contracts to identify those which are already suited to serve in the provider partnership role. New Jersey will rely on flex funding to supplement service needs, much as other jurisdictions in the midst of reform have successfully done.

5) Continued Focus on the Fundamentals

Throughout this process, DCF leadership must continue to develop all the foundational areas identified in *Focusing on the Fundamentals*. Those commitments include:

- Maintenance of targeted staffing levels
- Retention of existing staff and stabilization of staff by role
- Achieving caseload targets and balancing individual caseloads
- Coaching and supporting trainee staff as they mature
- Adjustment of staffing levels to meet changing demographic needs
- Supporting statewide roll-out of the New Jersey Spirit system
- Continued development of the ten concurrent planning sites and roll out of new sites
- Continued support of adoption practice and achievement of adoption finalization targets

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- Continued support of resource family recruitment and retention practice, including new efforts to revise existing regulations to better support families and more sophisticated targeting of resource family development by local area need
- Continued commitment to support robust safety practices including continued development of screening staff, support to ensure continued rapid investigative response, full utilization of structured decision-making tools, regular visitation, and the range of other critical safety-related practices, and support of Institutional Abuse Investigation Unit (IAIU) staff
- Meet aggressive targets for health care service delivery for children in out-of-home placement

DCF must continue to meet the range of other demands set forth in the MSA and the blueprint for piloting reforms between DYFS and DCBHS that aim to strengthen coordination and dismantle barriers to service. Lessons from other jurisdictions suggest that it is difficult and delicate to maintain focus and support for the basics through this next level of reform. Ignoring the basics has been the death knell of reform efforts in other jurisdictions. It is critical to recognize that it all must be attended to – and that capacity is not unlimited. The CPM cannot be implemented successfully if the foundation crumbles, and leadership must partner with stakeholders to ensure continued attendance to basic needs throughout the CPM implementation process.

6) Enhanced Planning and Coordination between DYFS and DCBHS

Genuine improvements require case practice changes that extend beyond the Modified Settlement Agreement, and beyond DYFS, which is why enhanced coordination between DYFS and DCBHS is a core strategy.

In 2006-2007, DCBHS undertook an assessment process that examined ways to make the system more accessible for youth and families and help families keep children at home, in school and out of trouble. As part of this assessment, DCBHS held nine (9) focus groups with key stakeholders and three (3) public hearings to gather to ideas and recommendations for restructuring of the Contracted System Administrator (CSA, the role currently performed by Value Options), issued a Request for Information (RFI) to give potential bidders an opportunity to showcase the services and technologies that are available, conducted three (3) regional public hearings to receive input directly from youth, families and advocates on case management, established a case management work group to explore unified case management services and established a Steering Committee to make recommendations on System of Care improvements.

A strong and consistent recommendation to DCF was to pilot unification and coordination of CMO and YCM services in three regions of the state, yielding integrated care coordination entities serving youth with high and moderate levels of needs. By unifying case management, DCF will be forming a single entity that will exercise significant responsibility for brokering services in a local area. The sole focus of this entity is to ensure the best and most appropriate services for each child served, and to strengthen coordination with DYFS for children involved in the child welfare system and in need of behavioral health services. Therefore, DCF has committed:

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- Unify case management (between CMOs and YCMs) and end dual case management between CMOs/YCMs and DYFS in three pilot areas in 2008.
- Deploy clinical staff to DYFS offices in three pilot areas to improve planning for children's behavioral health needs and coordination with the local behavioral health System of Care
- Statewide, enhance planning and coordination between DYFS and DCBHS for youth in residential care, prioritizing safely stepping children and youth down to less restrictive, community-based care
- Expand Team Lead roles to support stepping youth down from deep-end, residential care, organized and led from within the DYFS area offices
- In addition, by January 2008, DCF will publish a plan to improve DYFS' direct access to behavioral health services for children and youth involved with DYFS.

DCF is now soliciting joint proposals for CMO-YCM unification that allows local entities the opportunity to propose how unification of case management would occur. Proposals are due to DCF in October and will be implemented in 2008. This will begin the process of eliminating dual case management services both within DCBHS, between YCMs and CMOs, and between DCBHS and DYFS by transitioning youth who are dually-managed by a CMO or YCM and DYFS to the most appropriate entity. DYFS will take the lead in cases involving safety and permanency.

In areas where case management unification occurs, DCBHS case management entities will deploy clinical staff into DYFS Local Offices to provide technical assistance, support clinical practice and provide a functional bridge between the child welfare and child behavioral health systems. This pilot program may be expanded in 2008 to other DYFS offices to improve coordination between the Divisions.

DCBHS team leader positions are being reassigned to work within DYFS Area Offices where they will continue be the critical link to community providers, the Contract System Administrator (CSA), and DCBHS providers, but in an expanded role that has them supporting inter-Divisional efforts to return DYFS youth from out-of-home residential care. The work, often called "step-down," will begin with youth deemed ready to leave their present provider. Team leads will be an essential link in an effort to coordinate and problem-solve all of the challenges inherent to this work: access to community based services, family and kin options, educational placements etc. This will be an important step to strengthen the coordination and communication between DYFS and DCBHS.

Development of Continuous Quality Improvement Capacity

DCF embraces the oft-stated observation that what gets measured gets changed. In the first 18 months of its creation, DCF has collected, analyzed and published data on key system indicators – and will continue to expand the areas of measurement moving forward. A strong system utilizes both quantitative and qualitative sources of measurements. New Jersey has already made investments in both areas and commits to growing that capacity through this next phase of the reform.

Extensive examination of continuous quality improvement (CQI) in the child welfare field and other fields suggests that moving CQI as close to the field as possible improves the quality of the information collected and provides the best opportunity to ensure utilization of that

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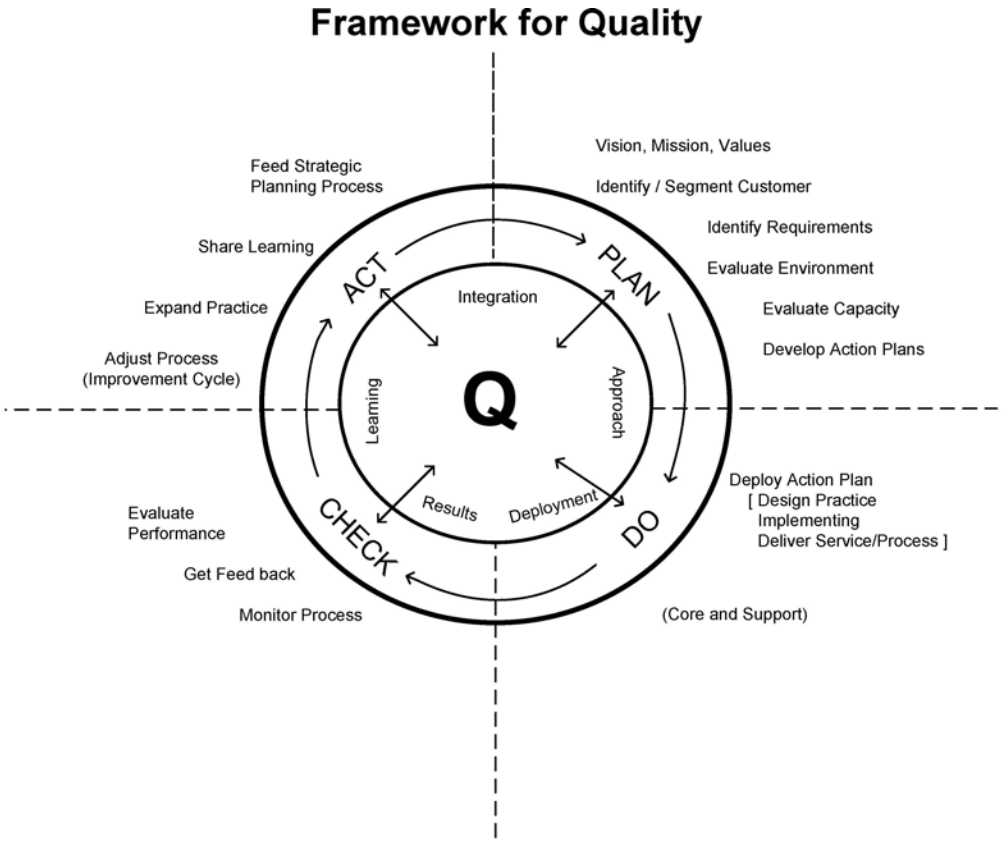
information where it counts the most, at the point of service delivery, which for DCF, is the work with children and families. To that end, over the past year, DCF has moved firmly away from the traditional child welfare quality assurance (QA) model of a centralized unit that conducts case audits in the field in favor of moving that capacity out regionally with technical assistance support from the central office. Each area office now has its own CQI coordinator responsible for coaching managers, supervisors, and staff on assessing performance. Those CQI coordinators are also responsible for collecting data on key indicators, sharing that data with their offices and area director staff, and the area directors, in turn, report that information to executive leadership. The central office provides technical assistance. CQI loops continuously through the field up through the area office to executive leadership and then back through executive leadership to area office to the field. Information sharing flows both ways, on the field level, influencing practice, and in turn, practice informs policy, resource distribution, and leadership focus. The diagram below illustrates the CQI process embraced by DCF.



In the first phase of its CQI development, DCF has focused on expanding access to Safe Measures, a powerful analytic tool that allows tracking against critical child welfare indicators by worker, supervisor, office, area, and statewide. For the first time, DCF opened up access to Safe Measures to staff. The central CQI technical assistance group traveled to every office in the state training staff at every level on how to utilize Safe Measures. Special training was then provided to the CQI coordinators who learned how to utilize the information in Safe Measures to create system performance analyses on key indicators. Central office technical assistance staff hold regular meetings with the CQI coordinators together in a group and provide individual tutoring and support to meet the individual needs of each area.

The investment in Safe Measures has given managers and staff the tools they need to make visible their practice – to celebrate progress and to identify and address challenges. The end

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results are measurable. For example, staff made extensive use of Safe Measures to track progress against the caseload standards set forth in the MSA. With constant consultation with the central office, area directors and managers targeted strained areas of practice. Hiring was directed to known areas of need and caseloads began to be distributed rationally across individual staff. Staff who struggled with their caseloads were easily identified and received extra support to help them attain the caseload standards. The end result was that DCF not only met but exceeded its caseload targets for June 2007.

The next important investment has come with the roll-out of New Jersey Spirit (NJS). While DCF has wrung maximum value out of the information contained in its legacy SIS system, NJS, when fully implemented, will collect far more information. Safe Measures is being adapted to NJS and the end result is that staff at every level of the organization will have access to an even wider range of performance measures. It will take sometime to see the return on NJS as it is an extensive system with a steep learning curve and given its complexity, DCF expects to make ongoing modifications and adjustments to business practices and utilization over this next year. Nonetheless, once the new reporting processes are up and running, DCF will have access to an extensive range of real time information on system performance.

Much of this early phase of CQI development has focused on quantitative measurement, in keeping with the schedule set forth in Phase I of the MSA. In the MSA, outcome measurement, for the purposes of monitoring, begins in Phase II. The MSA structure recognizes that it will take time for the state to produce the outcomes that are the ultimate goal of the reform and so deliberately built in a period to allow the state to develop and mature organizationally. In parallel, the state is developing the capacity to measure outcomes. While outside the scope of Phase I of the MSA, the state has utilized two sources: publishing data analyzed by the federal government as part of its Child and Family Service Reviews and a wide range of indicators produced as the result of a contract for longitudinal analysis with the Chapin Hall Center, a leading child welfare institute. Those two sources of information will provide a firm foundation for New Jersey to develop the capacity it needs by Phase II to be monitored with respect to outcomes.

With regard to the qualitative, New Jersey will focus on developing its quality service review (QSR) capacity, spurred on by the need to track implementation of the CPM going forward. New Jersey will also integrate the QSR development with its development of other qualitative tools, to ensure offices have all the qualitative feedback they need to track their progress. In particular, New Jersey will ensure a smooth integration with the federally required Child and Family Services Review (CFSR). The Federal CFSR process is mandatory and requires considerable attention and resources to support. The process of assessment for the Federal CFSR begins for New Jersey in October 2007 and requires intensive data analysis, stakeholder consultation, and preparation for the on-site CFSR. New Jersey's data sample must be prepared in fall 2008 and finalized by January 2009 in preparation for the on-site in spring 2009. In the past, New Jersey has dual-tracked the CFSR process alongside the other QA processes required as part of the lawsuit. Going forward, those processes must be integrated in order to ensure there are sufficient resources and attention paid to both important processes.

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Evaluating the CPM

The MSA identifies three tasks related to evaluating the CPM at this stage of the reform:

- Identifying a methodology to track implementation of the CPM
- Establishing a baseline against which to track implementation of the CPM
- Reporting by the federal monitor focused on the quality of the CPM and the steps taken to implement it

Specifically, the MSA states the following with regard to the CPM:

> *The parties acknowledge that a high quality CPM is essential to the children in the plaintiff class; that it will take several years to achieve the necessary level of performance; and that progress towards this goal shall be measured accordingly…. Beginning January 2007 the Monitor shall, in consultation with the parties, identify the methodology to be used in tracking successful implementation of the CPM. This methodology may be phased in over time, such that baselines may be created as soon as practicable, but baseline data shall be available for key practice elements no later than December 2007….In reporting during Phase I on the State's compliance, with the commitments [related to the CPM] the Monitor shall focus primarily on the quality of the CPM and the steps taken by the State to implement it.*

Methodology

Currently, the proposed methodology to be used in tracking successful implementation of the CPM shall primarily be a combination of either or both quality service reviews or the longitudinal outcome data such as that developed for DCF by the Chapin Hall Center for Children. Quality service reviews could be phased in over time with a schedule to be developed between DCF and the federal monitor by December 2008. During 2008, New Jersey could work with the Federal Monitor to develop the QSR tools and/or other qualitative or quantitative tools for their suitability for utilization as part of Phase II of the MSA.

If a QSR type of methodology is selected, at the beginning those reviews will be focused – they may be concentrated in selected areas of practice rather than full blown QSRs and they would be utilized in the first Immersion Sites. The QSR practice would then be extended to the balance of the state according to a schedule developed in consultation with the Federal Monitor, but which also weights heavily the developmental needs of the CPM practice in each area.

Finally, managing this proposed QSR process throughout Phase I will be challenging for the state. Any QSR takes considerable resources and time – and so requires trade-offs relative to other priorities. Nonetheless, an extensive review of best practice has convinced DCF that this could be an approach to measuring CPM implementation. Or it could be that a variation on the longitudinal outcome measures such as those developed by Chapin Hall could be best. Decisions about the best methodologies will be developed as CPM planning matures – DCF and the Federal Monitor have the advantage of on-site support and consultation by the CWPPG.

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Baseline

The baseline information for evaluating the CPM can be drawn from either the pre-existing Chapin Hall longitudinal outcome analyses or the QSRs previously conducted in New Jersey in September 2005 through March 2006. Over the next several months, as the Federal Monitor, DCF and the plaintiffs meet to discuss the MSA's Phase II measurements, they will then decide on baselines to be utilized in measuring the implementation of the CPM.

Monitoring

For Phase I of the agreement, the federal monitor focuses primarily on the quality of the articulated CPM and the processes associated with implementation. In New Jersey, the monitor participated fully in the development of the CPM. Understanding that the model may continue to grow and change with the system, to date, the federal monitor has expressed satisfaction with the substance and process described in the model.

The next challenge lies in monitoring the implementation. To that end, the federal monitor asked the state to provide this CPM implementation plan. The plan supports clear benchmarks for monitoring implementation. Examples include:

1) Training: What training do the casework staff, supervisors, and aides receive on the CPM? What percentage of those staff are trained?

2) Leadership: Did the Leadership Summit occur? When the federal monitor interviews executive management, area directors and managers, can they fully articulate the critical elements of the CPM? Are they continuing to perform well relative to the measures set forth in Focusing on the Fundamentals?

3) Immersion (Phase 1): Is the state successful in selecting four sites for immersion? Are the staff in those sites fully trained in the CPM? When the monitor visits those sites:
   - Do they witness CPM coaching?
   - Can the staff articulate the critical elements of the CPM?
   - Are family meetings taking place?

4) Timeframes: is the state adhering to the timeframes set forth for the implementation of the CPM? Are the timeframes set forth in the MSA being adhered to?

5) Service Expansion: Did the state issue the required RFPs? Did the state select provider partners in the immersion and then expansion areas? Do staff and families report broader access to services? Do they report greater satisfaction with services?

6) Evaluation: Has the state developed the capacity to implement the QSR? Has the state completed QSRs in the targeted site according to the QSR schedule set forth above?

Given the structure of the MSA, monitoring of outcomes begins with Phase II of the agreement.

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Conclusion

DCF staff are excited and ready to embark on this important next phase of the reform. They welcome the opportunity to partner with the children and families they serve, supported by the wider community of stakeholders. While this next phase will be arduous and demanding, there is no work more important than the work of learning to better serve New Jersey's most vulnerable children – and they welcome that challenge.