Progress of the New Jersey
Department of Children and Families
Monitoring Report for
Charlie and Nadine H. v. Corzine
January 1– June 30, 2007

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I. INTRODUCTION

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

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

- 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.

- 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 severely troubled children and youth that ha

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

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

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

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.

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:

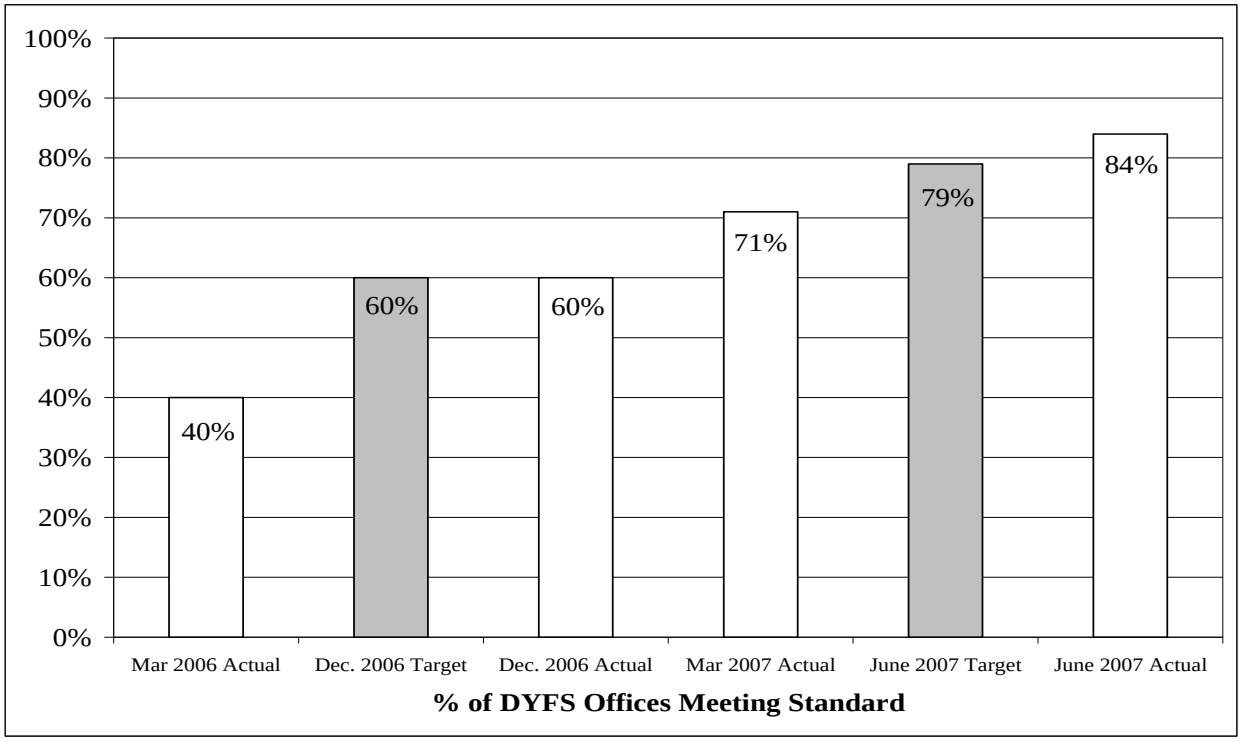
- Updating the appropriate program and personnel systems with worker leave information, updated trainee status, name spelling corrections, worker program area (i.e., intake, adoptions, permanency) Each of these corrections affect the "available pool" of workers by which the caseload averages are calculated.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

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

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

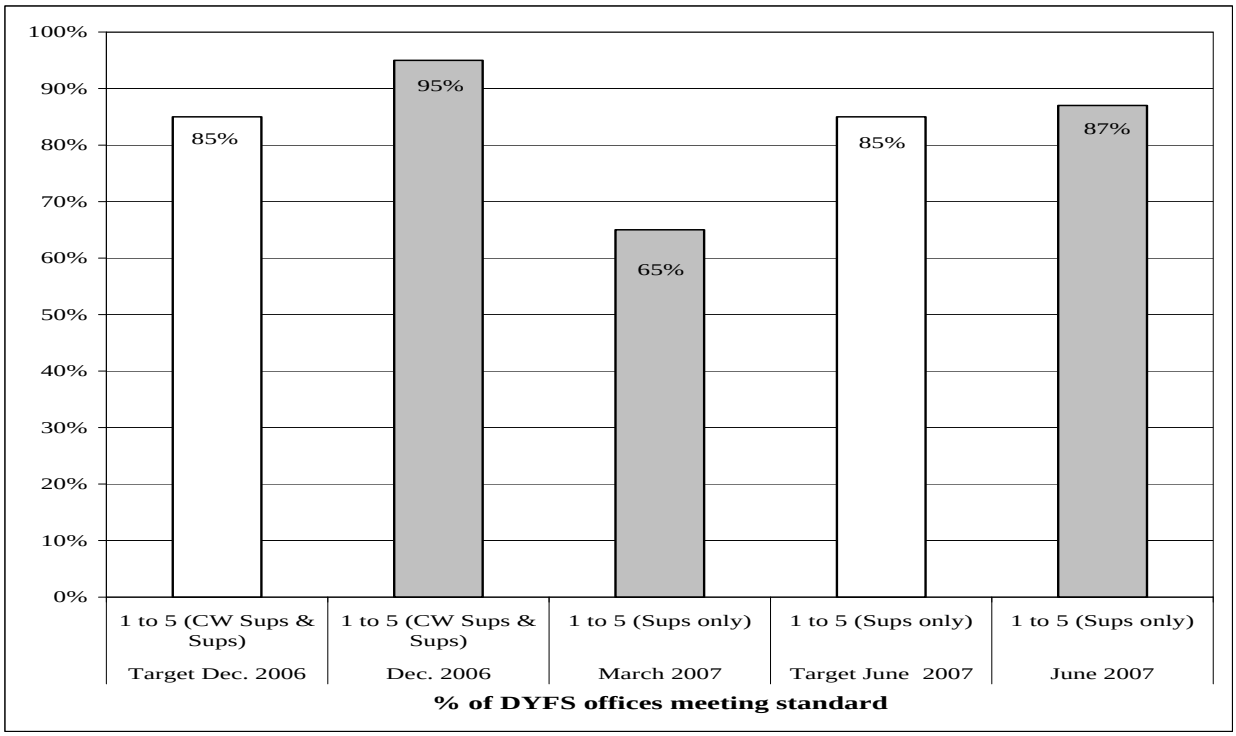


Source: New Jersey Department of Children and Families, Office of Policy and Planning
*Permanency caseload standard is 15 families and no more than 10 children in placement.
Note: DCF reports caseloal4.26 r3ata quenterld P82 0 l2015 0 0 7.1714i

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)

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.

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

Training

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

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.

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

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.

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.

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.

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

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.

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.

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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 m

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

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

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

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

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 fo

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 “des

V. APPROPRIATE PLACEMENTS AND SERVICES FOR CHILDREN

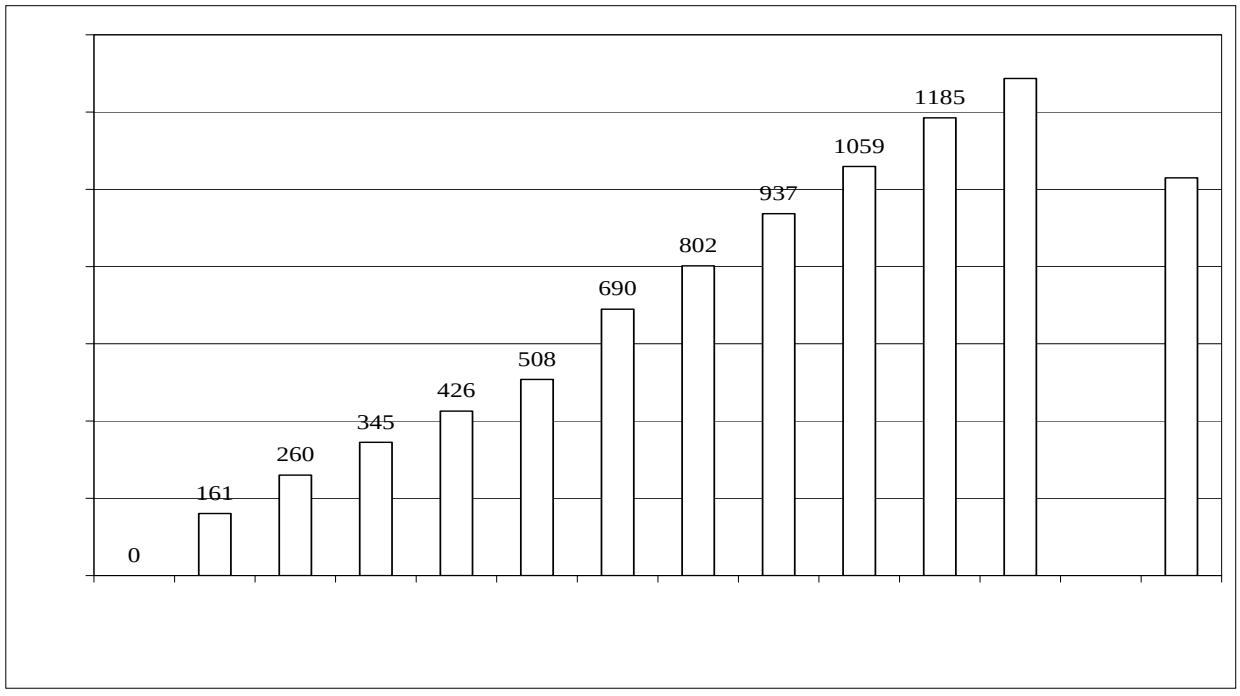
A. Resource Families

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



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**

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

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).

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

Length of waiting time	Number of Youth

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

system to correct the presumption of case closure. Further, DCF changed its written policies to create a presumption in

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

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

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.

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.

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

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.

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. Accord

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%

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).

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

[redacted]

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

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

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	23				

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

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%*

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%

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

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

APPENDIX B

New Jersey
Department of Children and Families

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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

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

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

- 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
-

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:

- 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

more stringent over time. Again, executive l

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:

- 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

- 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

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

Evaluating the CPM

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

Baseline

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.