

The logo for the New Jersey Department of Children and Families features a light blue circle containing three stylized human figures in a darker blue color. One figure is larger and stands on the left, while two smaller figures stand to its right, representing a family unit.

**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

*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.

## 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

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

- 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

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:

- 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 (1 office); 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.

### 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

- 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

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

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

#### 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

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

- 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:

- 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.

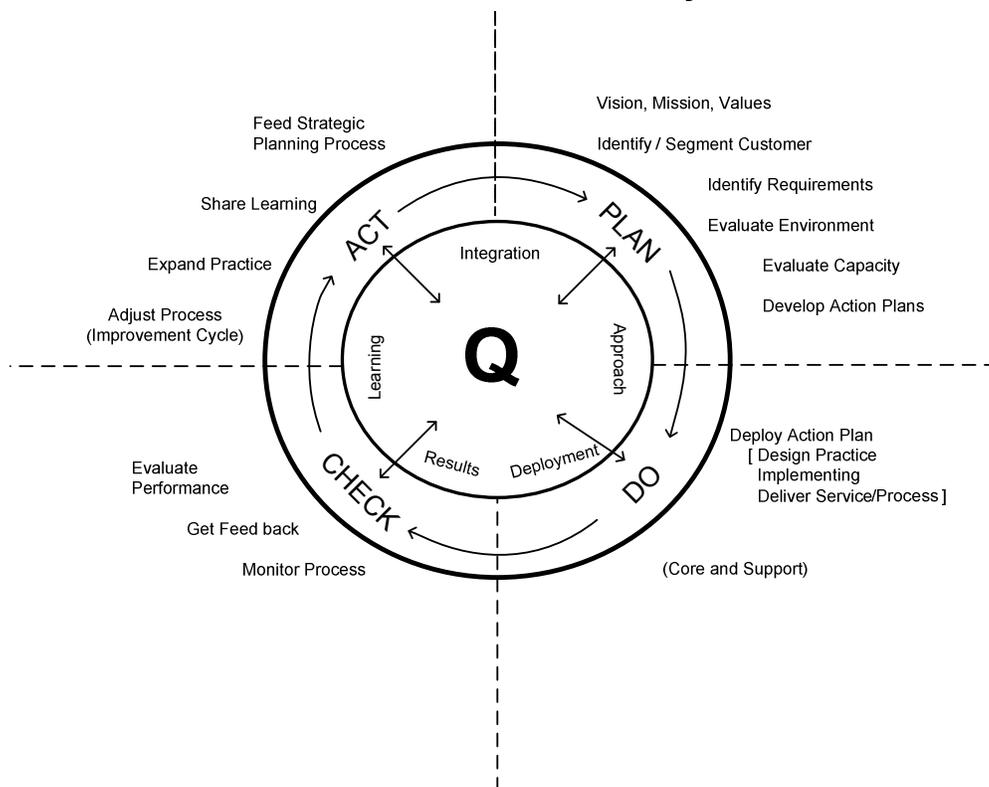
### **Development of Continuous Quality Improvement Capacity**

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

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.

### Framework for Quality



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

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.

## 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.

## 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.

## **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.