



**State of New Jersey**

**Annual Progress and Services Report**

**2017**

Allison Blake, Ph.D., L.S.W.  
Commissioner

June 30, 2017



State of New Jersey

DEPARTMENT OF CHILDREN AND FAMILIES  
P.O. BOX 729  
TRENTON, NJ 08625-079

CHRIS CHRISTIE  
*Governor*

KIM GUADAGNO  
*Lt. Governor*

ALLISON BLAKE, PH.D., L.S.W.  
*Commissioner*

June 28, 2017

Alfonso Nicholas, Regional Program Administrator  
Administration for Children and Families  
U.S. Department of Health and Human Services  
26 Federal Plaza, Room 4114  
New York, NY 10278

Dear Mr. Nicholas,

On behalf of the State of New Jersey, I am pleased to submit the New Jersey 2017 Annual Progress and Services Report (APSR) with the attached targeted plans, relevant assurances, fiscal documents CFS 101-Parts I, II and III, CFS 101 Addendum as well as the Annual Reporting of ETV Awards.

This submission contains detailed progress reports and plans for services covered under the Child and Family Services Plan, including Title IV-B subparts 1 and 2, the Chafee Foster Care Independence Program, the Child Abuse Prevention and Treatment Act, the Children's Justice Act Program and other related state child welfare initiatives.

We trust that this report satisfactorily addresses all federal requirements and we look forward to your response to this document. As always, we thank you for your continuing support of our efforts to improve outcomes for children and families of New Jersey.

Sincerely,

A handwritten signature in cursive that reads "Allison Blake /th".

Allison Blake, Ph.D., L.S.W.  
Commissioner

c: Evelyn Torres-Ortega  
Aubrey C. Powers  
Dawn M. Marlow

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## **Introduction**

New Jersey Department of Children and Families (DCF) celebrates its eleven year anniversary in 2017 as a State Department and continued to focus on integrating best case practice throughout its service structure in order to improve outcomes and to sustain the progress already made on behalf of the state's most vulnerable children and families. DCF remains focused on safety, permanency, and well-being while continuing to strengthen families and ensure a better today and even a greater tomorrow for every individual we serve.

## **Mission**

In partnership with New Jersey's communities, DCF will ensure the safety, well-being, and success of New Jersey's children and families.

## **Vision**

To ensure a better today and even a greater tomorrow for every individual we serve.

## **Values**

- We value the unique strengths, needs and abilities of all individuals.
- We achieve positive outcomes through individualized, family-oriented, child and youth centered services.
- We foster healthy relationships that promote safety and well-being for children, youth, adults and families.
- We are ethical, fair and transparent in all that we do.
- We are culturally aware, informed and responsive; we value and respect diverse traditions, heritages, and experiences.
- We work in partnership with individuals, families and the community, as well as with other state departments and within DCF, to build connection, strength and success.
- We are professional, highly-trained and committed to the communities we serve.
- We provide excellent customer service so anyone can easily find and access services when needed.
- We provide innovative solutions aligned with community needs.
- We are accountable to our partners, ourselves and the communities we serve.
- We are good stewards of the resources entrusted to us.
- We continually seek to learn and correct ourselves when needed to provide the very best solutions for children, youth, individuals and families.
- We recognize and respond to the impact of traumatic stress on those who have contact with our system.

- We listen to and communicate openly and honestly with the community and with our partners.

### **NJ Child Welfare System Structure**

Legislation was signed on July 11, 2006, establishing the New Jersey Department of Children and Families (DCF) as New Jersey's first cabinet-level department with responsibility for child welfare, child behavioral health, child abuse prevention, and community support programs for children and their families. The legislation transferred the administrative arms responsible for these programs from the Department of Human Services (DHS) to DCF. In June of 2012, legislation was signed that reorganized DCF into a single point of entry for all families with children with developmental disabilities and renamed the four divisions within DCF. The former Division of Youth and Family Services is now known as the Division of Child Protection and Permanency (DCP&P); the Division of Prevention and Community Partnerships is now the Division of Family and Community Partnerships (DFCP); and the Division of Child Behavioral Health Services is now the Children's System of Care (CSOC). Additionally, the Division on Women was transferred to DCF from the Department of Community Affairs. The programs and services administered by each Departmental component are outlined below but can also be viewed in greater detail at the DCF public website: <http://nj.gov/dcf/>

#### **Division of Child Protection and Permanency (DCP&P)**

DCP&P is New Jersey's lead child welfare and protection agency. Its mission is to ensure the safety, permanency and well-being of children and to support families.

- **Investigation and Assessment:** DCP&P operates a State Centralized Registry which is a 24 hour, seven day a week, centralized call center to receive all reports of child abuse, neglect, and referrals for child welfare assessments. CP&P investigates these allegations and assessments through a network of 46 Local Offices. In addition there are 9 Area Offices to support the production and operations of the local offices.
- **Placement:** Children in DCP&P protective custody may require temporary placement in out-of-home settings in order to preserve their safety. CP&P promotes the concept of family placement settings and will seek family placements for children entering care whenever it is safe and appropriate to do so.
- **Family Support Service:** Includes services provided to strengthen families and children in their own homes as well as foster and adoptive families and those in out-of-home placement.
- **Permanency:** Services are designed to achieve and maintain permanency - a sustained, stable family who will care for and nurture the child - through reunification, adoption, or Kinship Legal Guardianship. Permanency also

includes supporting youth in making a successful transition to independent adulthood

### **Division of Family and Community Partnership (DFCP)**

DFCP administers a continuum of community-based child abuse prevention and intervention programs that are culturally competent, strengths-based, and family-centered with a strong emphasis on child abuse prevention.

**Early Childhood:** Services focus on children under 6 years of age, including:

- Home Visitation
- Nurse Family Partnership
- Healthy Families
- Parents as Teachers
- Strengthening Families Initiative (NJSFI)
- Evidence-Based School Linked
- Children's Trust Fund

**School-linked Services:** Program services include:

- School Based Youth Services
- Family Empowerment Program
- Family Friendly Centers
- Adolescent Pregnancy Prevention Initiative
- Parent Linking Program
- NJ Child Assault Prevention Project

**Family Support:** Resources are focused on meeting the unique needs of families before child maltreatment becomes an issue.

- Family Success Centers

### **Domestic Violence**

- 24-hour hotline, emergency shelter, and related support services are available in each county.

- **Peace: A Learned Solution (PALS)** offers intensive therapeutic interventions for children exposed to domestic violence.

**Service Integration within and across counties:** DFCP works with local entities and organizations, such as the Task Force on Child Abuse & Neglect Prevention Subcommittee; Child Welfare Agencies and Human Service Advisory Councils to create a network for planning, prioritizing, and implementing effective prevention efforts that are county-focused and county-driven.

### **Children's System of Care (CSOC)**

CSOC serves children and adolescents with emotional and behavioral health challenges and their families; and children with developmental and intellectual disabilities. Services are based on the needs of the child and family and are provided in a family-centered, community-based manner. Perform Care is the point of entry into the CSOC system.

- **Mobile Response and Stabilization Services (MRSS):** Services are available 24/7 to help children/youth experiencing emotional/behavioral crises. Services are designed to defuse an immediate crisis, keep children and their families' safe, and maintain children in their own homes or current living situation.
- **Residential Services:** CSOC continues to provide residential services. As more and more community alternatives are made available, the overall percentage of children receiving residential care has decreased.
- **Family Support Organizations (FSO's):** FSO's are family-run, county-based organizations that provide direct family-to-family peer support, education, advocacy, youth partnership, and other services and support to families of children with emotional and behavioral problems.
- **In-Community Behavioral Assistance:** CSOC supports 46 community-based outpatient and partial care providers across the state and authorizes the enrollment with Medicaid of more than 300 intensive in-community providers and approximately 400 Behavioral Assistants statewide.
- **Care Management Organizations (CMO's):** Care management organizations (CMO's) are agencies that provide a full range of treatment and support services to children with the most complex needs. They work with child-family teams to develop individualized service plans. The CMO's goals are to keep children in their homes, their schools and their communities.
- **Eligibility Determination for Children with Developmental Disabilities:** As of January 1, 2013, CSOC assumed responsibility for determining eligibility for developmental disability services of children under age 18. This eligibility

process for children, which was formerly completed by the Division of Developmental Disabilities, is required under New Jersey law in order to access publicly available developmental disability services.

- **Traumatic Loss & Suicide Prevention (TL&SP):** TL&SP is responsible for reporting on the State's suicide prevention related activities. TL&SP also oversees the division's constituent relations and external inquiries. In addition, TL&SP serves as the division's liaison to the Judiciary. TL&SP also represents CSOC on several interagency committees including the Children in Court Improvement Committee and the Child Abuse and Neglect Task Force's Staffing and Oversight Review Subcommittee. TL&SP also serves as DCF's liaison to the State's County Inter-Agency Coordinating Councils (CIACCs).

### **Division of Women**

The New Jersey Division on Women (DOW) is a pioneering state agency that advances public discussion of issues critical to the women of New Jersey and provides leadership in the formulation of public policy in the development, coordination and evaluation of programs and services for women. DOW evaluates the effectiveness of program implementation and plans for the development of new programs and services.

The Division is also charged with establishing a liaison with state departments and other public and private agencies involved with laws, regulations and program development affecting women in joint efforts to expand opportunities for women. In this capacity, DOW collaborates with other state departments to understand and address the changing needs and concerns of women. DOW oversees Sexual Assault Direct Services, Sexual Assault Prevention Services and Displaced Homemaker Services.

- Funds, monitors and evaluates programs for the advancement of women;
- Develops new programs to serve women;
- Develops and analyzes policies that affect women;
- Educates and trains the public;
- Refers women to direct service providers;
- Provides information on women's issue to the general public;
- Provides technical assistance to agencies representing women;
- Represents women on boards, commissions, councils, committees and task forces

### **Department Units and Central Operations**

DCF administers a number of functional offices and units that directly impact the department's broad delivery of protective and supportive services to children and families.

- **Office of Performance Management and Accountability:** Manages the Qualitative Review Process and targeted reviews, as well as the CFSR and the APSR, including the Program Improvement Plan development and monitoring. In addition, the office oversees Research, Evaluation and reporting (RER), the Child Fatality and Near Fatality Review Boards, Domestic Violence Fatality and Near Fatality Review Board as well as the Executive Directed Case Review Process.
- **Office of Adolescent Services:** The Office of Adolescent Services (OAS) supports adolescents in the transition to adulthood to achieve economic self-sufficiency, independence, and engage in healthy life-styles by:
  - Ensuring that services provided through the Department of Children and Families are coordinated, effective, meet best practice standards, are youth driven, and adapt to the needs of families and communities,
  - Developing linkages with other service providers in order to create a more equitable and seamless service system.
  - Provide leadership and policy development in the field of adolescent services.
- **Office of Child and Family Health & Clinical Services:** The Office of Clinical Services is charged with providing support, guidance and leadership across DCF on child and family health related matters.

**Office of Strategic Development:** The Office of Strategic Development (OSD) was created in April 2014 as part of DCF's long term strategic planning process and, among other roles, will be focused on working with the Department's divisions, offices and service providers to help DCF become a trauma-informed system of care and transition toward more evidence-based/evidence supported programming. The Office of Strategic Development focus is to infuse implementation science best practices for program selection, quality implementation, and ongoing evaluation and continuous quality improvement. The OSD is committed to building capacity at both system and the programmatic level in order to ensure DCF's service array is:

- responsive to the changing needs of the families we serve
- supported for quality implementation and
- committed to positive outcome achievement through evaluation and ongoing quality improvement

Some accomplishments include:

***Keeping Families Together-*** During the time period of 10/1/15-9/30/16, DCF's OSD supported the launch of a recently awarded Keeping Families Together (KFT) program in Atlantic and Gloucester Counties and also released two additional RFP's for KFT programming in Hudson and Camden Counties, bringing the total number of families that

KFT was able to serve to 73. During this time, OSD also worked closely with the DCF Office of Research, Evaluation, and Reporting (RER) to develop an internal evaluation plan for KFT. As part of this process, OSD developed local level logic models with existing KFT grantees and partnered with RER to create and train KFT grantees on a series of reporting tools including a baseline family survey and quarterly reporting template.

***Trauma Focused CBT*** – DCF’s OSD released a RFP in April 2016 and made awards in August 2016 to two providers – one in Morris County and one in Somerset County. OSD partnered with the CARES Institute to offer training and consultation on TF-CBT to provider agencies. Providers began training in the model in November 2016.

***Supportive Visitation Services*** – DCF’s OSD released a RFP in October 2015 and made awards in January 2016 to one provider serving Morris/Sussex and Passaic Counties to provide families with supportive visitation services on a continuum from most restrictive (therapeutic) to least restrictive (unsupervised monitoring) based on assessment and visitation planning processes. OSD formed multiple Implementation Teams which included: an Operations Team to focus on billing, referral and communication processes; a Model Design Team to focus on developing the innovative model by creating a logic model and a practice profile; and an Evaluation Team to develop an evaluation plan and reporting structure for this initiative. The two Supportive Visitation Services programs began gradually providing visitation services to families in August 2016.

#### ***Family Preservation Services***

- December 2015 – June 2016 DCF’s OSD initiated an assessment process to better understand the needs of FPS families and the current landscape of resources provided to them. The assessment started with a literature review, and then was extended to a review of quantitative (i.e. data from the agency’s SACWIS system and Annual Reports) and qualitative data (both from internal DCF interviews and survey, in addition to interviews with implementing FPS providers).
- In July 2016 DCF’s OSD released a formal Request for Information (RFI) aimed at gathering additional data from provider partners about alternative evidence supported FPS models and provider capacity to sustain implementation of the alternative models; with particular consideration given to the implementation supports providers would need for quality delivery of the service.
- During September 2016 DCF’s OSD continued the process of assessment by facilitating exploratory discussions about FPS with other States currently implementing similar FPS interventions and the national FPS Model Developer in Seattle, Washington.

***Family Success Centers-*** NJ DCF supports a network of over 50 FSC statewide. DCF’s OSD began work with NIRN to develop a FSC Practice Profile to identify and operationalize the practice of FSCs; the principles, essential functions, and activities of FSC practitioners. The FSC practice profile development is necessary so that DCF and internal/external technical assistance providers can provide the competency-based supports needed for FSCs to fulfill their role effectively.

The development of practice profiles requires a specific methodology, five interrelated steps in an iterative process: document review, semi-structured interviews, systematic scoping review, vetting and consensus building and usability testing. An intentional teaming structure was utilized to support the development of the practice profile. From October 2015-September 2016 the following progress was made for completing the FSC practice profile.

***Developed Linked Teaming Structure*** – A three tiered teaming structure was developed to include:

- **Leadership Team** - shared in the responsibilities required to lead the development of a Practice Profile including but not limited to supporting the FSC Implementation Team. Leadership Team was comprised of members from DCF (i.e., Division of Family & Community Partnerships (DFCP); Office of Research, Evaluation and Reporting (ORER), Office of Strategic Development (OSD)), Rutgers University Institute for Families, and NIRN implementation experts.
- **Implementation Team** - provide the intensive support needed for the profile development. Implementation Team was comprised of members from the DCF State Leadership Team, FSC Directors, and NIRN implementation experts.
- **Stakeholder Team** – share the responsibility of providing input and feedback on draft FSC practice profile. The stakeholder team was comprised of the FSC network.

***Completed FSC Document Review*** - NIRN reviewed 43 FSC documents submitted by DCF and Rutgers University. NIRN completed the document review in January 2016. Eight guiding principles and eight essential were identified through the document review.

***Completed Semi-Structured Interviews*** - to gather feedback from the FSC network on the guiding principles and essential functions that emerged from the FSC document review, NIRN conducted semi-structured interviews with a subset of FSC sites and DCF Office of Family Support Services staff. This process was completed in July 2016. As a result of the semi-structured interviews slight revisions were made to the FSC guiding principles and essential functions.

***Worked on Systematic Scoping Review*** - reviewed published research that focused on community based, family-centered prevention strategies for child maltreatment. This process began in winter 2016 and remained in progress as of September 2016.

***Began Vetting and Consensus Process*** - NIRN completed the initial draft of the first FSC Practice Profile in August 2016. In September 2016 the implementation team began developing the plan for vetting the draft FSC practice profile with the Stakeholder Team (network of FSCs) to gather additional input and feedback on the draft practice profile and to build consensus for the development of the next iteration of the practice profile.

### Department Units and Central Operations Continued

- **Child Welfare Training and Professional Development & Partnership:** The Office of Child Welfare Training and Professional Development and the New Jersey Child Welfare Training Partnership are charged with the development of curriculum and delivery of educational training that enhance case practice and planning for the support of the protection, permanency and well-being of children and families for more than 5,000 child welfare professionals across the state.
- **Office of Education:** The Office of Education provides intensive 12 month educational services to children and young adults ages 3 through 21. The severity or uniqueness of their needs requires removal from the public school setting for a period of time.
- **Information Technology (IT):** Manages the NJ Spirit Application (SACWIS) and provides over 100 reports on DCF performance.
- **Office of Licensing:** The Office of Licensing (OOL) is the licensing and regulatory authority of the Department of Children and Families. OOL licenses and regulates child care centers, youth and residential programs, resource family homes and adoption agencies.
- **Institutional Abuse Investigation Unit (IAIU):** IAIU investigates allegations of child abuse and neglect in out-of-home settings such as foster homes, residential centers, schools, detention centers, and child care centers.
- **Office of Advocacy:** The Office of Advocacy supports families by providing information, referral and advocacy services.
- **Oversight Boards:** DCF is responsible for coordinating boards and taskforces that are in but not of the department to include but not limited to:

NJ Child Fatality & Near Fatality Review Board  
 Staffing Oversight and Review Committee  
 NJ Task Force on Child Abuse and Neglect:

- Children's Justice Act funding
- NJ Children's Trust Fund

These three CAPTA citizen review boards are staffed by representatives of DCF within the Office of the Commissioner and the Office of Performance Management and Accountability.

Information on these and other stakeholder boards can be viewed at:

<http://www.nj.gov/dcf/providers/boards/>

DCF table of organization can be viewed here: <http://www.nj.gov/dcf/about/TO.pdf>

## Collaboration

DCF endorses the practice of involving a wide variety of state and local partners in all aspects of its work to ensure the safety, permanency and well-being of children. Programs and services identified and assessed reflect a rich array of information and ideas that were developed with system partners and stakeholders through a variety of routine and specific collaborative efforts.

As part of the collaborative efforts, DCF embarked on updating a comprehensive strategic plan. Similar to the strategic plan in prior years, this comprehensive process included the input and recommendations of many stakeholders to include community partners, child welfare system partners, service providers, Citizen Review Panels, parents, resource parents and youth to help guide and steer the course for DCF. Through formalized engagement opportunities and informal consultations, this ambitious process helped spawn the 2016-2018 DCF Strategic Plan which can be reviewed here: [http://www.nj.gov/dcf/about/NJ%20DCF\\_Strategic%20Plan\\_2016\\_2018%201116%20FINAL.pdf](http://www.nj.gov/dcf/about/NJ%20DCF_Strategic%20Plan_2016_2018%201116%20FINAL.pdf) .

The DCF Strategic Plan was influenced by the 2014-2019 Child and Family Services Plan. The CFSP contains core strategies that are aligned with the DCF strategic plan and mimic the goals and objectives necessary to carry out the principles of the Mission, Vision and Priorities of DCF.

Since that time, DCF continues ongoing engagement in meetings with these system partners to elicit feedback as it relates to the progress of the implementation of the CFSP. Although formerly under a Modified Settlement Agreement which has now transitioned into the Sustainability and Exit Plan, DCF views the Federal Monitor as a partner in guiding practice performance. The Monitor Reports are a collaborative reporting vehicle that highlights the strengths as well as areas of focus DCF performance. The Federal Monitor seeks the input of several external stakeholders to include contracted service providers, youth, relatives, birth parents, advocacy organizations and judicial officers.

Through collaborative reviews such as the DCF Qualitative Review (QR) process, system partners are interviewed to gain insight and feedback into DCF performance and are key stakeholders in the production of county Performance Improvement Plans (PIPs). This feedback provides guidance into the action plans identified in the DCF Assessment of Performance. In early 2015, DCF convened a workgroup to include collaborative partners to revise the QR protocol and process in order to better meet DCF and the families we serve. The QR is a critical Continuous Quality Improvement (CQI) tool that provides the basis for assessing, promoting and strengthening best practice and combines case record reviews, stakeholder interviews, observations and professional deduction to identify patterns regarding children, youth, families and the people who support them. The revisions were test piloted and then implemented in January 2016. More information regarding the QR process can be reviewed at: <http://www.nj.gov/dcf/about/divisions/opma/>

During calendar year 2016, stakeholders from ten counties participated in over 1800 individual interviews to assist in evaluating case practice, planned strategies, supports and services across the state. In addition to DCF, interviewees included but are not limited to:

- Child, if age and developmentally appropriate;
- Biological mothers and fathers;
- Current caregivers or resource parents;
- Extended family supports;
- School personnel including teachers, guidance counselors or principals;
- Court Appointed Special Advocates (CASA), and other court personnel
- Community support providers

DCF Child Stat is another case conferencing collaborative assessment tool that can help identify critical decision making elements and themes both locally and statewide. DCF local staff co-presents an identified individual case with internal DCF staff and external partners. These partners identify how they helped with decision making and how they perceive the measured change in the family. They provide additional information that was not presented by the office on the family with an analysis from their own professional perspective. These partners share strategies integrated into assisting the family and lessons learned that can be tied back to the family presentation. In addition, individual case strengths and challenges/barriers as well as county level strengths and challenges/barriers are assessed. During calendar year 2016, both internal and external stakeholders participated in 14 Child Stat presentations. More information regarding the DCF Child Stat process can be reviewed at: <http://nj.gov/dcf/about/divisions/opma/>

The New Jersey Task Force on Abuse and Neglect engaged with DCF leadership as well as services providers, community advocates, parents and others to develop a strategic guide for preventing child abuse and neglect. This collaborative provides an overview of child maltreatment as a public health concern and opportunities for improving prevention efforts. Most important, as a living document, it provides a shared vision, strategic goals and strategic objectives to guide prevention efforts in New Jersey, 2014 through 2017. For more information on this living report please see:

<http://nj.gov/dcf/news/reportsnewsletters/taskforce/SupportingStrongFamiliesandCommunitiesinNew%20Jersey.pdf>

At the local, county and Area level CP&P maintains ongoing collaborative efforts to elicit feedback from community stakeholders. Each CP&P local office supports a Resource Development Specialist who conducts outreach collaborative efforts to develop and maintain local community supports. Local offices also hold resource fairs as well as invite community stakeholders to staff meetings to engage in partnerships to enhance performance and outcomes for the families served within the local community. CP&P Area offices support County Service Specialists who regularly host presentations and trainings as well as review of CP&P policy, performance and outcomes as well as introduction of new initiatives relevant to that community.

The Office of Adoption Operations, Resource Families and Interstate Services have transitioned all local Resource Family Recruiters under their office to assist in the efficiency of recruitment efforts. Resource Family Recruiters work with a host of community partners to expand the pool of resource homes available to children in need of out of home placements. Resource Retention Taskforce continues to identify strengths, needs, policies and services for resource families. This taskforce is a collaboration of DCF, resource parents, Foster and Adoptive Family Services and other community stakeholders.

The DCF Office of Performance Management and Accountability (PMA) has partnered with the Division of Child Protection and Permanency to host monthly Data Quality and Compliance meetings to review performance and outcome measures. These meetings include leadership from PMA and CP&P as well as any other identified DCF partners as needed depending on the relevant topic(s) discussed. These meetings allow for internal collaborative discussion and review child and family outcomes to identify system strengths and areas needing improvement, engage in strategies to enhance improvements and are also used as a vehicle to provide internal technical support, enhance internal collaborative partnerships and highlight and identify areas where further collaborative partnerships (both within DCF and external) can be strengthened.

Examples of other collaborative partnerships include:

- HSAC - Human Service Advisory Councils. In each county, a HSAC reviews county level human service activities and serves as the primary vehicle for making local recommendations to assist both county governments, the New Jersey Department of Human Services and DCF in decision-making.
- Children's Inter-Agency Coordinating Councils. The Children's Inter-Agency Coordinating Councils (CIACC) serve as the mechanism to develop and maintain a responsive, accessible, and integrated system of care for children with special social, emotional and behavioral needs.
- Youth Advisory Boards. DCF's Youth Advisory Boards consist of current and former foster youth who gather and discuss how to improve the policies, procedures and services provided by DCF.
- Children in Court Improvement Committee. The Children in Court Improvement Committee (CICIC) allocates and administers federal grants for Children in Court Improvement projects affecting the lives of children in foster care.
- Advisory Council on Domestic Violence. The twenty-member Advisory Council on Domestic Violence is appointed by the Governor and represents government and non-profit groups. The council is charged with studying needs, priorities, programs, and policies throughout the State; ensuring that service providers and community organizations are aware of needs and services; making recommendations for community education and training programs; monitoring the effectiveness of laws concerning domestic violence and making recommendations for their improvement.

- Domestic Violence Fatality and Near Fatality Review Board. The Board's primary objectives are to identify domestic violence related fatalities and near fatalities; engage in quantitative and qualitative reviews of statewide fatalities; and recommend system changes in order to promote victim safety, offender accountability, and work towards prevention of domestic violence fatalities.
- Child Fatality and Near Fatality Review Board. The Child Fatality and Near Fatality Review Board members are appointed by the Governor and have expertise or experience in child abuse. The purpose of the Board is to review fatalities and near fatalities of children in order to identify their causes, relationship to governmental support systems, and methods of prevention.
- New Jersey Task Force on Child Abuse and Neglect. The purpose of the New Jersey Task Force on Child Abuse and Neglect is to study and develop recommendations regarding the most effective means of improving the quality and scope of child protective and preventative services provided or supported by State government.
- Governor's Advisory Council Against Sexual Violence. The multidisciplinary Governor's Advisory Council Against Sexual Violence is comprised of governmental and non-governmental members from across the State, who are charged with reviewing and recommending policies, procedures, protocols, legislation, trainings, and standards related to sexual violence and recommending solutions for the prevention of sexual violence.
- New Jersey Advisory Commission on the Status of Women. The Commission is composed of eleven members appointed by the Governor. The Commission advises elected officials and the DCF Division on Women regarding issues affecting women; acts as a resource for municipal, county, and local commissions and for women's organizations throughout the State; and empowers women through partnership, programming and publicity.
- Youth Suicide Prevention Advisory Council. The Youth Suicide Prevention Advisory Council meets regularly to examine existing needs and services and makes recommendations to DCF for youth suicide reporting, prevention, and intervention.
- Staffing and Oversight Review Subcommittee (SORS). The New Jersey Task Force on Child Abuse and Neglect Staffing and Oversight Review Subcommittee (SORS) reviews staffing levels of CP&P and develops recommendations regarding the most effective methods of recruiting, hiring, and retaining staff within the organization.

For additional information on collaborative partnership and initiatives to broaden and strengthen DCF's stakeholder relationships view the DCF Public website at:

<http://nj.gov/dcf/>

# **Section A**

# **Update on Assessment of Performance**

New Jersey is about to embark on Round 3 of the CFSR in July 2017 and has recently submitted the Statewide Assessment Tool in June 2017, therefore please refer to the NJ Statewide Assessment submission for the Update on Assessment of Performance.

# 2015-2019 CFSP First Year Action Plan Results

**Core Strategy 1 – Strengthening the Case Practice Model**

The Case Practice Model (CPM) is the foundation of the work at the Department and is envisioned to be infused in all interactions with children, youth and families. The core of the CPM is partnerships with families through engagement of formal and informal supports, joint planning and teaming for desired outcomes, as well as individualized services to address the specific and unique needs of families. Over the next five years, the Department will build on the implementation of the CPM model to pilot initiatives aimed as refocusing staff attention on CPM core strategies like teaming and case planning. Through these efforts, it is expected that families will experience thorough joint planning and teaming will aid in providing supports for the family after child welfare involvement has ended.

Line #	Date Added	5 Year Intent	Year 1 Action Plan 10/1/13-9/30/14	Measures	Results (date)
1-1	14-Jun	<b>Families will experience collaborative service planning through timely completion of case plans and greater quality of case plans.</b>	Assess Sustainability Plans for counties	Build on sustainable initiatives	<p>In terms of sustainability, developed a master formula that details the number of facilitators, coaches and master coaches based on staffing allocations per each Local Office</p> <p>The formula involves having a master coach for each casework supervisor tier; a coach for each unit; and any one in the family service specialist title trained as a facilitator</p> <p>Back to Basics (B2B) pilot involves an in-depth case review of the family's history to</p>

			<p>Initiate a county based pilot (Cumberland) to re-engaged staff in CPM</p>	<p>Increase of quality of case planning (NJS) by 5% in Cumberland</p>	<p>gain a greater understanding of the families strengths and opportunities for growth. Knowing a family’s history prepares the case worker to meet the family where they are as when caseworkers are informed, they are in a better position to help the family. Many county Program Improvement Plans (PIP) from the Qualitative Reviews are focused on strategies to improve engagement with the families.</p> <p>Baseline used for quality of case plans in Cumberland was the 2013 QR results for two case plan indicators: Case Planning process and Case Plan Implementation. Cumberland’s 2013 QR results for these two indicators was 42% for each. Although outside of the year 1 time frame-Cumberland completed their next QR in February of 2015. Their results of each indicator yielded a significant increase of 75% and 83%.</p> <p>In August 2014, initiated B2B pilot in Local Offices in Salem and Cumberland counties- this concept was a re-introduction of getting back to the fundamentals of engagement strategies and building teams and trusting relationships with children and families consistent with DCF 2007 case practice model.</p> <p>Although there appears to be an increase in the quality of case planning- an error was identified in the methodology that included</p>
			<p>Assess and phase into other counties based on results</p>	<p>Determine baseline in quality of case planning (QR) by 5% in Cumberland</p>	

				Assess results and implement next steps	incorrect measurable factors. There was a lack of measurability for supervision and overall assessment. CP&P will collaborate with RER to assist in using correct methodology.
1-2	14-Jun	<b>Teaming process will lead to positive permanency outcomes</b>	Focus on increasing family engagement in initial teaming in two pilot counties (Hudson and Bergen)	Increase frequency of initial teaming by 5% in pilot counties	The Hudson and Bergen FTM expansion pilot was successfully completed in both Hudson and Bergen Counties. This piloted started in December 2013 and concluded in March 2014. There was a 20-30% increase in initial FTMs and a significant decrease in family decline and unavailable category which means that the family was not available within the 30 day time frame to have the family team meeting.
			Ensure adequate staff are trained on	Expand pilot based on lessons learned	CP&P will expand pilot to the 4 Camden Local Offices in October 2014.
				5% of increase in staff as FTM facilitators/	The results of Bergen and Hudson revealed a significant reduction in families declining the initial FTM when a master coach was used. There was an increase in the development

			teaming	coaches in pilot counties	of coaches, master coaches and facilitators. There was a 5% increase in coaches but only a slight increase in facilitators. The majority of family service specialists (IE casework staff) are already facilitators. This process was particularly helpful in bringing up staff who are in support positions. We have identified that there are 410 staff who serve in support positions and the goal is to bring them up as facilitators, coaches and master coaches. This will enable building capacity for teaming in the local offices. This process will continue into year 2.
1-3	14-Jun	<b>Families' needs and histories are understood and inform engagement strategies</b>	Strategic phase in of case conferencing model Focus on Supervision	Increase an additional 7 Local offices through the immersion process of the case conferencing model- Focus on Supervision.	The Focus on Supervision (FOS) process seeks to support the supervisory techniques CP&P supervisory staff through a partnership with community providers that is consistent with and builds upon the DCF Case Practice Model (CPM). The purpose of FOS is to expand upon the existing skill set of Casework Supervisors and Supervisors, who are responsible for facilitating supervision. The goal of FOS is to create a Case Conferencing model that supports the development of critically thinking staff that leverage the support and knowledge of subject matter experts, Local Offices consultants, and their peers and supervisors. Case conferences help create a team approach to working with families and in the assessment of and planning for safety, permanency, and well-being. Local Offices who have been immersed in FOS have

					<p>developed sustainability plans which include keeping an account of the cases conferenced in this model to later determine any impact of the conference.</p> <p>During this fiscal year 9 additional Local offices have completed the immersion process.</p>
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**Core Strategy 2 - Refinement of the Service Array**

DCF will conduct a robust statewide assessment of the array of services available to children, youth and families. Services must be flexible and reflect current thinking on interventions as well as be nimble enough to respond to emerging needs for its service recipients. The statewide assessment process will result in better availability of services to address needs in the population; including prevention services and services to children in need of out of home placement.

Line #	Date Added	5 Year Intent	Year 1 Action Plan 10/1/13-9/30/14	Measures	Results (date)
2-1	14-Jun	<b>The needs of the children and families served by DCF are well understood and services are in</b>	Initiate a statewide needs assessment process beginning with analysis of existing information on needs through other	Meta-analysis of DCF Data such as NJS, CSOC, Census data, Data set identified	NJ developed and finalized the Needs Assessment Plan in 2013 and began implementation planning. DCF contracted with Rutgers University to complete the data analysis. Meetings were held to explore the

		<p><b>alignment with identified needs</b></p>	<p>assessment processes and quantitative data</p>		<p>data sets to be shared. In addition, we identified individuals to attend the weekly workgroup, and the internal and external stakeholder advisory boards. By September we began sharing secondary data sets with Rutgers for analysis. The first interim report, on the activities of the needs assessment for the first phase, was issued December 2014: <a href="http://nj.gov/dcf/childdata/continuous">http://nj.gov/dcf/childdata/continuous</a></p> <p>NJ is in the first stage of a 3-year Needs Assessment process focused on identifying the strengths and needs of children and youth at risk of entering out of home placement and those already in out of home placement through the Division of Child Protection and Permanency (CP&amp;P). The following data sets have been identified:</p> <ol style="list-style-type: none"> <li>1. New Jersey's Statewide Automated Child Welfare Information System (SPIRIT)</li> <li>2. Children's System of Care (CSOC) behavioral health care data</li> <li>3. Division of Family and Community Partnerships' Community Program Directory</li> <li>4. DCF County Needs Assessment Service Inventories</li> <li>5. NJ Department of Mental Health and Addiction Services' Directory of Mental Health Services</li> <li>6. DMHAS Addiction Services Treatment Directory</li> <li>7. United States Census</li> </ol> <p>The OSLS worked with the most recent data</p>
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					related to the number of child abuse substantiations, violence reporting, total student population and poverty rating to develop a funding formula to determine the amount of child abuse prevention funds that the provider NJ Child Assault Prevention program (NJ-CAP) should allocate to each county.
2-2	14-Jun	<b>Families will have access to evidence supported services to address their needs</b>	Conduct Area-wide contracting meetings to refine local service array process	Increase understanding of the strengths and gaps in service array	<p>The Office of Contract Administration (OCA) collaborated with its colleagues from CP&amp;P, DCF's Offices of Strategic Development and Clinical Services to review contracts administered by each of DCF's four (4) Business Offices that serve CP&amp;P Area and Local Offices. The meetings concluded in January 2015. For each Area, we identified services that are well-received by families and the Division and others that are challenging to work with for a variety of reasons. We also identified services that are incongruent with CP&amp;P's case practice model or best practices; and areas of unmet need (i.e. geographic or language barriers). DCF is incorporating the information it gathered from this process to develop contracts for evidence based services.</p> <p>Below are examples of the information gathered from this process as well additional steps we have taken to work towards the refinement of our service array.</p> <p>The Department currently supports and has</p>

					<p>experience with successful implementation of a continuum of evidence (evidence-based (EB), evidence informed (EI), and promising practice (PP) services across the state. DCF’s Division of Children’s Systems of Care (CSOC) supports the implementation of several evidence-based models, including Functional Family Therapy and Multisystemic Therapy. Multiple Offices of DCF’s Division of Family &amp; Community Partnerships (FCP) partner with community providers to successfully implement evidence based /evidence informed programs and/or curriculum. In FCP’s Office of Early Childhood (OEC) the NJ Home Visiting Initiative (NJHV) is an interdepartmental collaboration with NJ Department of Health and DCF’s Division of Family &amp; Community Partnerships. Three evidence-based home visiting models that meet the Department of Health and Human Services criteria for evidence of effectiveness are currently implemented in all 21 NJ counties, serving 5,000 families with young children (prenatal to 5) each year. Examples of EB/EI programming in FCP’s Office of School Linked Services (OSLS) include: the NJ Child Assault Prevention Program (NJ CAP); the DHHS, Office of Adolescent Health supported Parent Linking Program; Traumatic Loss Coalition for Youth – Suicide Prevention; and School Based Youth. FCP’s Office of Family Support Services (OFSS) has begun surveying the statewide network of Family Success Centers (FSCs) to determine which EB/EI programs are being utilized the parent education/parent child groups.</p>
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					<p>Additional DCF's partners including our Regional Diagnostic and Treatment Centers and community providers have been pioneers in the adoption and implementation of evidence-based and evidence informed practices including Trauma-Focused Cognitive Behavioral Therapy, Combined Parent-Child Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing, Expressive Arts Therapy, and Parent-Child Interaction Therapy to name just a few.</p> <p>Though evidence-based and evidence informed practices are being incorporated by community partners, providers, and within our own system, we also identified services that are incongruent with CP&amp;P's case practice model or best practices; and areas of unmet need (i.e. geographic or language barriers). We also identified nonspecific programming and treatment and legacy contracts which offer services that may have been appropriate and state of the art for the time, but have become less relevant to meeting the needs of today's families. We recognize the need to realigning our service dollars to purchase more programming that holds promise to achieve positive outcomes with some of our most vulnerable children and families versus</p> <p>The Traumatic Loss Coalitions for Youth (TLC)          NJ Child Assault Prevention (CAP)          School Based Youth Services Program (SBYSP)          * as we are working to ensure each program</p>
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					<p>are using an evidence based curriculum, a great number independently use evidence based curricula. The work of school based is evidence informed as an overwhelming amount of research indicates the effectiveness of supporting the social and emotional health of youth in the school. Parent Linking Program (PLP)</p> <p>OFSS has begun surveying the FSCs to determine which Evidence Based Programs are being utilized across the state.</p>

<p>2-3</p>	<p>14-Jun</p>	<p><b>Children have family based settings that allows them to remain connected with their siblings in OOH placement</b></p>	<p>Resource homes are available to serve larger sibling groups (SIBS homes).</p> <p>Siblings placed apart have regular contact with one another.</p>	<p>Increase available homes for large sibling groups by 10%</p> <p>Children with 3 or more siblings able to be placed together is increased by 5%</p> <p>60% of children visit regularly with their siblings</p>	<p>The number of large SIBS homes (accepting of 5 or more siblings) has remained constant with a total number of 24 homes statewide.</p> <p>Currently, the Office of Resource Families is developing a plan to expand the SIBS program to include sibling groups of 4 or more due to an increase in the number of this population entering placement in CY2013. The proposed program includes supportive services and additional resources. The Local Offices are currently engaging families to determine the number of families willing and able to take a larger sibling group. Recruitment events for large sibling groups continue to occur</p> <p>2014 data indicates 25.2% of 4 or more sibling group placed together. This target was not met and will be a continue focus for action in the following year.</p> <p>Larger sibling groups appear to have a higher rate of replacements due to the lack of homes to accommodate them together. CP&amp;P is developing special recruitment efforts to target existing resource families who will be explored to accommodate 4 or more siblings.</p> <p>The MSA target for sibling visits is 85%. As of June 2014- this measure has not been met however for all sibling groups- 68% were visiting.</p>
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**Core Strategy 3 – Organizational Development**

Organizational development builds on the accomplishments made in training and development of its workforce; coupled with the increased availability of access to the tools necessary for staff to effectively and efficiently work with the children, youth and families we serve. This Core Strategy also includes steps to strengthen the technology available to staff to effectively and efficiently work with children, youth and families. The strengthening of the organization helps staff accomplish the broader positive outcomes for those it serves.

Line #	Date Added	5 Year Intent	Year 1 Action Plan 10/1/13-9/30/14	Measurement/Evidence	Results
		<p><b>Families benefit from well trained staff who are competent in their ability to engage and team with families.</b></p>	<p>Maintain support for certificate programs in specialty areas like domestic violence, managing by data, adolescent services</p> <p>Use educational incentive programs to recruit and retain social workers into the agency</p>	<p>Percentage of staff completing the program (total completion/total enrolled)</p> <p>Percentage of staff completing the program (total completion/total enrolled)</p>	<p>95% of all students enrolled completed the DV certificate program. 100% of all Data Fellows completed the program and 95% of those the adolescent advocacy program completed</p> <p>42 students were enrolled in the DV program and 41 completed the program , 44 were enrolled in the Data Fellows Program and 44 completed the program, lastly and 40 were enrolled in the adolescent advocacy program and 38 completed the program.</p> <p>Since inception, in total, 124 people completed the Violence against Women Certificate course, 171 people completed the Managing by Data course and 223 completed the certificate program in Adolescent Advocacy.</p>

3-1	14-Jun		(BCWEP, MCWEP)	<p>Percentage of staff still employed 2 years post program (total retained/total graduated)</p>	<p>BCWEP- 95% of all those hired into the BCWEP program completed the program and were hired. In total 369 students graduated the program and from that 354 were hired. After two years 284 or 88% were still on the job.</p> <p>Overall the attrition rate of BCWEP is at 4.4%</p> <p>The DCF Data Fellows program teaches staff how data can improve outcomes for children and families. It is at the center of our department-wide commitment to operate as a learning organization. As of September 30, 2014, the Fellows program had 167 active Fellows, with an additional 40 candidates in the 2014-15 cohort which began September 10, 2014.</p> <ul style="list-style-type: none"> <li>• Round 1 (2011-12): 100 enrolled/93 completed; 96% retention</li> <li>• Round 2 (2012-13): 40 enrolled/35 completed; 100% retention</li> <li>• Round 3 (2013-14): 46 enrolled/44 completed</li> </ul> <p>MCWEP- This is a fairly new program This program is too new to have Percentage of staff still employed 2 years post program (total retained/total graduated) will look to incorporate into year 2</p>

3-2	14-Jun	Align staff training to critical or emerging areas of practice	<p>Conduct a trauma focused symposium to provide basic understanding of trauma to front line staff</p> <p>Conduct training on serving victims of human trafficking</p>	Staff participating in training opportunities (total staff trained/total staff of agency)	<p>320 people attended the first of 4 symposia planed on Trauma. 172 DCF staff participated or 3.7 % of DCF staff in the first of 4 trauma symposia. Remaining participants were external stakeholders who were afforded this collaborative training opportunity.</p> <p>4,892 staff were training during the review period in Human Trafficking awareness- In total 6359 individuals have attended 1 or more "Human Trafficking" prior to 9/30/2014</p>
3-3	14-Jun	<p><b>Provide enhancements to technology to improve workflow for staff and transparency to ensure staff are prepared</b></p>	Continue NJ SPIRIT releases as scheduled	Release schedule followed	<p>DCF released 4 NJ Spirit modifications:</p> <p>Release 5.0 (October 2013)            A New disclaimer message was added to the NJ SPIRIT Login screen. Users now are required to acknowledge they have read and understand the confidentiality disclaimer before being granted access to NJ SPIRIT.            Improved Resource Services Selection Options were made available. A new Inactive Services expando was added to the search results display. This new feature allows workers to view and select an inactive service with the condition the service was in an active status when it was provided. Improved CWS Assessment/Contact Activity notes were made available. Contact Activity Notes generated from within a CWS Assessment in NJ SPIRIT now automatically associate with the correct CWS Assessment regardless of how many CWS Assessments are in pending. In an effort to improve the search functionality in NJ Spirit, NEW features were</p>

					<p>added to the Case and Resource Non-Restrictive Search window. Person Merge was made easier. Local Office merge liaisons complete a Person Merge for duplicate person records in NJ SPIRIT. NJ SPIRIT was enhanced to allow the merge to proceed, even if the merged person is on an investigation; granted the investigation is fully approved. A NEW Medical/Mental Health Type category of Psychiatric Activity was added to the Medical History window. In addition, values for Psychiatric Evaluation, Medication Monitoring and Other are now also available in the Activity drop down for selection. The Placement and Service Ending window in NJ SPIRIT was enhanced to give supervisors the ability to override a Birthday Batch placement end reason when appropriate. Various fields on the Allegation tab of the Investigation window in NJ SPIRIT have been expanded to display more text. The LOBA check limit was increased from \$500 to \$600 to accommodate the recent increase in Independent Living Rent allowance. Upon investigation approval, staff now receives a reminder to complete an Early Intervention System Services referral for children under the age of three years old involved in a Substantiated or an Established investigation. In addition, staff is required to document the referral information on the Medical History Tab of the Medical Mental Health Window in NJ Spirit. The Auto-recall functionality was enhanced to prohibit the recall of work to an inactive worker. Supervisors now have the ability to reroute the pending work to an active worker, while workers are able to reroute the pending work to a supervisor, who in</p>
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					<p>turn may reroute to the appropriate worker. Staff now receive message asking them to accept the USPS standardized address when creating/editing a person or resource mailing address in NJ Spirit. Accepting the U.S. Postal Service standardized address will help to ensure the accurate and timely delivery of mail.</p> <p>Release 5.1 (November 2013)</p> <p>NJ Spirit has been enhanced to accept either a completed Family Risk Assessment or a Family Risk Re-assessment to satisfy the requirement that one be completed within 30 days before closing an in-home case. Changes were made to Institutional Abuse Investigative Units online summary and forms to better support case practice. Human Trafficking values were added to Intakes for CPS and CWS.</p> <p>Release 5.2 (January 2014)</p> <p>NJ SPIRIT now allows for the extension of Medicaid coverage for qualifying young adults between the age of 18 and 26. Qualified candidates with existing DCF Medicaid in NJ SPIRIT will automatically be transferred to the new Federal Medicaid program in their 18th or 21st birthday month. NJ SPIRIT will automatically terminate this Medicaid at the end of the young adult's 26th birthday month. Enrollment and termination of new Medicaid will be administered through the DCF Office of Child and Family Health.</p>
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				<p>Release 5.3 (July 2014)</p> <p>Redesign the current or previous agency involvement section of the 'Intake Window' and the 'Other Intake Narrative' section on the screening Summary Report to be more user friendly. To better assist supervisors in managing their staff's pending work, a new 'Worker Search' has now been added to the Non- Restrictive Search window in NJS. This new search feature will give supervisors the ability to view all pending approvals for a particular worker. Functionality has been added to NJS which allows Local Office Adoption Staff to attach scanned documents to the adoption planning window. Add the subsidy amount to the subsidy agreement window and related batches. An alert was added to the out of home placement process. An email will now be sent to the primary worker when a child on their caseload has been placed/replaced. This will only occur when the placement line was created by someone other than the primary worker. This is designed to ensure that proper notification exists especially for when placements occur after hours by emergency staff. Correct investigative Extension screen approval process to allow for appropriate approval by assigned supervisors. Upgrade to the latest version of Internet Explorer from version. Twenty five incidents were dedicated to the implementation and improvement of our Trust Account functionality. These incidents were spread over multiple areas of the application: Online, Reports, Interfaces, and Database. Three incidents were AFCARS PIP</p>
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					<p>related:</p> <ul style="list-style-type: none"> <li>• The addition of the subsidy amount to the subsidy agreement window and mapping to AFCARS adoption element #36</li> <li>• AFCARS element #49 (foster home structure) was correctly mapped to also pick up contract agency roles (#57 &amp; #58) to report the primary and secondary caregivers marital status.</li> <li>• Enhancement to the current element #64 (SSI) mapping to adjust for the improvements to the trust account functionality.</li> </ul> <p>Correct the General Search screen to allow the wildcard search to work properly on the respective address and town fields.</p>
3-4	14-Jun		<p>Provide access to tools to enhance knowledge and skill</p> <p>Post longitudinal data for internal use</p>	<p>CP&amp;P policies are available on DCF internet page</p> <p>HZ Longitudinal data available on DCF intranet</p>	<p>In promoting a more collaborative and transparent agency all DCF policies are now available as of July 2014 on the DCF internet page for all stakeholders to review and elicit feedback on- see <a href="http://www.nj.gov/dcf/policy_manuals/toc.shtml">http://www.nj.gov/dcf/policy_manuals/toc.shtml</a></p> <p>The CPP Longitudinal Outcomes are now posted to DCF's intranet annually with data by State and County.</p>

3-5	14-Jun		<p>Update Safe Measures to version 5</p> <p>Deploy new screens for tracking performance based on organizational need</p>	<p>Change over time during year 1 in the number of staff utilizing Safe Measures to regularly track and monitor workload and performance</p> <p>Screen shots of new screens</p>	<p>During this period, CLC workers viewed different screens in Safe Measures 442,262 times while supervisors viewed Safe Measures screens 1,041,743 times. SafeMeasures usage by staff remained steady during this period. Supervisors usage, however, increased by 5%.</p> <p>New screens continue to be developed to meet the needs of the users. Existing screens also continue to be enhanced.</p> <p><b><u>New Screens:</u></b></p> <ul style="list-style-type: none"> <li>• NYTD follow- up screen: tracks surveys completed by youth age 21 as per the NYTD federal requirement</li> <li>• Race/Ethnicity screen: tracks clients with missing race/ethnicity information</li> <li>• Missing Clients</li> </ul>
3-6	14-Jun		<p>Request technical assistance (TA) to further development of the information and data associated with the Systemic Factors</p>	<p>Request is planned and initiated</p> <p>Follow plan as needed</p>	<p>Ongoing T/TA is continuing for Retention and Recruitment through Market Segmentation. Additional support in enhancing reporting for the CFSR Systemic Factors began in February 2015 and will continue. NJ has completed the introductory call with the Capacity Building Centers and will be moving forward in the summer of 2015 with the State Capacity Assessment.</p>

**Core Strategy 4 – Continuous Quality Improvement**

Continuous Quality Improvement (CQI) at the Department includes the development of a fully functioning and sustainable system that has the organizational structure to support high quality data collection including case record review processes, data analysis, with stakeholder feedback processes as well as ways for public dissemination of information. Many of the component parts are present and with some refinements will form the basis for the CQI system.

Line #	Date Added	5 Year Intent	Year 1 Action Plan 10/1/13-9/30/14	Measures	Results (date)
4-1	14-Jun	<b>Develop a robust and fully functioning CQI system</b>	Gather understanding about current status of CQI activities	Baseline accounting of CQI activities statewide	Developed and administered a statewide CQI survey to assess existing CQI effort in the state. Results of the survey then informed regional Leadership CQI focus groups. In addition, a “CQI activities” session/conversation was held with the Local Office Managers; information was gathered about how: CQI activities are prioritized; tracked; analyzed; and inform ongoing decision making. Developed a CQI Grid to track existing Department CQI activities. The CQI Grid is updated as new CQI activities emerge. DCF’s commitment to ongoing learning and quality improvement is keenly demonstrated with the NJ’s Data Fellows program. A 4th cohort of Fellows began during this reporting period and continued the practice of reviewing Department data, prioritizing needs based on the data, developing hypotheses, conducting reviewing reviews and making recommendations to the
			Initiate policy and process development to guide practice	Draft policies	

					<p>Department for improvements.                  DCF convened planning groups to review ChildStat processes to improve the presentations. 2014 launched the revised Child Stat overview on permanency with reunified families. In June 2014, an education day was held for statewide offices to introduce and review the new and improved ChildStat focus. Education day covered how to: better integrate data; utilize Strengthening Families Protective Factors; and engage in ongoing practice reflection. In addition, there was an increase in external stakeholders worked with local offices in co-presenting with local office staff the family and child's story.                  PMA continued to facilitate twice a month the Key Performance Indicators (KPI) calls with each leadership from DCP&amp;P Area Offices. The calls provide an opportunity to look at practice compliance and data accuracy.                  Completed the draft of the DCF Statewide CQI Plan, the branding for the DCF CQI initiatives, and updated the DCF website with the new CQI narrative and logo.                  PMA drafted CQI policies, reviewed additional Department policies that are connected to CQI and/or Administrative Order, and developed a plan to finalize CQI policies.</p>
4-2	14-Jun				
			Identify core components of CQI training	Draft CQI employee training	The State consulted with other Child Welfare systems and Child Welfare Organizations to learn about their process for adopting a CQI plan and its accompanying employee training. NJ drafted Employee Orientation on CQI.

4-3	14-Jun		<p>Operate a quality data collection process</p> <p>Initiate process to build additional controls around data collection</p> <p>Complete AFCARS PIP</p>	<p>Pilot accountability/quality control after a targeted review and follow next steps</p> <p>PIP completion</p> <p>To further work on NJ quality data collection we maintained regular (Weekly to bi-weekly) Data Quality &amp; Compliance meetings between DCP&amp;P and PMA. These meetings offer leadership an opportunity to have data inform its decision making while verifying if the data being used is accurately measuring what is needed. NJ continues to hold 16 Qualitative Reviews (QR) and various targeted case reviews all with quality assurance measure in place to ensure rater reliability.</p> <p>Enhancements to the SACWIS system have been ongoing to mitigate the AIP findings with quarterly reports submitted timely to ACF. There are additional enhancements to the SACWIS system still pending with anticipated completion dates of April 2016. Once ACF determines that the technical requirements and data quality requirements have been met and maintained, the AIP is considered complete. An estimated completion date for the AIP is 4/2017.</p>
4-4	14-Jun			

			<p>Operate a case record review process</p> <p>Continue implementation of the QR process and made modifications as needed</p>	<p># QRs completed</p> <p>Annual summary report published</p>	<p>In 2014, PMA led QR reviews in 15 of the state's 21 counties, with a sample that included 1,770 interviews linked to 180 children/youth. The report is to be published on the DCF site in the coming months</p> <p>The Overall Child and Family Status Indicator was recognized as a strength, with 90% of cases reviewed being rated as acceptable. (Strength is indicated when 70% or more of all cases receive an "acceptable" rating). DCF has consistently maintained this positive trend, as the Overall Child and Family Status Indicator was also identified as a strength in the 2013 and 2012 QRs, with 91% and 90% of cases rated as acceptable, respectively.</p> <p>The Overall Practice Performance Indicator was identified as an area in need of improvement, with 66% of cases reviewed being rated as acceptable. However, it should be noted that 66% represents a significant (9%) increase from the previous year, when 57% of the cases were rated as acceptable in the Overall Practice Performance Indicator.</p> <p>NJ has been having internal conversation in preparation for the CFSR Round 3. Several key colleagues attend the Boston MA conference which discussed the changes in the round 3 approach. We attend a peer network that has been exploring the cross walk of the QRs and CFSR tools. Key DCF team members have also been talking with fellow colleagues in other states who are preparing for the CFSR in 2015. In addition we have held an in person meeting and conference calls with ACF to discuss the CFSR.</p>
			<p>Begin discussions to understand implications of Round 3 case reviews</p>		

					Ongoing Technical Assistance calls will be arranged with ACF as well as an internal DCF-CFSR workgroup. DCF has started discussions about the impact of the CFSR tool on the QR and possible training needs on the CFSR tool plus changes needed to the QR sample methodology.
4-5	14-Jun		Complete targeted reviews on the quality of investigations as well as the quality of services to older adolescents	Results of the reviews and recommendation follow up	During the time frame, PMA led several targeted review: Measure 16, (Jan. and August 2014), M54 (Nov. 2013), M55 (Feb 2013 and Aug. 2014) and Investigative Practices (September 2014). At this time the following reports are on the DCF web site: 2013 M54 report (still working on the 2014), 2013 M55, 2014 Investigation Report. See reports for recommendations.
4-6	14-Jun		Analyze and disseminate quality data Complete in-depth Data Quality and Compliance meetings to review outcomes with each CP&P Area that integrate data from AFCARS, the MSA, longitudinal measures	Lessons learned	DCF has completed in-depth reviews of quantitative and qualitative data across each county in the State with local teams. Through this process, strengths and challenges emerged for each area highlighting the regional differences in population, partners, performance and outcomes. See Collaboration section for more detail.

4-7	14-Jun		Provide data reports on key agency performance indicators to the public	# of reports posted publically	DCF now post the following reports on the DCF website: Monthly Commissioner’s Dashboard, Monthly Screening and Investigation Report, Annual Child Abuse and Neglect Report, Annual Educational Stability Report
4-8	14-Jun				
			Integrate feedback from stakeholders into processes and systems	review of PIP participants and PIPs for statewide themes	Area and county based Program Improvement Plans (PIP) have been shared with Area Quality Coordinators in an effort to communicate strategies for practice enhancements across the state. The development of PIPs now incorporates input from stakeholders, staff at multiple levels of the system, and PMA Office of Quality QR team leads. PMA tracks trends in QR performance and quarterly PIP updates.
			Counties with QRs during period have completed Program Improvement Plans from a systems perspective with input from stakeholders		
4-9	14-Jun		Identify future opportunities to discuss CFSP goals with stakeholders	Calendar of meetings with CFSP as agenda items  Plan for feedback from stakeholders	The approved NJ 2015-2019 CFSP has been made public for all stakeholders to review and provide feedback on the progress and performance see Federal Reporting at <a href="http://www.state.nj.us/dcf/childdata/njfederal/">http://www.state.nj.us/dcf/childdata/njfederal/</a>  On-going meetings with key stakeholders as outlined in the collaboration section cycle on a monthly basis with discussions that center around the improvement of outcomes as it relates to the goals and strategies of the CFSP. As a transparent agency, available data is made public and is monitored, tracked and adjusted through continuous stakeholder feedback.

			Update on strategic plan	Update on strategic plan: See DCF Today 2013-2014at <a href="http://www.state.nj.us/dcf/childdata/continuous/">http://www.state.nj.us/dcf/childdata/continuous/</a>
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**Core Strategy 5 – Strengthening and Enhancing Partnerships**

DCF is committed to the process of collaboration with stakeholders and community partners to improve outcomes for those we serve. Accountability and transparency are two key components to enhancing partnerships. Additionally, partnership must reflect the voices and input of those served by the system. Formal systems of data collection and information gathering from stakeholders and partners must be in place and leveraged in decision-making and planning for true systems change.

Line #	Date Added	5 Year Intent	Year 1 Action Plan 10/1/13-9/30/14	Measures	Results (date)
5-1	14-Jun	<b>Partnerships are strengthened through transparency</b>			
5-2	14-Jun		Make data reports available to the public through the DCF webpage	CIACC reports and Data Dashboard are available monthly on the DCF website	DCF now post the following reports on the DCF website: Monthly Commissioner’s Dashboard, Monthly Screening and Investigation Report, Annual Child Abuse and Neglect Report, Annual Educational Stability Report, CIACC reports
5-3	14-Jun		Partner with entities in the research committee to	# of research projects approved	DCF’s research review committee approved 6 research projects from 10/1/13 to 9/30/14. 5

			<p>disseminate knowledge</p>	<p># of articles published</p>	<p>of these projects are still ongoing.</p> <ul style="list-style-type: none"> <li>• Mother and Infant Childhood Home Visiting Program Evaluation (MIHOPE)</li> <li>• Home visitation enhancing linkages project (HELP): Enhancing evidence based home visitation to address substance abuse, mental health and DV</li> <li>• HomeStyles: Shaping Home Environments and Lifestyles Practices to Prevent Childhood Obesity</li> <li>• Youth Perspectives on the Youth Advisory Boards</li> <li>• Evaluation of the New Program for Domestically Trafficked Adolescents</li> <li>• The Assessment of Parent Linking Programs Project</li> </ul> <p>External researchers submitted 2 reports during this time period, but neither was published in a peer-reviewed journal.</p> <p>The Parent Linking Program expansion project Promoting Success for Expectant and Parenting Teens NJ was approved to be evaluated by John Hopkins University (JHU)</p>

5-4	14-Jun	<b>Youth perspective is incorporated into the DCF system</b>			
5-5	14-Jun		The Youth Advisory Boards are restructured and systems recommendations to DCF are made	# of engaged youth in YABs  DCF response to recommendations	A total of 836 unduplicated youth attended local YAB meetings A total of 196 youth attended 3 YAB Statewide Quarterly Networking meetings  DCF made efforts to update policy and started to make changes and improvement to practice, policy, and resources through trainings, reminders to staff, and started to directly work on contract language and resource capacity regarding issues and needs presented. DCF also staff met with some YABs directly to address and explore specific concerns presented.
5-6	14-Jun	<b>Mechanisms are available to receive stakeholder feedback and feedback is used to inform the system</b>			
			Resource families are engaged have structured opportunities to provide input and feedback on the system	Final Report on Resource Family Assessment  Next Steps are implemented	The first survey on resource family assessment was conducted and the response rate was not representative enough of a survey necessary to make any assumptions. As a result, the survey was modified and resent to 1000 resource families. Participants will have the option of either completing an online survey or completing the survey by mail. Once the survey results are received, the results will be analyzed and recommendations will be considered in the resource family retention framework.

5-7	14-Jun		Family surveys are completed by those engaged in the Teaming process	Quarterly reports on FTM survey	FTM surveys continue to be provided to FTM participants and quarterly reports are issued by PMA for CP&P leadership. In 2013 a time limited workgroup revised the FTM survey to better assess the impact of an FTM on case planning and incorporating the family's voice. The revised survey (in both English and Spanish) was shared with CP&P in April 2014.
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# 2015-2019 CFSP Second Year Action Plan Results

**Core Strategy 1 – Strengthening the Case Practice Model**

The Case Practice Model (CPM) is the foundation of the work at the Department and is envisioned to be infused in all interactions with children, youth and families. The core of the CPM is partnerships with families through engagement of formal and informal supports, joint planning and teaming for desired outcomes, as well as individualized services to address the specific and unique needs of families. Over the next five years, the Department will build on the implementation of the CPM model to pilot initiatives aimed as refocusing staff attention on CPM core strategies like teaming and case planning. Through these efforts, it is expected that families will experience thorough joint planning and teaming will aid in providing supports for the family after child welfare involvement has ended.

Line #	Date Added	5 Year Intent	Year 2 Action Plan 10/1/14-9/30/15	Measures	Results (date)
1-1	14-Jun	<b>Families will experience collaborative service planning through timely completion of case plans and greater quality of case plans.</b>	Provide opportunities for children and youth to understand their rights while in care, including what they can expect regarding their health, safety and court involvement.  Update the existing transitional plan to make it more goal oriented and facilitate planning conversations with adolescents.	Creation of a bill of rights policy for children and youth.  Publishing the updated transition plan form and policy to incorporate identification of goals, conversations and youth voice.	The Children and Youth Bill of Rights was published on September 29, 2015 in the DCF Policy Manuals.  The updated Transitional Plan for YOUth (TPYS) Success was published on September 15, 2014 in the DCF Policy Manuals. An accompanying one day training was launched for DCF staff and contracted providers to review the new form and to develop strategies for quality completion. During this time more than 100 staff (public agency and contracted provider) were trained. This training is offered on an ongoing basis across the state. In addition, the TPYS plan was embedded into NJSPIRIT.

			<p>Assess Sustainability Plans for counties</p>	<p>Build on sustainable initiatives</p>	<p>There is also a focus on Supervisor conferences though the Back to Basics pilot and FOS and Initial FTM work is embedded in these practice initiatives.</p> <p>The case plan document itself has been enhanced to make it more meaningful for families and more user friendly for staff to use. The enhanced case plan will include the family's voice and will be developed in collaboration with the family. The enhanced case plan is completed and signed by the family with their caseworker in the field.</p>
<p>1-2</p>	<p>14-Jun</p>	<p><b>Teaming process will lead to positive permanency outcomes</b></p>			

1-3	15-Jun	<b>Families' needs and histories are understood and inform engagement strategies</b>	<p>Focus on increasing family engagement in initial teaming into other pilot counties</p>	<p>Increase frequency of initial teaming by 5% in other pilot counties</p> <p>Continue to Expand pilot based on lessons learned</p> <p>5% of increase in staff as FTM facilitators/coaches in pilot counties</p>	<p>This pilot was conducted in Camden, Monmouth and Ocean Counties.</p> <p>In review of the data, there were favorable outcomes for the FTM expansion pilot. From October 2014 to September 2015 in Camden/Monmouth and Ocean, there was not any real change in the Declined and Unavailable. However, there was an increase in the Initial FTMs in 6 out of the 8 offices, however, it was not a 5% increase.</p> <p>Despite the positive outcomes from this initiative it was not expanded in other areas as there are several practice initiatives being implemented across the state (MRSS, Early Childhood Initiative, FOS, YARH etc.).</p> <p>There was an increase in Camden /Monmouth/Ocean number of Master Coaches from 31 in 2014 to 40 in 2015, the number of Coaches remained stagnate as Coaches became MCs and Facilitators became Coaches. Also there was an increase in the number of Facilitators from 489 to 506.</p>
			<p>Ensure adequate staff are trained on teaming</p> <p>Strategic phase in of case conferencing model Focus on Supervision</p>	<p>Increase immersion of Local Offices by 5 additional offices</p>	<p>Currently the last five offices are training in the FOS model. FOS</p>

			<p>PMA/CP&amp;P          formulate          methodology          measure          outcomes</p>	<p>to          to          FOS</p> <p>Measureable tool is          identified and          initiated</p>	<p>refresher trainings are being conducted for supervisory staff who missed the training.</p> <p>The Qualitative Review tool was modified to accommodate this one time very small FOS review. There were 10 Local Offices that were selected to participate. The review period was identified as January 1, 2015 through June 30, 2015. Initial preparation for this review which included conference calls with the reviewers was coordinated between June 2015 and November 2015.</p>
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**Core Strategy 2 - Refinement of the Service Array**

DCF will conduct a robust statewide assessment of the array of services available to children, youth and families. Services must be flexible and reflect current thinking on interventions as well as be nimble enough to respond to emerging needs for its service recipients. The statewide assessment process will result in better availability of services to address needs in the population; including prevention services and services to children in need of out of home placement.

Line #	Date Added	5 Year Intent	Year 2 Action Plan 10/1/14-9/30/15	Measures	Results (date)
2-1	15-Jun	<b>The needs of the children and families served by DCF are well understood and services are in alignment with identified needs</b>	Through the support of the ACYF Federal Planning Grant conduct data analysis, a needs assessment, and refine an intervention framework in order to address ongoing service gaps related to the need for evidence-based, trauma-informed, protective factor focused and comprehensive life skills and other critical program for adolescent and young adults being served through CP&P. Initiate second phase of statewide needs	Create an intervention that works to prevent homelessness for youth in care, 14-21.  Continue      Meta	On August 30, 2015, DCF was notified that we were one of six grantees nationally to receive Phase II Youth At-Risk of Homelessness (YARH) implementation funding through a Federal Cooperative Agreement in the amount of \$670,000 (\$2,010,000 for three years). This funding is designed to support initial implementation and testing of a three component intervention strategy developed during the YARH Phase I planning grant. During Phase II, DCF is continuing to partner with Child Trends, CSSP, and Corporation for Supportive Housing for this project to develop an intervention to prevent homelessness for youth in care, 14-21. The intervention approach will pilot in Burlington, Mercer, and Union Counties and will include the following services: radical permanency, reconceptualization of life skills, educational advocates, near peer and professional mentors, and supportive housing (utilizing Project Based Section 8 Housing Vouchers)  During the monitoring period preliminary work was done to establish topics of the focus group i.e., major objectives, develop questions, identify participants.

			assessment process	analysis of DCF Data such as NJS, CSOC, Census data,  additional Data set identified if needed  focus groups interviews of key stake holders both internal and external	
2-2	15-Jun	<b>Families will have access to evidence supported services to address their needs</b>	Convene Evidence Based Advisory Group to include multidisciplinary internal and external stakeholders	Identify guidance strategies on the selection, adoption, implementation, evaluation and quality improvement practices for evidence-based/evidence informed programs.	To increase access to evidence-based (EB)/evidence-informed (EI) services for families, it is critical that the Department develop guidance strategies on the selection, adoption, implementation, evaluation, and quality improvement practices for EB/EI programs. Several steps have taken place in Year 2 to move this work forward. First, an EB Advisory Group with multi-disciplinary internal and external stakeholders was convened to begin planning for the development of such guidance. At the same time, the Department researched what is needed to successfully integrate EB/EI programming into the service array and began to recognize that obtaining positive outcomes cannot be addressed simply by adopting evidence-based models with the highest ratings or that hold the most promise in the literature. Scholarly research and practitioner experience in the area of implementation science go a long way in explaining disconnect experienced between research and practice—and most encouragingly, offers pathways for organizations and systems to anticipate and inoculate against the barriers of successful implementation from the beginning. In March 2015, the Department created a position in the Office of Strategic Development (OSD) and hired a staff member with experience using implementation science principles to launch a statewide network of evidence based programs. During this period, the Department was also contacted by the Annie E. Casey

		<p>Convene Implementation Science Learning Group</p>	<p>Identify evidence based methods to support quality implementation and scaling up of evidence based/evidence</p>	<p>Foundation’s (AECF) Evidence-Based Practice Group (EBPG) to participate in a discussion on how to increase the utilization of evidence-based programs within public systems. The Department shared its successes and challenges and was later invited to submit a formal proposal to the Foundation for support. In the summer of 2015, DCF submitted a proposal to AECF’s EB Practice Group seeking additional expert consultation from the field of implementation science to assist the Department in utilizing implementation science frameworks and methods to develop the an EB/EI Blueprint for the Department. The Department’s proposal was awarded in December 2015.</p> <p>To integrate more EB/EI programs into the DCF service array the Department looked to the field of implementation science to identify evidence-based methods for quality implementation and scaling of EB/EI programs. The Department invited Dr. Allison Metz from the National Implementation Research Network (NIRN) to provide an overview of implementation science, and in March 2015, Dr. Metz presented “Foundations in Implementation Science - Applying Active Implementation to Improve Outcomes” to DCF leadership and invited staff. This half day meeting sparked discussions and questions across multiple DCF Divisions and Offices as to whether implementation science principles could help to strategically refine the quality of our internal and/or external practices and programs and ultimately result in better outcomes for our families.</p> <p>To formalize and continue this conversation, DCF convened an intradepartmental implementation science learning group to increase DCF’s internal understanding of implementation science principles and its possible application to our existing efforts. This short term learning group met from May through August. The group utilized the modules and lessons provided on NIRN’s Active Implementation Hub. The Active Implementation Hub materials are designed to increase understanding and knowledge of implementation science content, activities, and assessments. Participants were asked to complete online self-paced modules, attend streamed web lessons as a group, and participate in 8 one hour meetings to debrief on the modules and web lessons. During the group’s final meeting in August, members collectively identified themes that emerged throughout three month process and developed broad recommendations on how to integrate implementation science into the work of the Department.</p> <p>Some of the theme/recommendations included:</p> <ul style="list-style-type: none"> <li>• Ensure Effective Interventions: Developed and/or purchased services</li> </ul>
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			<p>informed programs and the application to our existing efforts of integrating more EB/EI programs into our service array.</p>	<p>must be effective interventions (i.e., evidence-informed, well-define, etc.) and have clear standards (i.e., logic models, practice profiles, etc.) for the interventions' activities and expected outcomes.</p> <ul style="list-style-type: none"> <li>o Support Implementation of Effective Interventions - Strategies for Capacity Building: Implementation supports must be aligned and "in service to" the effective interventions. Sufficient training, effective coaching, staff performance assessments and the development and use of data systems to inform decision making are critical implementation supports to address.</li> <li>o Insist on Enabling Context for Effective Interventions to Thrive: Collaboration within DCF Divisions and Offices for alignment of implementation approaches and developing funding strategies to support effective implementation practices are two examples of the conditions needed to support effective interventions.             <ul style="list-style-type: none"> <li>• Work within a Multilevel Linked Teaming Structure: Each initiative should move through a program implementation/development cycle utilizing linked teaming structures. Developing communication protocol with clear expectations for information sharing, articulating next steps, and following up are a must for effective feedback loops and ongoing process and performance improvement.</li> </ul> </li> <li>o Pay Attention to the Multiple Stages of Implementation: There are multiple layers of work that must occur in a given order to effectively implement programs/models. There is a need to be more strategic, disciplined, planful, and realistic about what we should do and when we should do it as we move from choosing an effective intervention to the achievement of outcomes.</li> </ul> <p>To support Division/Office Administrators who may have identified gaps in services and/or are considering launching new programming to meet community needs, the Department initiated a process for Divisions/Offices to request assistance from the Office of Strategic Development (OSD). Examples of requests could include:</p> <ul style="list-style-type: none"> <li>• Assistance with the clarification/identification of needs,</li> <li>• Researching evidence-based/evidence-informed program models to address those needs,</li> <li>• Assisting with designing a research-based program intervention/approach to pilot when an EB/EI intervention is not available,</li> <li>• Developing/reviewing RFP proposals prior to release,</li> <li>• Developing/reviewing logic models, and/or</li> </ul>
		<p>Provide Technical Assistance to New Initiatives</p>	<p>Infuse evidence-based methods to support quality implementation and scaling up of evidence-based/evidence-informed programs into our service array</p>	

					<ul style="list-style-type: none"> <li>Leading the new initiative through implementation science-informed program development cycles. To ensure a streamlined, uniform, evidence-informed approach is taken, OSD drafted a Program Development Roadmap that highlights processes for assessment of need; identification of possible solutions; and support for the implementation, evaluation, reporting, and monitoring of a new initiative purchased service for CP&amp;P involved families. When Divisions/Offices lack staff capacity to lead the new initiative through an implementation science-informed program development cycle, OSD designates staff to lead the new initiative through the program development cycle, addressing each of the factors in the NIRN equation with a stage-based approach and linked teaming structures. In Year 2, this process is being applied to two small scale pilots for CP&amp;P involved families – Keeping Families Together Supportive Housing and Supportive Visitation Services as well as one statewide prevention initiative – Family Success Centers.</li> </ul>
2-3	14-Jun	<b>Children have family based settings that allows them to remain connected with their siblings in OOH placement</b>	<p>Resource homes are available to serve larger sibling groups (SIBS homes).</p> <p>Siblings place apart have regular contact with one another.</p>	<p>Increase available homes for large sibling groups by 10%</p> <p>Children with 3 or more siblings able to be placed together is increased by 5%</p> <p>Increase sibling visitation by 5%</p>	<p>CY 2015 ended with a total of 24 SIBS homes. The same number as last year but ORF maintained this amount despite the opening and closing of SIBS homes throughout the year.</p> <p>In CY2015, 34% of sibling groups of 4 or more children were placed together, which reflected a 9% increase when compared to Year 1.</p> <p>Tracking of sibling groups of 3 began in October 2015.</p> <p>Year 2 monitoring period ended with 76% of sibling visitation. This reflects an 8% increase when compared to year 1 submission. This is a Sustainability and Exit Plan (SEP) To be Achieved measure and more exploration is needed to identify challenges and formulate strategies to increase this measure.</p>

**Core Strategy 3 – Organizational Development**

Organizational development builds on the accomplishments made in training and development of its workforce; coupled with the increased availability of access to the tools necessary for staff to effectively and efficiently work with the children, youth and families we serve. This Core Strategy also includes steps to strengthen the technology available to staff to effectively and efficiently work with children, youth and families. The strengthening of the organization helps staff accomplish the broader positive outcomes for those it serves.

Line #	Date Added	5 Year Intent	Year 2 Action Plan 10/1/14-9/30/15	Measures	Results
3-1	14-Jun	Families benefit from well trained staff who are competent in their ability to engage and team with families.	<p>Maintain support for certificate programs in specialty areas like domestic violence, managing by data, adolescent services</p> <p>Use educational incentive programs to recruit and retain social workers into the agency (BCWEP,</p>	<p>Percentage of staff completing the program (total completion/total enrolled)</p> <p>Increase MCWEP program to 4 cohorts/80 students</p>	<p><u>Domestic Violence VAWC Program</u> (Sept. 2014 to June 2015) – there were a total of 52 individuals that were enrolled into the program. Out of the 52 participants, 3 dropped out of the program, 44 staff completed the program and 5 individuals will complete the program in the next cohort of classes. 85%</p> <p><u>Managing by Data (Data Fellows):</u> Cohort 4 2014-15: 43 were enrolled, 40 completed the program and 40 were retained for 100% of talent who completed the program.</p> <p>Cohort 5 2015-16: 43 were enrolled.</p> <p><u>MCWEP:</u></p> <ul style="list-style-type: none"> <li>➤ There have been 4 Cohorts of 74 students. <ul style="list-style-type: none"> <li>▪ Cohort 1: 32 students graduated</li> <li>▪ Cohort 2: 6 students graduating in December.</li> <li>▪ Cohort 3: 17 Students</li> <li>▪ Cohort 4: 15 Students</li> </ul> </li> <li>➤ 5% of students have withdrawn or been removed from the program.</li> <li>➤ 43% of the students that have graduated are still retained, however</li> </ul>

			MCWEP)	Percentage of staff still employed 2 years post program (total retained/total graduated)	there has not been a long enough duration for the majority of the students to provide the % for retention 2 years post program. 2 have been noted.
3-2	15-Jun	Align staff training to critical or emerging areas of practice	<p>Conduct a trauma focused symposium to provide basic understanding of trauma to front line staff</p> <p>Complete Case Plan Transfer of Learning (TOL) training to expand to all CP&amp;P Local Offices</p>	<p>Provide 3 more trauma focused workshops</p> <p>All 46 Local offices will have completed TOL training</p>	<p><b>Trauma Focus:</b> Since 2014 there have been 22 trauma focused symposiums and learning experiences at the Office of Training and Professional Development as well as regionally held events in local offices. A total of 1,229 individuals have participated to gain a stronger understanding of trauma. Resiliency Summits have been conducted, focusing on vicarious trauma and ways to ensure frontline talent understands the effects, how to seek assistance and ways to remain healthy. To ensure a focus on trauma, there have been 75 courses taught that focus on trauma and stress reductions, since 2014. Through these courses 1,901 participants have gained knowledge to identify and manage stress.</p> <p><b>Transfer of Learning:</b> As an additional note, there will be expanded learning initiatives in this area.</p> <p><b>Technical Improvements:</b> Additional improvements have been made to ensure timely viewing of grades by supervisors for class participants. All Pre-service and Office of Training and Professional Development facilitated classes are uploaded on to TAWS for supervisors view. Training on how to access the grades was provided at the Field Training Unit Supervisor’s Meeting, Assistant Area Director’s Meeting and</p>

			<p>Technical improvements to training website to display test data</p>	<p>Supervisors will be able to readily view test performance of their workers.</p>	<p>the Area Director’s Meeting. 175 supervisors were trained and can also provide assistance to other supervisors. An additional note: The University partnership classes are sent to supervisors in the monthly grade report.</p> <p><b>NJSPIRIT:</b>                  Since 2014 there have been additional trainings to ensure talent understands how to integrate NJSPIRIT into their trainings and to answer questions sufficiently. January 2015, a three day training was conducted for the University Partnership Trainers</p>
			<p>“Boot camp” training to be provided to all training staff on NJ SPIRIT functions including safety assessment</p>	<p>Training staff will fully understand how to integrate the NJSPIRIT actions into regular classroom training so that training emulates the mixture of activities (meeting with families, conferencing with supervisors, and writing up for NJSPIRIT) that occur.</p>	<p>In collaboration with its Child Welfare Training Partnership, NJ DCF developed a three day training that outlines and applies the promotive and protective factors of the Youth Thrive model in the context of child welfare practice with adolescents. The training is required for supervisory and management staff as well as all (non-intake) DCF case carrying staff. It is also a contractually required training for contracted providers serving adolescents.</p>
			<p>Collaborate with external partners to create a Youth Thrive training for</p>	<p>CP&amp;P staff and contracted providers serving adolescent population will be</p>	

			adolescent serving CP&P staff and contracted providers.	afforded the opportunity to participate in the new Youth Thrive training/number of participants trained	
3-3	14-Jun	<b>Provide enhancements to technology to improve workflow for staff and transparency to ensure staff are prepared</b>	Continue NJ SPIRIT releases as scheduled	Release followed schedule	<p>Enhancements included documentation of diagnosis information for all children under investigation and/or in placement went live in January 2015.</p> <p>Release 5.4 (January 2015) The State made numerous modifications and enhancements within Release 5.4. The major objectives are detailed below: The Diagnosis aspect of our Medical Mental Health window was enhanced to achieve SACWIS and AFCARS compliance. These enhancements now allow for:</p> <ul style="list-style-type: none"> <li>• A single data entry point</li> <li>• Better capturing beginning and end dates of diagnosis</li> <li>• Provides a comprehensive list of diagnosis's</li> <li>• System derived AFCARS disability categorization</li> </ul> <p>Online improvements were made to our Person Management screen.</p> <ul style="list-style-type: none"> <li>• The Race, Birth Date, Gender, Hispanic/Latino, and Federally Recognized Tribes fields are now required.</li> <li>• New reminder for staff to check accuracy of fields on Person Management window prior to CPS investigation or CWS assessment approval.</li> </ul> <p>Enhancement made to the NCANDS files to capture changes to the Medical Diagnosis's as well as investigative start date and time. Developed a new Maintain Diagnosis window to allow users to edit and update a person diagnosis. General fixes for the already existing Family Reassessment form currently being used by staff.</p> <p>Release 5.5 (June 2015) The State made numerous modifications and enhancements within Release 5.5. Some major objectives are detailed below: The Case Summary for Closing/Transfer form has been greatly improved. NJS will now allow workers to create/save multiple forms, which will reflect the</p>

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history of case transfers/closings. The form may be found in the Options Dropdown of the Maintain Case>Closing History Tab.

The Transitional Plan window has been enhanced to require the completion of all fields at the time of approval. This will help make sure all pertinent information is captured on the Transitional Plan form.

For payment purposes NJ Spirit uses a Resource Provider's (OPEN Mailing Address). If an open mailing address does not exist, NJ Spirit then uses the providers' Primary/Physical Address. To facilitate the accurate/timely delivery of non-board payments to providers, it is very important the NJ Spirit address be recognized by the US Postal Service. Answering "YES" to the address standardization pop-up message in NJ Spirit will help ensure checks reach the intended recipient.

Allow for documenting Worker Safety Concerns in NJ Spirit. A new Worker Safety value has been added to the 'Category' and 'Type of Activity' on the NJ Spirit Contact Activity Note. Once the Worker Safety note is created and saved, it will appear as a separate and distinct Worker Safety Expando appearing directly under the Case folder throughout NJ Spirit. Also, Worker Safety will appear to the right of the Case Name/ID and the case hyperlink will automatically display in Red; making the cases containing safety concerns more easily identifiable to staff.

Add Intake Expando back to Intake Inquiry and Substantiated Perpetrator Search windows -- restricted case intakes will continue to be blocked.

Seven incidents were AFCARS related:

- (AFCARS PIP)(CODE)-AFCARS Foster Care File Main Selection Criteria. While reporting AFCARS foster and adoption, the file excludes all children 19 and over and includes all children below 18. For those that are between ages 18 and 19, the report includes only those for whom the State has made IV-claimable pay.
- ACARS PIP (CODE) Foster Care 47 and 48. The program code needs to be modified to report the latest TPR date regardless of the relationship for each field (mother and father).
- ACARS PIP (CODE) Adoption 19 and 20. The program code needs to be modified to report the latest TPR date regardless of the relationship for each field (mother and father).
- AFCARS - Foster Care - Batch - Need to modify how Elements 11-15 report when 10 is Not Yet Determined.
- AFCARS - FC Batch - "Not Yet Determined" (CD\_CLNC\_DGNSD = 'U') change

				<ul style="list-style-type: none"> <li>AFCARS - Adopt Batch - "Not Yet Determined" (CD_CLNC_DGNSD = 'U') change</li> <li>(AFCARS PIP) (CODE) - private adoption cases need to report the following data elements - 9, 10, 33, 34</li> </ul> <p>Add KC# search to current Case Search window                  Add Contact Activity Note dropdown value of 'Place: Shelter Facility/Shelter Home'. Some of the MSA measures require that the worker see their children at their placement site.                  Capability to Change Congregate Care resource name online needs to be available for selected user groups. New Security profile needed.</p> <p>Please see Update on Assessment SACWIS for more detail</p>
3-4	14-Jun	<p>Provide access to tools to enhance knowledge and skill</p> <p>Post longitudinal data for internal use</p>	<p>CP&amp;P policies are available on DCF internet page</p> <p>HZ Longitudinal data available on DCF intranet</p>	<p>CP&amp;P policies linked to the New Jersey Youth Resource Spot website: <a href="http://www.njyrs.org/">http://www.njyrs.org/</a></p> <p>Child/Family Health intranet pages are updated regularly; health resources and policies are available to staff.</p> <p>The CPP Longitudinal Outcomes are now posted to DCF's intranet annually with data by State and County.</p>
3-5	15-Jun  15-Jun	<p>Continue to support the Use of Safe Measure</p> <p>Deploy new screens for tracking performance based on organizational need</p>	<p>Maintain or increase the number of staff using Safe Measures to monitor workload and performance</p> <p>Screen shots of new screens</p>	<p>In CY2015, DCF maintained their status as having the highest usage of any SafeMeasures-subscribing agency in 2015, with well over four million page views. DCF added 787 new users in 2015, totaling 4,159 and representing a 14.2% increase in overall active SafeMeasures users.</p> <p>Annual Credit Reporting for Clients Age 14-21                  Interim Placements Open More Than Two Weeks</p> <p>There are currently 185 people with active user accounts to DCF's longitudinal</p>



**Core Strategy 4 – Continuous Quality Improvement**

Continuous Quality Improvement (CQI) at the Department includes the development of a fully functioning and sustainable system that has the organizational structure to support high quality data collection including case record review processes, data analysis, with stakeholder feedback processes as well as ways for public dissemination of information. Many of the component parts are present and with some refinements will form the basis for the CQI system.

Line #	Date Added	5 Year Intent	Year 2 Action Plan 10/1/14-9/30/15	Measures	Results (date)
4-1	14-Jun	<b>Develop a robust and fully functioning CQI system</b>	Gather understanding about current status of CQI activities	Update accounting of CQI activities statewide	A work group has drafted a robust and comprehensive CQI plan for CPP that outlines several core strategies to improve the flow of information and assure continuous quality improvement.  This is currently in the final draft phase and once approved will be available on the DCF/ OPMA web page.
			Review and approve Draft CQI policies	Publish CQI policies	
4-2	15-Jun		Initiate draft CQI training	Target training to DOW/FCP staff	A training curriculum was developed by OPMA staff and delivered to the Department on Women staff and staff in the department of prevention. OPMA is in the planning process of rolling this training out to all staff.  Continuous Quality Improvement trainings were offered to all FCP and DOW staff beginning in 2014 and concluding in February 2015. Those these trainings have concluded, new employees are offered the opportunity to participate in these trainings on an ongoing basis. Staff also presented program logic models at staff meetings beginning in 2014 and concluding in FFY 2015.  Active Implementation Science focus group work began in March 2015. The cross department work group held eight meetings beginning in May 2015 and concluding in August 2015. The group identified supports which are in place or are needed, and provided a broad list of recommendations of how to integrate

		<p>Initiate Implementation Science focus group to engage in the Active Implementation Hub's (<a href="http://implementation.fpg.unc.edu/?o=nirn">http://implementation.fpg.unc.edu/?o=nirn</a>) modules and lessons</p>	<p>Increase knowledge and understanding of the Active Implementation Framework and provide recommendations</p>	<p>implementation science into the work of DCF. It is anticipated that these themes will be presented to DCF Leadership and next steps will be identified. DFCP and DOW worked with FRIENDS National Resource Center to develop the Training and Technical Assistance Capacity Building Framework training. This training framework included the following training topics:</p> <ul style="list-style-type: none"> <li>• Logic Models</li> <li>• Logic Model Implementation</li> <li>• Protective Factors</li> <li>• Developing Evaluation Plans</li> <li>• Presenting Your Logic Model</li> <li>• Implementation Overview</li> </ul> <p>The CQI Plan has been developed and is waiting for final approval by DCF leadership.</p>
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			Identify core components of CQI Framework	Draft CQI Framework	
4-3	14-Jun				
			Operate a quality data collection process	<p>Pilot accountability/quality control after a targeted review and follow next steps</p> <p>review of existing data collection tools to determine areas where tools need to be enhanced or designed</p>	<p>Hired additional staff in FFY2015 to organize and develop processes for consistent quality data collection across FCP and DOW. Further analysis activities will occur in 2016</p> <p>After collaborative meetings and review of existing data collection it was determined that a standard case record review tool for both intake and permanency cases was identified as an area that needed to be developed to ensure data entry into the SACWIS system is occurring as well as assessing the quality of other performance outcome measures. Both local and area CPP offices have many internal reviews and tools they are using and as part of the CQI plan however they are not utilized consistently statewide. These assessment tools will be explored further to be incorporated into a state wide review tool so as to collect quality data on a state wide basis outside of the QR process.</p>
			Initiate process to build additional controls around data collection	Continue work of AFCARS PIP-enhancements during	Enhancements to the SACWIS system have been ongoing to mitigate the AIP findings with quarterly reports submitted timely to ACF. There are additional enhancements to the SACWIS system still pending with anticipated completion dates of April 2017. Once ACF determines that the technical requirements and

4-4	14-Jun		year 2 period	data quality requirements have been met and maintained, the AIP is considered complete. An estimated completion date for the AIP is April 2018.
		Continue work on the AFCARS PIP		
4-5	14-Jun		# QRs completed 2015	16 Counties completed QR.
		Operate a case record review process	Annual summary report published	2014 QR annual report post on DCF website in August 2015. <a href="http://nj.gov/dcf/about/divisions/opma/Qualitative%20Review%20-%202014%20Annual%20Report.pdf">http://nj.gov/dcf/about/divisions/opma/Qualitative%20Review%20-%202014%20Annual%20Report.pdf</a>
4-5	14-Jun	Complete targeted reviews on the quality of investigations as well as the quality of services to older adolescents for 2015	Results of the reviews and recommendation follow up	Investigation targeted review is completed biennially and tentatively scheduled to occur in Year 3. In August 2015, a targeted review of adolescents who had had case closed without achieving permanency was completed and CPP showed improvements in the area of education and employment when working with these young adults.
4-6	14-Jun			
4-7	14-Jun	Provide data reports on key agency performance indicators to the public	# of reports posted publically	DCF continues to post the following reports on the DCF website: Commissioner's Monthly Report, Monthly Screening and Investigation Report, Annual Child Abuse and Neglect Report, Annual Educational Stability Report
4-8	14-Jun			

4-9	15-Jun		<p>Integrate feedback from stakeholders into processes and systems                  Counties with QRs during period have completed Program Improvement Plans from a systems perspective with input from stakeholders</p>	<p>Review of PIP participants and PIPs for statewide themes</p>	<p>Stakeholders attend the qualitative review exit conference. At that time the outcomes are presented and both the strengths and areas needing improvement are reviewed. Following this stakeholders are invited to sit down with CPP leadership and staff for that County and work on completing the PIP a two year process since the changes made to the QR review.</p>
			<p>Provide Technical Assistance to Local offices on PIPs</p>	<p>PIP's will be updated as needed and that the improvement practices identified are attainable and measurable.</p>	<p>After the QR a data set or County Story is put together by the Office of Quality and presented to County Leadership. This data story contains information both from Key Performance Indicators and Longitudinal Outcome data. It also assists counties in making that connection between data and quality. County leadership as well as stakeholders within the county are involved in the creation of the PIP and County leadership ensures the activities identified in the PIP are completed. PIPs are tracked by Area and Local Office staff within the county. If counties do not show progress in performance indicators or outcomes after their subsequent QR, PIPs will be adjusted. Representatives from the office of quality and RER assist the leadership and staff in the development and measurement of the County PIP and participate in ongoing PIP planning meetings throughout the year to provide technical assistance. Changes in the PIP planning and tracking were identified as an area that required additional support and changes as there was not a significant change in performance with subsequent county QR's. These changes will be further explored in 2016.</p>

**Core Strategy 5 – Strengthening and Enhancing Partnerships**

DCF is committed to the process of collaboration with stakeholders and community partners to improve outcomes for those we serve. Accountability and transparency are two key components to enhancing partnerships. Additionally, partnership must reflect the voices and input of those served by the system. Formal systems of data collection and information gathering from stakeholders and partners must be in place and leveraged in decision-making and planning for true systems change.

Line #	Date Added	5 Year Intent	Year 2 Action Plan 10/1/14-9/30/15	Measures	Results (date)
5-1	14-Jun	<b>Partnerships are strengthened through transparency</b>			
5-2	14-Jun		Make data reports available to the public through the DCF webpage	CIACC reports and Data Dashboard are available monthly on the DCF website	DCF now post the following reports on the DCF website: Commissioner’s Monthly Report, Monthly Screening and Investigation Report, Annual Child Abuse and Neglect Report, Annual Educational Stability Report, CIACC reports
5-3	14-Jun		Partner with entities in the research committee to disseminate knowledge	# of research projects approved	DCF’s research review committee approved 15 research projects from 10/1/14 to 9/30/15: <ul style="list-style-type: none"> <li>Prevent Child Abuse of New Jersey’s “My Life, My Choice” Program Data Analysis: Assessing Knowledge, Attitudes, and Skills Towards Human Trafficking from Youth with Increased Risk of Domestic Minor Sex Trafficking in New Jersey</li> <li>New Jersey Project LAUNCH</li> <li>An Evaluation of the Promoting Success for Expectant &amp; Parenting Teens in New Jersey: the Parent Linking Program Expansion Program (PSNJ-PLP)</li> <li>Family Success Center Annual Participant Survey</li> <li>New Jersey Collaborative Adoption Recruitment Education and</li> </ul>

				<p>Support (NJ CARES)</p> <ul style="list-style-type: none"> <li>• A qualitative exploration of child welfare worker’s perception on childhood problematic sexual behavior in the child welfare system.</li> <li>• NYTD follow up</li> <li>• Teachers’ Perception of the Effectiveness of a Professional Learning Community to Build Students’ Academic Self-Efficacy</li> <li>• Study of High School Strategies to Improve Graduation Rates</li> <li>• Evaluation of a Service provision program for Victims of Sex Trafficking.</li> <li>• Improving Outcomes for Families of Infants and Young Children in Newark, NJ: Integrating Best Practices of Child Protection and Early Childhood</li> <li>• Domestic Violence Liaison Program Evaluation</li> <li>• Reducing Costs of Purchased Transportation for State Agencies</li> </ul> <p>DCF/DCP&amp;P has partnered with Johns Hopkins University (JHU) to develop an evaluation plan for the Child/Family Nursing Initiative. currently being piloted in 3 Counties of CP&amp;P supervision, as part of the ongoing partnership with Rutgers University FXB-School of Nursing.</p>	
5-4					
5-5	15-Jun	<p><b>Youth perspective is incorporated into the DCF system</b></p>	<p>Create a policy to provide and ensure a safe, healthy, and inclusive environment for all the youth and families we serve, including LGBTQI youth and families</p> <p>NJ Statewide Youth Advisory Boards (YABs) present concerns and recommendations to DCF twice per year.</p> <p>DCF to update policy, practice, programming where appropriate in response to the YABs</p>	<p>LGBTQI Policy to be published as well as accessible in policy manuals for DCF staff and external stakeholders</p> <p>DCF reports back to YABs on progress twice per year.</p> <p>Publish policy/practice change</p>	<p>The LGBTQI policy was published on 9/14/2015.</p> <p>Quarterly meetings with DCF leadership to voice concerns and/or identify need for change in policy or practice were held. Leadership provided feedback regarding the topics/concerns to the YABs.</p> <p>In March 2015, OAS was offered 100 Project Based Section-8 Housing Vouchers from the NJ Department of Community Affairs to provide long term, stable and supportive housing opportunities for young people aging out of care. This new service addresses housing challenges/concerns that have consistently been brought up by the YABs.</p>

			DCF presents updates and progress with Adolescent Service Providers.	Hold quarterly Provider Meetings	The Office of Adolescent Services continued to hold quarterly meetings with adolescent-serving contracted providers to both share and gather information. Topics covered during this period include: uses and changes to services for youth, services and supports for expectant and parenting youth, criminal record expungement, post-secondary and career planning and preparation; and accessing child care.
5-6	15-Jun	<b>Mechanisms are available to receive stakeholder feedback and feedback is used to inform the system</b>			
			DCF to engage stakeholders through the Youth At-Risk of Homelessness Federal Planning Grant	Focus groups, planning sessions and surveys are initiated  Reports information to the public through emails, newsletters, and the public website	DCF conducted a Charrette planning session on 10/30/14 that included over 100 staff, stakeholders, and youth. Topics for this planning session included housing, housing for specific populations, employment/education, and permanency/social connections. Recommendations were gathered and a report was published by the Corporation for Supportive Housing.  DCF also collected data through surveys and focus groups during this reporting period. DCF created newsletters and conducted community presentations to ensure stakeholders were engaged and aware of the YARH project.

			Resource families are engaged have structured opportunities to provide input and feedback on the system	Initiate Retention Taskforce	In 2015, a Resource Family Retention Task Force was convened. The task force was charged with making recommendations to improve the support and retention of New Jersey's resource families. There were over 80 members on this task force consisting of staff from all levels, outside stake holders, youth and a number of resource families. Resource families had an opportunity to share their experiences and influence the recommendations.
5-7	14-Jun		Family surveys are completed by those engaged in the Teaming process	Quarterly reports on FTM survey	On a monthly basis the OQ collects the Family surveys and culls the aggregate data to identified trends in Areas Needing Improvement and Strengths. This information is forwarded in memo form to the CP&P leadership.

# 2015-2019 CFSP Year Three Action Plan Results

**Core Strategy 1 – Strengthening the Case Practice Model**

The Case Practice Model (CPM) is the foundation of the work at the Department and is envisioned to be infused in all interactions with children, youth and families. The core of the CPM is partnerships with families through engagement of formal and informal supports, joint planning and teaming for desired outcomes, as well as individualized services to address the specific and unique needs of families. Over the next five years, the Department will build on the implementation of the CPM model to pilot initiatives aimed as refocusing staff attention on CPM core strategies like teaming and case planning. Through these efforts, it is expected that families will experience thorough joint planning and teaming will aid in providing supports for the family after child welfare involvement has ended.

Line #	Date Added	5 Year Intent	Year 3 Action Plan 10/1/15-9/30/16	Measures	Results (date)
1-1	14-Jun	<b>Families will experience collaborative service planning through timely completion of case plans and greater quality of case plans.</b>	Train staff in enhanced Case Plan  Create the Voluntary Service Agreement Form	# staff were trained on the enhanced Case Plan  Policy release	The enhanced case plan –A total of 3,484 individuals completed 1 or more Case Plan Enhancement Sessions in 2016. All initial staff was trained in the Enhanced Case Plan in June 2016.  The Voluntary Services Agreement form and instructions was published in the DCF Policy Manual in July 2016 (and was subsequently updated in November 2016).

1-2	14-Jun	Teaming process will lead to positive permanency outcomes			
			Shift the focus to increasing the quality of family engagement in family teaming	Establish quality baseline	In order to better understand the barriers to quality teaming a statewide workgroup was convened. It was determined in order to establish a quality baseline, changes to the Family Agreement (FA) needed to be completed. Work in Year 4 will include implementing carbonized FA.
			Ensure adequate staff are trained on teaming	Identify ratio standard and areas that were underdeveloped in meeting ratio capacity	We have identified the following ratio standard for local offices: 1 Master Coach/ CWS: 15 facilitators/ caseworkers. 1 Coach/ Supervisor: 5 facilitators / caseworkers. The CWS role matches well with Master Coach's role and the CWS will be responsible for overseeing the development of facilitators within their unit. In Year 4 However, we identified capacity limitation in the Local Offices. CPP will partner with OTPD to include CPM3 into New Worker training.
			# of PRT Held	The PRTs were held in January 2016 for 56 youth. The	

1-3	15-Jun	<b>Families' needs and histories are understood and inform engagement strategies</b>	<p>Permanency Roundtables (PRT) will be reinstated to assist older youth in achieving permanency</p>	<p>Was the video distributed</p>	<p>Permanency Action Plans were tracked and the outcomes will be analyzed. In addition, two trainings were held for judges and attorneys that work with the child welfare system to discuss the importance of permanency for older youth as well as the PRTs.</p>
			<p>Create permanency for older youth video</p>	<p>Service contracts and evaluation activities</p>	<p>The video highlighting the importance of permanency for older youth is complete and is on the NJ Youth Resource Spot website and has been used during trainings within DCF.</p>
			<p>Pilot and implement YARH Component 1 Connect to Family and Connecting to Well-Being in Burlington, Mercer, and Union Counties.</p>		<p>Contracts/services for all components began July 1, 2016 and the initial implementation of the pilot services is in process and under evaluation.</p>
			<p>Strategic phase in of case conferencing model Focus on Supervision</p>	<p>All Local Offices are immersed in Focus on Supervision</p> <p>Measureable</p>	<p>The Qualitative Review tool used in New Jersey was amended and revised to accommodate this very small FOS review. There were 10 Local Offices that were selected to participate. Preparation for this review which included conference calls with the reviewers were coordinated between June 2015 and November 2015. The review was</p>

			PMA/CP&P to formulate methodology to measure FOS outcomes	tool is identified and initiated	completed in December 2015 and results were shared with leadership in February 2016, the results were analogous to QR results. The mini QR for FOS cases was an internal opportunity to see if FOS had an impact and if local offices are maintaining the integrity of this case conferencing model. Local offices continued conducting the FOS conferences but data collection and monitoring was identified as an area needing improvement. Moving forward, the focus will be around data collection on FOS cases.
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**Core Strategy 2 - Refinement of the Service Array**

DCF will conduct a robust statewide assessment of the array of services available to children, youth and families. Services must be flexible and reflect current thinking on interventions as well as be nimble enough to respond to emerging needs for its service recipients. The statewide assessment process will result in better availability of services to address needs in the population; including prevention services and services to children in need of out of home placement.

Line #	Date Added	5 Year Intent	Year 3 Action Plan 10/1/15-9/30/16	Measures	Results (date)
2-1	15-Jun	<b>The needs of the children and families served by DCF are well understood and services are in alignment with identified needs</b>	Through the support of the ACYF Federal Planning Grant conduct data	Create an intervention that works to prevent homelessness	DCF completed the Phase I data analysis and needs assessment for the Federal Planning Grant (Youth At-Risk of Homelessness, YARH). An intervention framework was designed from this planning phase and DCF applied and was awarded Phase II funding to implement new services to

<p>analysis, a needs assessment, and refine an intervention framework in order to address ongoing service gaps related to the need for evidence-based, trauma-informed, protective factor focused and comprehensive life skills and other critical program for adolescent and young adults being served through CP&amp;P. Initiate second phase of statewide needs assessment process</p>	<p>for youth in care, 14-21.  Continue Meta analysis of DCF Data such as NJS, CSOC, Census data,  additional Data set identified if needed</p>	<p>prevent and address youth homeless for youth with experience in foster care ages 14-21. New services were posted through a RFP process to be piloted in Burlington, Mercer, and Union Counties. These services included permanency, life skills, education advocates, mentoring, and supportive housing. DCF awarded new contracts on 5/1/16 and started implementing new programming through the summer into fall of 2016.  Drafted internal report on qualitative findings in June 2016. Surveys were moved to Phase III of the needs assessment expected completion in 2017.  DCF partnered with Rutgers University to produce the most recent report entitled DCF Needs Assessment 2016 Report #2: Qualitative Finding. This report is based on qualitative data collected in 2016 (e.g. focus groups). The report updates interim findings on DCF's three year multi-phase needs assessment process to identify the resources needed to serve families with children at risk for entering out-of-home placement and those already in placement.</p>
<p>Continue next steps in Focus Groups</p>	<p>Conducted focus groups interviews of key stake holders both internal and external.</p>	<p>Several Focus groups have been completed. These include CPP field staff, CPP support staff, CPP leadership and focus groups of bio families, along with interviews of key stake holders such as County welfare representatives, Mental Health Providers, a Judge, visitation program coordinators, Domestic violence agencies. These are to be completed and coded by Rutgers for the July 2016 report.</p>
<p>NJ CAP: To train and educate parents and children on the</p>	<p># of trainings conducted according to identified</p>	<p>NJ CAP service needs changed in all counties due to the data provided in the four data points examined. The four data points utilized to determine the level of need in each county were: child abuse substantiation, student population (K-8),</p>

			<p>signs of abuse and neglect</p> <p>Utilize technology to determine greatest service need</p> <p>Continue CP&amp;P Statewide Needs Assessment</p> <p>Continue CP&amp;P Needs Assessment</p>	<p>services needs</p> <p>Complete written report on Needs Assessment</p> <p>Conduct Statewide survey on needs of children, youth and families involved with CP&amp;P</p>	<p>school violence, and child poverty. There were a total of 536 unduplicated schools trained. There were 101,900 unduplicated parents, school staff, students, and adults within the community trained.</p> <p>The Development of four Family Success Centers in specific counties, data mapping was used to determine service need by reviewing CWS referrals and poverty levels The RFPs were awarded for the following areas – Middlesex County, Monmouth County, Ocean County and Salem County.</p> <p>Working on finalizing internal report on qualitative findings related to the needs of children and families in NJ. Final report expected in March 2017.</p> <p>Surveys moved to Phase III of the needs assessment expected completion in June 2017.</p>
2-2	15-Jun	<b>Families will have access to evidence supported services to address their needs</b>	<p>Draft Evidence-Based/Evidence-Informed Blueprint for the Department</p>	<p>Identify guidance strategies on the selection, adoption, implementation, evaluation and</p>	<p>DCF will partner with a national implementation science consultant to assist NJ in drafting a blueprint. The consultant will assist DCF in engaging and gathering input from DCF’s EB Advisory group and identified providers with experience implementing EB programs in order to develop guidelines for the selection of EB/EI programs, quality implementation, evaluation, and quality improvement</p>

		<p>Apply implementation science-informed approach to identified programming including purchased CP&amp;P core services and one purchased prevention service.</p>	<p>quality improvement practices for evidence-based/evidence-informed programs</p> <p>Infuse evidence-based methods to support quality implementation and scaling up of evidence based/evidence informed programs into our service array.</p>	<p>practices. DCF anticipates the process of choosing the expert implementation science consultant will occur by December 2015 and the development of the blueprint will begin in spring/summer 2016.</p> <p>Keeping Families Together- During the time period of 10/1/15-9/30/16, DCF's OSD supported the launch of a recently awarded Keeping Families Together (KFT) program in Atlantic and Gloucester Counties and also released two additional RFP's for KFT programming in Hudson and Camden Counties, bringing the total number of families that KFT was able to serve to 73. During this time, OSD also worked closely with the DCF Office of Research, Evaluation, and Reporting (RER) to develop an internal evaluation plan for KFT. As part of this process, OSD developed local level logic models with existing KFT grantees and partnered with RER to create and train KFT grantees on a series of reporting tools including a baseline family survey and quarterly reporting template.</p> <p>Trauma Focused CBT – DCF's OSD released a RFP in April 2016 and made awards in August 2016 to two providers – one in Morris County and one in Somerset County. OSD partnered with the CARES Institute to offer training and consultation on TF-CBT to provider agencies. Providers began training in the model in November 2016</p> <p>Supportive Visitation Services – DCF's OSD released a RFP in October 2015 and made awards in January 2016 to one provider serving Morris/Sussex and Passaic Counties to provide families with supportive visitation services on a continuum from most restrictive (therapeutic) to least restrictive (unsupervised monitoring) based on assessment and visitation planning processes. OSD formed multiple Implementation Teams which included: an Operations Team</p>
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			<p>to focus on billing, referral and communication processes; a Model Design Team to focus on developing the innovative model by creating a logic model and a practice profile; and an Evaluation Team to develop an evaluation plan and reporting structure for this initiative. The two Supportive Visitation Services programs began gradually providing visitation services to families in August 2016.</p> <p>Family Preservation Services</p> <ul style="list-style-type: none"> <li>December 2015 – June 2016 DCF’s OSD initiated an assessment process to better understand the needs of FPS families and the current landscape of resources provided to them. The assessment started with a literature review, and then was extended to a review of quantitative (i.e. data from the agency’s SACWIS system and Annual Reports) and qualitative data (both from internal DCF interviews and survey, in addition to interviews with implementing FPS providers).</li> <li>In July 2016 DCF’s OSD released a formal Request for Information (RFI) aimed at gathering additional data from provider partners about alternative evidence supported FPS models and provider capacity to sustain implementation of the alternative models; with particular consideration given to the implementation supports providers would need for quality delivery of the service.</li> <li>During September 2016 DCF’s OSD continued the process of assessment by facilitating exploratory discussions about FPS with other States currently implementing similar FPS interventions and the national FPS Model Developer in Seattle, Washington.</li> </ul> <p>Family Success Centers- NJ DCF supports a network of over 50 FSC statewide. DCF’s OSD began work with NIRN to develop a FSC Practice Profile to identify and operationalize the practice of FSCs; the principles, essential functions, and activities of FSC practitioners. The FSC practice profile development is necessary so that DCF and internal/external technical assistance providers can provide the competency-</p>
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			<p>based supports needed for FSCs to fulfill their role effectively.</p> <p>The development of practice profiles requires a specific methodology, five interrelated steps in an iterative process: document review, semi-structured interviews, systematic scoping review, vetting and consensus building and usability testing. An intentional teaming structure was utilized to support the development of the practice profile. From October 2015-September 2016 the following progress was made for completing the FSC practice profile.</p> <p>Developed Linked Teaming Structure – A three tiered teaming structure was developed to include:</p> <ul style="list-style-type: none"> <li>• Leadership Team - shared in the responsibilities required to lead the development of a Practice Profile including but not limited to supporting the FSC Implementation Team. Leadership Team was comprised of members from DCF (i.e., Division of Family &amp; Community Partnerships (DFCP); Office of Research, Evaluation and Reporting (ORER), Office of Strategic Development (OSD)), Rutgers University Institute for Families, and NIRN implementation experts.</li> <li>• Implementation Team - provide the intensive support needed for the profile development. Implementation Team was comprised of members from the DCF State Leadership Team, FSC Directors, and NIRN implementation experts.</li> <li>• Stakeholder Team – share the responsibility of providing input and feedback on draft FSC practice profile. The stakeholder team was comprised of the FSC network.</li> </ul> <p>Completed FSC Document Review - NIRN reviewed 43 FSC documents submitted by DCF and Rutgers University. NIRN completed the document review in January 2016. Eight guiding principles and eight essential were identified through the document review.</p>
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		<p>Provide Technical Assistance to New Initiatives</p>	<p>Completed Semi-Structured Interviews - to gather feedback from the FSC network on the guiding principles and essential functions that emerged from the FSC document review, NIRN conducted semi-structured interviews with a subset of FSC sites and DCF Office of Family Support Services staff. This process was completed in July 2016. As a result of the semi-structured interviews slight revisions were made to the FSC guiding principles and essential functions.</p> <p>Worked on Systematic Scoping Review - reviewed published research that focused on community based, family-centered prevention strategies for child maltreatment. This process began in winter 2015 and remained in progress as of September 2016.</p> <p>Began Vetting and Consensus Process - NIRN completed the initial draft of the first FSC Practice Profile in August 2016. In September 2016 the implementation team began developing the plan for vetting the draft FSC practice profile with the Stakeholder Team (network of FSCs) to gather additional input and feedback on the draft practice profile and to build consensus for the development of the next iteration of the practice profile.</p> <p>Through the YARH Phase II implementation grant, DCF is providing technical assistance to new providers through the support of the Center for the Study of Social Policy (Youth Thrive) and Corporation for Supportive Housing (youth supportive housing.)</p> <p>Technical Assistance has been provided to Philadelphia, Arizona, North Carolina and Wisconsin by the Professional Center on their new initiatives for Transfer of Learning and Simulation learning experiences. The technical assistance has been in the form of visits to New Jersey for a hands on experience of our vision of Transfer of Learning as well as interventions that could assist in capitalizing on knowledge</p>
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					retention and new applied behaviors.								
2-3	14-Jun	<b>Children have family based settings that allows them to remain connected with their siblings in OOH placement</b>	Resource homes are available to serve larger sibling groups (SIBS homes).	Increase available homes for large sibling groups by 10%	As of September 30, 2016 there were 27 (5+) SIBS homes and 56 (4 capacity) SIBS homes. Data ending in February 2016 indicates that we have placed 43.5% of sibling groups of 4 or more together.								
				Children with 3 or more siblings able to be placed together is increased by 5%	Tracking of sibling groups of 3 began in October 2015. From October to December 2015, 54.4% of sibling groups of 3 children were placed together. Data ending as of February 2016 indicates that 59.5% of sibling groups of 3 children were placed together. Sibling group sizes of 3 or more siblings increased by 4% between CY2015 and CY2016 resulting in a slight decrease in placing these sibling groups together.								
			Siblings place apart have regular contact with one another.	Increase sibling visitation by 5%	DCF made tremendous progress in ensuring that siblings placed apart have contact with one another. Performance in this area improved by 8% between FFY 2013 ad FFY 2014.  Performance in Sibling visits between FFY2015 and FFY 2016 remained steady. However, DCF saw a 1% increase when comparing September 15 to September 16								
		Continue to increase kinship placements	Increase kinship placements in target counties by 5%	9 out of 21 counties increased kinship placements by 5%. The increase ranged between 5% and 20%	<table border="0"> <tr> <td>Camden County</td> <td>14%</td> </tr> <tr> <td>Cape May County</td> <td>20%</td> </tr> <tr> <td>Cumberland County</td> <td>10%</td> </tr> <tr> <td>Gloucester County</td> <td>7%</td> </tr> </table>	Camden County	14%	Cape May County	20%	Cumberland County	10%	Gloucester County	7%
Camden County	14%												
Cape May County	20%												
Cumberland County	10%												
Gloucester County	7%												

			<p>Continue to reduce shelter placements for older youth</p>	<p>Reduction in shelter placement in target counties by 3%</p>	<table data-bbox="1150 198 1811 695"> <tr> <td>Hunterdon County</td> <td>5%</td> </tr> <tr> <td>Middlesex County</td> <td>6%</td> </tr> <tr> <td>Ocean County</td> <td>8%</td> </tr> <tr> <td>Passaic County</td> <td>6%</td> </tr> <tr> <td>Salem County</td> <td>13%</td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td colspan="2">4 counties were able to decrease their shelter placements by 3%.</td> </tr> <tr> <td colspan="2">The decrease in shelter placements ranged between 6% and 10%</td> </tr> <tr> <td>Cape May County</td> <td>-5.6%</td> </tr> <tr> <td>Morris County</td> <td>-6.5%</td> </tr> <tr> <td>Salem County</td> <td>-7.7%</td> </tr> <tr> <td>Warren County</td> <td>-9.7%</td> </tr> </table>	Hunterdon County	5%	Middlesex County	6%	Ocean County	8%	Passaic County	6%	Salem County	13%			4 counties were able to decrease their shelter placements by 3%.		The decrease in shelter placements ranged between 6% and 10%		Cape May County	-5.6%	Morris County	-6.5%	Salem County	-7.7%	Warren County	-9.7%
Hunterdon County	5%																												
Middlesex County	6%																												
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**Core Strategy 3 – Organizational Development**

Organizational development builds on the accomplishments made in training and development of its workforce; coupled with the increased availability of access to the tools necessary for staff to effectively and efficiently work with the children, youth and families we serve. This Core Strategy also includes steps to strengthen the technology available to staff to effectively and efficiently work with children, youth and families. The strengthening of the organization helps staff accomplish the broader positive outcomes for those it serves.

Line #	Date Added	5 Year Intent	Year 3 Action Plan 10/1/15-9/30/16	Measures	Results (date)
		<b>Families benefit from well trained staff who are competent in their ability to engage and team with families.</b>	Maintain support for certificate programs in specialty areas like domestic violence, managing by data, adolescent services	Percentage of staff completing the program (total completion/total enrolled)	There were 43 participants enrolled in the 2015-2016 Manage by Data Fellows cohort, of which 40 completed.  Post BA in Adolescent Advocacy Certificate Program 2015-2016 school year 27 out of 32 students completed the program.
			Domestic Violence (VAWC) Training: DCF staff are educate on the culture, how to deal with domestic violence and the understanding of domestic violence. Employees receive a certificate upon completion	Domestic Violence (VAWC) Training: Percentage of staff completing the program (total completion/total enrolled)	Domestic Violence (VAWC) Training: During the VAWC Program (Sept. 2015 to June 2016), There were 53 graduates that completed the program in this year’s cohort. 12 of the graduates were from the previous cohorts. No one withdrew from the program and there were 9 students that did not complete the required workshops.

			<p>David Mandell Training: Provides training for CP&amp;P staff on the Safe and Together Model. This model focuses on interventions with the perpetrator in the child welfare arena. Training will take place in June 2016.</p>	<p>David Mandell: Percentage of staff completing the program (total completion/total enrolled)</p>	<p>David Mandell Training: Overview and Skill Building Training occurred in June 2016, various CP&amp;P staff, contracted and non-contracted staff and court staff were trained. There were a total of 99 registered participants that attending the training on June 28th and June 29th 2016.</p>
			<p>DVL Training: DVLs are required to provide four DV related trainings to CP&amp;P staff in the local office per contract year.</p>	<p>DVL: Total Number of CP&amp;P staff trained in the Los</p>	<p>The DVL's provided 68 trainings to an audience of 1549 CP &amp;P staff.</p>
			<p>Provide SF Protective Factors Training- Improving Outcomes for families with Young Children ages Birth to Age 5 through Protective Factors training FCP to strengthen families in special needs</p>	<p>SF Protective Factors- Provide training in the SF Protective Factors Framework to (CP&amp;P staff and community partners) in 2 target counties—120 attendees in Cumberland</p>	<p>The trainings occurred as scheduled and provided Essex additional trainings which doubled the anticipated number of participants.</p>

	<p>County (Jan/Feb 2016); and an additional 150 attendees in Essex County (Feb/Mar 2016)</p> <ul style="list-style-type: none"><li>• Hire an additional ECS staff person to serve as the Cumberland County EC Liaison— pending by 9/30/16</li><li>• Initiate weekly case conferences in Cumberland County that include FCP-ECS and community partner participation-- pending by 9/30/16</li><li>• Establish the EC referral process and begin implementation in Cumberland pending by 9/30/16</li></ul>	<p>This did not occur as initially planned. A series of interviews did occur, and which produced one viable candidate. Unfortunately, it did not work out.</p> <p>Biweekly case conferencing is happening in Cumberland County, and includes participation from the Central Intake Liaison from the County Hub.</p> <p>The referral process includes referring through the local Central Intake Hub and that is occurring since the Central Intake Liaison is attending the biweekly conferencing.</p>
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3-1	14-Jun		Use educational incentive programs to recruit and retain social workers into the agency (BCWEP, MCWEP)	<p>Increase MCWEP program to 5 cohorts/90 students</p> <p>Percentage of staff still employed 2 years post program (total retained/total graduated)</p>	<p>MCWEP: Cohort 5: 19 will began in September 2016.</p> <p>We currently have 21 graduates that have been employed 2 years post-graduation.</p>
3-2	15-Jun	Align staff training to critical or emerging areas of practice	<p>Complete a formalized curriculum of Medicaid training to all CP&amp;P LO Medicaid staff</p> <p>Develop and provide forums for ongoing Medicaid technical</p>	<p># of trainings held – yearly # of staff (per LO) attending Medicaid training; training attendance corresponds to Medicaid security designation</p>	<p>Medicaid Training &amp; Technical Assistance Training is provided annually to all LO staff with designation of “Medicaid Liaison”; in October 2015, OCS provided LO “ML”s 4 opportunities to attend a training session - of the 91 “ML”s identified at the time, 87 attended</p> <p>OCFH maintains and periodically updates various Medicaid-related resources on the DCF intranet: Contact information for OCS, NJ FamilyCare local offices &amp; HMOs, dental resources, and DCF-contracted nurses;</p>

			<p>assistance</p>		<p>Information about Medicaid programs for children not in placement, parents, undocumented clients Information about the Medicaid Extension (MEYA) as part of the Affordable Care Act.</p>
			<p>Partner with DHS to expand Medicaid knowledge within DCF</p>	<p># of DHS-sponsored trainings attended by DCF staff</p>	<p>1 OCFH Leadership staff member participated in NJ Medicaid Academy (Jun-Dec 2016), a professional development and leadership program for selected state managers across the New Jersey Department of Human Services, Department of Health and the Department of Children and Families, designed to strengthen both the Medicaid expertise and leadership capacity of NJ managers so they can be the foundation for meeting the many potential challenges faced by the State's Medicaid program. This knowledge has been used to enhance current training topics and guidance. In addition, OCFH leadership staff has built professional relationships with the Medicaid units and improved partnership with families that have dual involvement.</p>
			<p>Complete Case Plan Transfer of Learning (TOL) training to expand to all CP&amp;P Local Offices</p>	<p>All 46 Local offices will have completed TOL training</p>	<p>As of April 2016, all 46 Local Offices have completed the Case Plan Transfer of Learning Training.</p> <p>There are currently multiple initiatives underway through the Office of Training and Professional Development and University Partnership to increase understanding of Knowledge Transfer and Transfer of Learning and applied new behaviors and practices.</p> <p>Phase 1 of the Case Work Supervisor Project was completed in late 2016 . This is a two year initiative that is supported by Casey Family Programs. Through this project the Case Work Supervisor will experiences blended learning experiences that will expose them to core competencies that make an effective leader. The Program is designed to ensure they have an understanding of elements to take the retained knowledge and develop new behaviors and</p>

			practices, which directly correlates to Transfer of Learning.
			Phase 1 of the Local Office Manager Initiative project was completed. Transfer of Learning and applied behavioral learning sessions, will expose the Local Office Mangers to specific models and theories on coaching and providing feedback to those they lead to ensure either a reinforcement and increase in a talents use of a specific behavior that will effect outcomes for children, families and the organization or to provide the strategic behavior specific feedback that will assist talent in extinguishing a behavior and replacing it with a desired behavior that will be internalized and maintained over time.
	Technical improvements to training website to display test data	Supervisors will be able to readily view test performance of their workers.	Additional improvements have been made to ensure timely viewing of grades by supervisors for class participants. All Pre-service and Office of Training and Professional Development facilitated classes are uploaded on to TAWS for supervisors view. Training on how to access the grades was provided at the Field Training Unit Supervisor’s Meeting, Assistant Area Director’s Meeting and the Area Director’s Meeting. 175 supervisors were trained and can also provide assistance to other supervisors. An additional note: The University partnership classes are sent to supervisors in the monthly grade report.
	“Boot camp” training to be provided to all training staff on NJ SPIRIT functions including safety assessment	Training staff will fully understand how to integrate the NJSPIRIT actions into regular classroom training so that training emulates the	In 2016, the University Partnership Trainers were provided and overview of Safe Measures. Office of Training and Professional Development staff were all formally presented Safe-Measures in 2015. Our University Partnership presented all new contractors Safe-Measures in 2016.

			Launch of the Youth Thrive training	<p>mixture of activities (meeting with families, conferencing with supervisors, writing up for NJSPIRIT) that occur.</p> <p>CP&amp;P staff and contracted providers serving adolescent population will be afforded the opportunity to participate in the new Youth Thrive training/number of participants trained</p>	<p>The training launched in May 2016 and trained over 500 professionals including both DCF staff and contracted providers.</p>
3-3	14-Jun	<b>Provide enhancements to technology to improve workflow for staff and transparency to ensure staff are prepared</b>	Continue NJ SPIRIT releases as scheduled	Release schedule followed	<p>Releases are more structured and routine as NJ SPIRIT has moved to a more systematic release schedule. The priority of releases has gone from a reactive mode (i.e. fixing bugs and "putting out fires") to a proactive mode (i.e. developing functionality to meet our changing business practice and federal requirements).</p> <p>Release 5.6 (November 2015) – 62 incidents</p>

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The State made numerous modifications and enhancements within Release 5.6. Some major objectives are detailed below:

Development of a new Approval Reroute Window - This useful tool offers Supervisors the flexibility to reroute one or more pieces of pending work from a worker to another worker within their unit. In addition, Case Work Supervisors and above now have the capability to reroute pending work items from one worker to any other worker within their office.

A new Missing Person Form (CP&P 2-3) is now available in the Create Casework>Forms section of NJS. Workers use this form to compile all information needed to better assist law enforcement and the National Center for Missing and Exploited Children in locating missing youth.

Enhancement to allow IAIU to move a completed and/or pending Investigation (and the intake linked to the investigation) from one Resource record to another Resource record if the Intake was linked to an incorrect Resource record.

AFCARS - Modification to Elements 23 and 24 to compensate for the Contract Home Conversion project.

Six incidents were NYTD related:

- Recreate NYTD\_REPORT\_PERIOD table with normal columns.
- NYTD submission file changes
- NYTD online changes
- NYTD - create an alert for partial interface failures
- Modify cycle 108 to include all 3 NYTD nightly interfaces
- NYTD - changes to NYTD J batch (served population), baseline and tickler batches

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Automate the parameter setting process for FFP and IVE reimbursement batches.

Create a new 'Corrective Action' area to track and maintain information on corrective action recommendations and follow up completed by IAIU.

Add 2 new 'demographic/legal characteristic' reference values to the 'matching tool' tab in the Maintain Resource section.

Enhance the 'Adoption Planning' window outcome tab, to make the "Consent of and Date signed' a required field when staff try to close the adoption planning window with the reason Adoption Finalized.

Create a new exception to the "Person Merge" online window. Add new validation check to see if the 'Remove' person has an open DCP&P Medicaid, and the 'Keep' person also has an open DCP&P Medicaid. If true, prevent Person Merge online in NJ SPIRIT.

Modify select investigations DCP&P forms to include a new subsection, FAQs.

Develop an exception to prevent the ability to create a new Adoption Planning record when one is already in open status for the client under the same case.

Enhance Trust Account module to allow the transaction date to default to the system date and require that the transaction date is not editable. This requirement complies with Federal Regulations.

Give specified adoption security group the ability to correct an adoption finalization date online in NJS.

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(AFCARS PIP)(CODE)- When runaway is the living arrangement at the end of the report period, it must be excluded from the placement count.

Release 5.7 (June 2016) – 105 incidents

The State made numerous modifications and enhancements within Release 5.7. Some major objectives are detailed below:

The NJ SPIRIT Independent Living Stipend Payment was enhanced to become more automated and efficient. The Independent Living Stipend Payment Requests for youth ages 16-21, now receive their Independent Living Stipend on a reloadable debit card, called the Q Card. After the first payment, youth may switch to direct deposit.

Improved Case Plan functionality intended to be both family and worker friendly:

- Elimination of the 26-81b (modified case plan), as part of the effort to restructure and streamline the case planning process.
- A redesigned Family Summary window to effectively capture case progress and reflect the most up-to-date practice.
- Creation of three new targeted family agreements as standalone forms that encompass various aspects of the family engagement.
  - o The (26-25a/b) – Used to document family agreements developed during a Family Team Meeting (FTM).
  - o The (26-26a/b) – Used to document family agreements outside the FTM.
  - o The (26-24) – Used to document family agreements developed during the investigation/assessment.

A NEW Interstate Compact for the Placement of Children

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(ICPC) module was added to NJ SPIRIT. This new feature was designed to better assist Interstate staff in documenting and tracking ICPC requests and child placement information in NJ SPIRIT. Two windows make up the ICPC module; the Placement Request (100A) and the Report on Placement Status (100B). Both windows contain data prefilled from NJ SPIRIT, as well as many user enterable fields which will allow for the entry of additional child/case related details.

Functionality was added to NJ SPIRIT which gives Child Health Unit Staff the ability to attach scanned documents to the Medical Mental Health Window.

NJ SPIRIT was enhanced to give Local Office Merge Liaisons the ability to view Person Merge denial reasons via the Person Merge Delete window.

Several NJ SPIRIT windows were enhanced to display the contracted agency name along with its corresponding resource.

NJ SPIRIT was enhanced to automatically generate email notifications to Primary Case Workers when a Case Participant Removal request is submitted on any of their assigned cases in NJ SPIRIT.

Functionality was added to NJ SPIRIT to accommodate circumstances where a KLG is vacated and workers need to reopen a participant, or a Teen Mom Spin-off Case is required.

New KLG Vacated and Teen Mom values will be available for selection in the following windows of NJS:

- Legal Action/Legal Status
- Placement/Service Ending
- Participant Status

3-4	14-Jun			<ul style="list-style-type: none"> <li>Case Closure</li> </ul> <p>Functionality was added to NJ SPIRIT that gives SCR screeners the ability to capture Human Trafficking information and Special Instructions in NJS.</p> <p>To better assist staff with the intake and investigation process, an Allegation Description window was added to NJ SPIRIT. This window displays Allegation Based System indicators and descriptions of abuse and neglect.</p> <p>New values were added to the contact activity note section to better support Family Team Meeting (FTM) documentation and reporting:</p> <ul style="list-style-type: none"> <li>FTM Declined – Supervisory Review</li> <li>Family Team Meeting Declined</li> </ul> <p>NCANDS – Recompile batch to incorporate new fields added to the Intake as a result of Human Trafficking enhancement.</p> <p>Upgrade NJSPIRIT from WebSphere Application Server (WAS) 7.0 to 8.5</p>
		Create new IL Stipend Request window in NJS	Launch of new window in NJS	The new NJ window for the IL Stipend launched in May 2016.
		Provide access to tools to enhance knowledge and skill	CP&P policies are available on DCF internet page	Policies continue to be available to both internal staff and external stakeholders

3-5	15-Jun		Continue to support the Use of Safe Measure	Maintain or increase the number of staff using Safe Measures to monitor workload and performance	Overall, DCF has increased the number of staff using SafeMeasures in 2016 by 11%. The highest percentage of this increase was amongst caseworkers at 14%, followed by Office Managers at 5% and supervisors at 3%.
	15-Jun		Deploy new screens for tracking performance based on organizational need	Screen shots of new screens	<p>In 2015, new screens continued to be developed to meet the needs of the users. Existing screens also continue to be enhanced.</p> <p>Updated Initial FTM within 45 days            FTMs in First Year of Removal screen            FTMs in Subsequent years of Removal-Goal of Reunification            FTMs in Subsequent years of Removal- non reunification goal            Resource caseloads            Resource Home licensing            Transitional Plans prior to closing cases</p>
	15-Jun		Train CQI staff on access and use of longitudinal data	Number of people trained, topics covered with access to local data	<p>On June 6, 2014, DCF and Hornby Zeller Associates conducted training for county staff that included use of statewide, county wide and local office aggregate data as well as case level data outcomes. As of Dec 2016, DCF has given access to more than 200 staff from different counties to statewide and county level data as well as local office data.</p> <p>In March 2016, the OCFH partnered with RER to compare</p>
			Increase access to county and case level outcome data		

		Use available and accessible systems (NJS, SM) to accurately track and report on psychotropic medication use by children in out-of-home placement and compliance with best practice standards	OCFH to partner with RER to develop an electronic psychotropic medication report	<p>NJS data against manual tracking processes to confirm that relevant and necessary data is being captured accurately in NJSPIRIT. The Year 3 monitoring period, is the testing phase for the electronic system.</p> <p>The OCFH anticipates that an automated report will be implemented for monitoring psychotropic medication monitoring in FFY 18.</p>
3-6	15-Jun	Continue technical assistance (TA) to further development of the information and data associated with the Systemic Factors	<p>Employ monthly phone calls with CB Regional Office support</p> <p>Monthly OPMA/CP&amp;P Collaboration Meetings</p>	<p>DCF OPMA management engaged in monthly calls with the CB regional office to ascertain assistance to enhance knowledge and skill set needed to develop compliance for Systemic Factors associated with the CFSR. DCF held statewide CFSR Kickoff with DCF Stakeholders in July 2016.</p> <p>OPMA/CP&amp;P Collaboration meetings were conducted at least monthly to share information and strategies with a focus on outcome data for CFSR results.</p>

<b>Core Strategy 4 – Continuous Quality Improvement</b>					
<p>Continuous Quality Improvement (CQI) at the Department includes the development of a fully functioning and sustainable system that has the organizational structure to support high quality data collection including case record review processes, data analysis, with stakeholder feedback processes as well as ways for public dissemination of information. Many of the component parts are present and with some refinements will form the basis for the CQI system.</p>					
Line #	Date Added	5 Year Intent	Year 3 Action Plan 10/1/15-9/30/16	Measures	Results (date)
4-1	14-Jun	<p><b>Develop a robust and fully functioning CQI system</b></p>	<p>Gather understanding about current status of CQI activities</p>	<p>Update accounting of CQI activities statewide</p>	<p>In 2015, NJ DCF implemented a CQI Review process that included the development of a CQI Workgroup. This group completed a review of NJ DCF’s existing CQI processes, identified strengths and areas of improvement and developed recommendations to inform the development of an enhanced CQI plan.</p> <p>NJ DCF has adopted a CQI approach that is rooted in a scientific reasoning framework. The framework is being integrated in various CQI processes and information regarding the framework has been posted on DCF’s website. DCF developed a CQI logo and branding strategy to support the integration of the framework.  <a href="http://www.nj.gov/dcf/about/divisions/opma/CQI%20framework.pdf">http://www.nj.gov/dcf/about/divisions/opma/CQI%20framework.pdf</a></p> <p>The finalized CQI Plan is scheduled to be published on DCF website and distributed to all CP&amp;P Areas in 2017</p>
			<p>Identify core components of CQI Framework</p>	<p>Publish CQI Framework and Expectations</p>	
			<p>Finalize Statewide CQI Plan</p>	<p>CQI Plan published on DCF website and distributed to all CP&amp;P Areas</p>	

<p>Build capacity of PMA staff to support CQI activities</p>	<p>DCF hired additional staff in the Office of Quality</p> <p>Outlined CQI designated roles</p>	<p>In 2015, DCF hired 9 QR Team Leads to enhance the Office of Quality’s capacity to provide program improvement technical assistance. In 2016, DCF hired a Director and Assistant Director of the Office of Quality to lead the development and implementation of the CQI system.</p> <p>See CQI link: <a href="http://www.nj.gov/dcf/about/divisions/opma/cqi.html">http://www.nj.gov/dcf/about/divisions/opma/cqi.html</a></p> <p>On July 28, 2016 there was a one day in-house CQI training conducted by Charyl Yarbrough, PHD, Assistant Director, RER. The training provided an overview of CQI; definition, goals and principals. The training also outlined NJ’s CQI framework focusing on identifying the problem and theory of change. The purpose of the training was to provide guidance for enhanced technical assistance in program improvement development. The training was informed by NJ’s CQI plan and the Children’s Bureau five foundational components of CQI and based on the work of Casey Family Programs and the National Child Welfare Center for Organizational Improvement.</p>
<p>Review and approve Draft CQI policies</p>	<p>Developed and implemented CQI training for staff designated CQI roles</p> <p>Implement the CQI State CQI steering to lead the development and monitoring of DCF CQI policy</p>	<p>The CQI State CQI steering committee formed. The Committee completed a review of historical CQI policies and is in the process of drafting a formal CQI policy and an administrative order. The committee finalized the formal CQI communication plan which outlines strategies to systematically share relevant and timely information, ensure information reaches key audiences and elicit feedback and recommendations from staff and stakeholders. The plan also highlights the existing designated CQI roles to support communication and information sharing across all levels of staff. The CQI communication plan is available to all staff and is posted on the DCF intranet.</p>

4-2	15-Jun			
			Initiate draft CQI training	Target training for FCP/DOW
				Capacity building and CQI trainings have been offered to all current FCP and DOW staff. New staff members, or staff members who wish to review training topics, are offered training as needed. Additional training topics will be identified and established as needed or as requested by FCP/DOW staff.
4-3	14-Jun			
			Operate a quality data collection process	Pilot accountability/quality control after a targeted review and follow next steps
				<p>DCF utilizes various proactive, systematic processes to address data quality. DCF has staff positions dedicated to ensuring data quality. AFCAR and NCANDS Coordinators are data analysts that review ongoing periodic reports designed to monitor timely entry and compliance of data. The coordinators then work directly with the Area Quality Coordinators to improve the accuracy of this data, as applicable. The coordinators provide training as needed for new system functionality and for ongoing data quality improvement initiatives.</p> <p>Data from New Jersey Spirit is transformed through the SafeMeasures (SM) software application into a reporting system available as a case management tool. SM is available to frontline caseworkers, supervisors, and managers throughout the agency and assist with ensuring data quality. SM contains over 100 screens with child level data and is used to guide workflow, track timely data entry, verify data quality and measure performance. Staff can utilize SM to ensure case level data is accurate and report discrepancies to supervisors and</p>

4-4	14-Jun		<p>Initiate process to build additional controls around data collection</p> <p>Continue work on the AFCARS PIP</p>	<p>Continue work of AFCARS PIP-enhancements during year 3 period</p>	<p>the NJ Spirit Help Desk.</p> <p>The Office of Information and Technology (IT) staffs the NJSPIRIT Help Desk to address any technical issues related to the used of NJSPIRIT. Data quality is supported by this process, when an IT staff member identifies patters in user concerns; the staff member submits an incident report in the IT incident tracker to initiate the formal processes for addressing concerns. Once an official incident is created, an IT staff member is assigned to explore the problem and propose viable solutions. If changes are made, IT provides an update to staff throughout the Department.</p> <p>DCF also uses SafeMeasures to extract and aggregate data from NJSPIRIT so that front end users can track progress on cases. There is functionality within the system to monitor the work flow of staff. The systems supports data quality by giving staff automated prompts to promote consistent data entry.</p> <p>AIP incident resolved during the 10/1/15-9/30/16:</p> <p>NJS Release 5.8 resolved incident 24119: AFCARS Element 66 - Modify the code to include only room and board for the last full month of placement. Incident resolved 7/13/16.</p>
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4-5	14-Jun	Operate a case record review process	# QRs completed 2016	<p>The QR process and protocol was revised for January 2016. The purpose of these revisions to the protocol was to simplify and clarify the language used and integrate these elements into case practice. QRs are conducted in all of New Jersey's twenty-one (21) counties over a two year period. Starting in 2016, ten counties were reviewed; the eleven subsequent counties will be reviewed in 2017, with this pattern remaining the same over subsequent years. Each review will include a minimum of 10 cases and a maximum of 30 cases depending on the percentage of children and youth served in the county under review. This is a change from previous years when each county had the same number of cases reviewed despite differences in population served. Three lists will be generated for the county under review determined by the office size. The sample will consist of Placement, or "out-of-home" (OOH) (Age 0-17) cases; In-Home (INH) (Age 0-17) cases; and Adolescent (ADO) (Age 18-21) cases.</p>
		Continue implementation of the QR process and made modifications as needed	Annual summary report published	<p>It was determined that the annual report will become part of a larger DCF report "Our Work with Children, Youth &amp; Families" which is expected to be published in 2017.</p>
		Complete targeted reviews on the quality of investigations as well as the quality of services to older adolescents for 2016	Results of the reviews and recommendation follow up	<p>In September 2016, a targeted quality review of CP&amp;P's investigative practice was conducted. Reviewers examined the quality of practice of 327 randomly selected CPS investigations assigned to DCF Local Offices between February 1 and February 14, 2016 involving 497 alleged child victims. Overall, reviewers found that 271 (83%) of the investigations were of acceptable quality. Although close, DCF did not meet the SEP performance standard for this measure.</p> <p>The findings from the September 2016 review reflect some</p>

clear strengths in CP&P investigative case practice, as well as areas in need of further development. Key strengths include:

- Caseworkers interviewed the mother of the alleged child victim in 98 percent of the investigations;
- Caseworkers interviewed the father of the alleged child victim in 82 percent of the investigations;
- Pre and post-investigation worker/supervisor conferences took place in 98 percent of the investigations and
- Eighty-seven percent of pre-investigation conferences were found to be of acceptable quality; 82 percent of post-investigation conferences were found to be of acceptable quality.

The September 2016 review also found that an area in need of improvement in CP&P's investigative practice includes securing and integrating significant collateral information into investigative decision making. Reviewers determined that all applicable collateral information was integrated into decision making in 76 percent of investigations.

Overall, recommendations for improvement include: continued training and coaching of staff and supervisors on areas of investigative practice; complete documentation of investigative activities and events and use of statewide presentations; and specialized workshops focused on quality improvements.

In August 2016, a targeted case record review of the 66 youth who exited care without achieving permanency between July and December 2016; this measure was applicable to 59 youth. Forty-nine youth had documentation of a housing plan upon exiting CP&P care, and in an additional seven cases, there was documentation of consistent efforts by the caseworker to help the youth secure housing. Overall, there was compliance with this measure in 56 (95%) of cases. DCF has met the performance level required by the SEP for the first time this monitoring period.

				<p>The August 2016 review also found that 49 youth from 59 applicable cases were either employed or enrolled in education or vocational training programs, and there was documentation of consistent efforts by the caseworker to help the youth secure education or employment in an additional seven cases. Overall, there was compliance with this measure in 53 (90%) cases. DCF has now met the SEP performance standard.</p> <p>DCF will include the findings from the Investigative Case Practice Review, and Older Youth 18 – 21 Case Review in its Our Work with Children and Families report to be released in 2017.</p>	
4-6	14-Jun				
4-7	14-Jun		<p>Provide data reports on key agency performance indicators to the public</p>	<p># of reports posted publically</p>	<p>DCF Adoption report-Annual          Commissioner Monthly report          Investigations report-Monthly          Children's Inter Agency Coordinating Council (CIACC)-Monthly          Demographics report- Quarterly          Governor's Transparency Report- Quarterly          Abuse/Neglect Report-Annual          Needs Assessment-Annual          QR report- Annual          Fatality Report-Annual          Educational Stability-Bi-Annual          Child Welfare Hub-Annual          Safe Haven Report-Annual</p>
4-8	14-Jun				
			<p>Integrate feedback from stakeholders into processes and systems</p>	<p>Review of PIP participants and PIPs for statewide</p>	<p>The statewide PIP themes identified and the respective strategies employed during this monitoring period:</p> <p>Engagement - Some Area and Local offices working to increase</p>

4-9	15-Jun		<p>Counties with QRs during period have completed Program Improvement Plans from a systems perspective with input from stakeholders</p>	<p>themes</p>	<p>utilization of genograms and Eco maps during the initial intake and FTM process. In situations, with difficult to engage parents, some areas will require engagement attempts by supervisory staff, FTM coaches, and FTM Master Coaches. CP&amp;P is developing training with Robin’s Nest, which teaches staff “How to speak to children about the trauma of removal”. CP&amp;P is the preliminary stages of creating a Memorandum of Agreement with DOC, to establish and foster a relationship between DOC social workers and CP&amp;P staff, to ultimately increase CP&amp;P engagement with incarcerated parents.</p> <p>Teaming – Some Area and Local Offices have utilized support staff (i.e. FTM coordinator, CPS) to track and monitor different teaming activities. Telephone conferences will be utilized in between FTM meetings. This encouraged cohesive communication and collaboration.</p> <p>Assessment - Earlier and more frequent collaboration with Clinical Consultant, CADC’s and resource workers to obtain a comprehensive multi- disciplined perspective of the family. In addition, during the 1st MVR permanency workers will conduct FTM prep work to obtain the family’s complete story and supports.</p> <p>Case Planning - The completion of the case plan will be done according to policy with evidence of case plan being a living document. Evidence of planning will be reflected in the dialogue with families and community partners.</p>
			<p>PMA will provide technical assistance with CPP and onsite assistance with PIP development ion and monitoring</p>	<p>PIP’s will be updated as needed and that the improvement practices identified are attainable and measurable.</p>	<p>OPMA staff are more closely involved in assuring PIP’s are updated as needed and that the improvement practices identified are attainable and measurable.</p> <p>OPMA staff provide TA as well as onsite assistance as needed. The Area Data Meetings are now referred to as Area Data Stories and are presented in conjunction with the QR results to provide a more comprehensive identification of areas of case practice strengths and challenges. Separate data stories are</p>

			<p>Conduct QR Summit will be held to review the QR data from the previous year, discuss opportunities for improvement to the QR process, and to set improvement goals for the QR process.</p>	<p>Was the summit held</p>	<p>held for leadership and each office in the county. The data story is a presentation to Area Leadership and Local Office staff. The data story, presented by the Office of Quality staff, combines QR results with quantitative data including longitudinal data, Key performance indicators (KPI) and case practice performance trends to link quantity and quality measures. The data story explains the results of the QR and incorporates other data to provide a holistic “story” of the quality, performance and outcomes measures. The data presentation is combined with case examples, or the story behind the data, to reinforce the connection between data indicators and case practice. The data story allows for a question and answer period to ensure staff has an understanding of the data presented. The data story is the start of the QR PIP process and ensures decisions about the PIP are not based solely on the results of the QR. The Data Story also provides an initial opportunity for the local offices to provide insight into the root causes of identified problems.</p> <p>The QR summit did not occur during the Year 3. Office of Quality implemented a new QR protocol in CY2016, and wanted to have the QR Summit after a year of implementation. Toward the end of 2016, we realized that we wanted to expand the QR Summit by making it a CQI Summit. It was decided that to hold the annual Summit toward the end of the year. So the Office of Quality that would implement any changes for the new year.</p>
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**Core Strategy 5 – Strengthening and Enhancing Partnerships**

DCF is committed to the process of collaboration with stakeholders and community partners to improve outcomes for those we serve. Accountability and transparency are two key components to enhancing partnerships. Additionally, partnership must reflect the voices and input of those served by the system. Formal systems of data collection and information gathering from stakeholders and partners must be in place and leveraged in decision-making and planning for true systems change.

Line #	Date Added	5 Year Intent	Year 3 Action Plan 10/1/15-9/30/16	Measures	Results (date)
5-1	14-Jun	<b>Partnerships are strengthened through transparency</b>			
5-2	14-Jun		Make data reports available to the public through the DCF webpage	CIACC reports and Data Dashboard are available monthly on the DCF website  Continue to post data to the Governor's Transparency Website	Continue to publish monthly CIACC: <a href="http://www.nj.gov/dcf/childdata/interagency/">http://www.nj.gov/dcf/childdata/interagency/</a> Commissioner's Monthly Report: <a href="http://www.nj.gov/dcf/childdata/continuous/">http://www.nj.gov/dcf/childdata/continuous/</a>  Continue to publish quarterly Governor's Transparency Website: <a href="http://nj.gov/transparency/performance/dcf/">http://nj.gov/transparency/performance/dcf/</a>  DCF has a number of data reports —listed in Line # 4-7—, on agency key performance indicators that are available to the public. In addition to the reports, the New Jersey Child Welfare Data Portal, developed collaboratively between DCF and the Rutgers University Institute for Families, allows the publics to

				retrieve child welfare data in a new way. Built upon the principals of transparency and accountability, the Data Portal allows users to explore key indication of child well-being through customizable visualization and query tools. After selecting a measure, users can select variables to gain further insight into a report. In addition, users can selectively filter the variables, retrieving data in exactly the way they need.
5-3	14-Jun	Partner with entities in the research committee to disseminate knowledge	# of research projects approved	<p>The following are the 13 Research Projects approved between 10/1/15 and 9/30/16:</p> <ul style="list-style-type: none"> <li>- Mother and Infant Childhood Home Visiting Program Evaluation (MIHOPE)</li> <li>- Home visitation enhancing linkages project (HELP): Enhancing evidence based home visitation to address substance abuse, mental health and DV.</li> <li>- The Assessment of Parent Linking Programs Project</li> <li>- NJ Project LAUNCH</li> <li>- NJ Home Visiting Local Program Evaluation</li> <li>- Evaluation of a Human Trafficking Prevention Program: The Empowering Young Men to End Sexual Exploitation Curriculum</li> <li>- Child and Family Nurse Program Evaluation</li> <li>- Evaluation of a Service Provision Program for Victims of Sex Trafficking</li> <li>- Quick Cents for Youth</li> <li>- Batterers' Intervention Program Evaluation</li> <li>- Improving Outcomes for Families of Infants and Young Children in Newark, NJ: Integrating Best Practices of Child Protection and Early Childhood</li> <li>- Domestic Violence Liaison Program Evaluation</li> <li>- National Quality Improvement Center for Adoption and Guardianship Supports and Preservation (QIC-AG)</li> </ul>
			Evaluation of the CFN Pilot by JHU will be approved as a	DCF/DCP&P has partnered with Johns Hopkins University (JHU) to develop an evaluation plan for the Child/Family Nursing Initiative currently being piloted in 3 Counties of CP&P supervision, as part of the ongoing partnership with Rutgers

			<p>research project by DCF</p> <p>JHU will provide a comprehensive outcomes-based evaluation of the CFN Pilot so as to inform program practices and improve resources for CP&amp;P.</p> <p>OCFH - Evaluation actions will begin</p> <p>Interim results will be drafted and reviewed as part of a team process</p>	<p>University FXB-School of Nursing.</p> <p>On September 1, 2016, the primary data collection for the Comprehensive Outcomes-Based Evaluation began.</p> <p>JHU did not submit the interim report within the Year 3 time frames; however, OCFH did meet regularly with JHU throughout Year 3 to monitor status and progress of the evaluation efforts and to provide guidance around CP&amp;P and Child/Family nursing practice to determine outcome measures.</p>	
5-4					
5-5	15-Jun	<p><b>Youth perspective is incorporated into the DCF system</b></p>	<p>Create a policy to provide and ensure a safe, healthy, and inclusive environment for all the youth and families we serve, including LGBTQI</p>	<p>LGBTQI Policy to be published as well as accessible in policy manuals for DCF staff and external stakeholders</p>	<p>The LGBTQI policy was published in August 2016 in the DCF policy manuals.</p>

			<p>youth and families NJ Statewide Youth Advisory Boards (YABs) present concerns and recommendations to DCF twice per year.</p> <p>DCF reports back to YABs on progress twice per year.</p>		
			<p>DCF to update policy, practice, programming where appropriate in response to the YABs</p> <p>Publish policy/practice change</p>		<p>DCF continues to update policy, practice and programming regarding YABs.</p>
			<p>DCF presents updates and progress with Adolescent Service Providers.</p> <p>Hold quarterly Provider Meetings</p>		<p>Three quarterly meetings were held with contracted adolescent service providers to provide information on adolescent programs and initiatives.</p>
5-6	15-Jun	<p><b>Mechanisms are available to receive stakeholder feedback and feedback is used to inform the system</b></p>			
			<p>DCF to engage stakeholders through the Youth At-Risk of Homelessness Federal Planning Grant</p> <p>Focus groups, planning sessions and surveys are initiated</p> <p>Reports</p>		<p>During Phase II Year 1 (9/30/15-9/29/16) DCF focused efforts on engaging DCF staff and providers to inform implementation efforts of the new pilot services.</p> <p>As a priority listed in DCF's Strategic Plan, DCF is committed to</p>

			<p>information to the public through emails, newsletters, and the public website</p>	<p>transparency and provides the general public information through the DCF Webpage: <a href="http://www.nj.gov/dcf/">http://www.nj.gov/dcf/</a>  <a href="http://messagingtoolkit.att.com/onlineSignup/NJDCF/signup">http://messagingtoolkit.att.com/onlineSignup/NJDCF/signup</a>  <a href="http://www.nj.gov/dcf/news/press/2017/approved/press_archive.html">http://www.nj.gov/dcf/news/press/2017/approved/press_archive.html</a>  <a href="http://www.nj.gov/dcf/news/reportsnewsletters/">http://www.nj.gov/dcf/news/reportsnewsletters/</a>  <a href="http://www.nj.gov/dcf/news/testimony/approved/testimony_archive.html">http://www.nj.gov/dcf/news/testimony/approved/testimony_archive.html</a>  <a href="http://www.nj.gov/dcf/contact/email.html">http://www.nj.gov/dcf/contact/email.html</a>  <a href="https://www.facebook.com/NewJerseyDCF/">https://www.facebook.com/NewJerseyDCF/</a></p>
		<p>Resource families are engaged have structured opportunities to provide input and feedback on the system</p>	<p>Initiate Retention Taskforce</p>	<p>The recommendations were approved in early 2016 and now have become New Jersey’s Resource Family Retention Plan. Part of the recommendations is to distribute a longitudinal survey where we will chart our progress and get continual feedback from resource families.</p>
5-7	14-Jun	<p>Family surveys are completed by those engaged in the Teaming process</p>	<p>Quarterly reports on FTM survey</p>	<p>The Office of Quality consistently produces quarterly FTM reports and shares them with CP&amp;P leadership.</p>
		<p>State DV Plan Initiative: The Division on Women has embarked on the creation of a new</p>	<p>State DV Statewide Initiative: Schedule interviews/surveys, focus</p>	<p>The first phase which is the stakeholder engagements was completed by September 30, 2016. During Phase I, a preliminary stakeholder engagement planning table was developed and will be utilized to guide the next steps for the strategic planning process which includes completing the process of identifying stakeholders and corresponding questions; communicating with</p>

			<p>and innovative plan that identifies and meets the needs of survivors and the communities NJ serves. The focus of this plan is inclusivity and accessibility</p> <p>Safety and Accountability Initiative (SAA): Pilot Project to assess cultural accessibility and inclusivity in Institutional Responses to DV.</p>	<p>groups and starting stakeholder engagement in the process.</p> <p>Safety and Accountability Initiative (SAA): DOW will complete assessments on the local county and state level to ensure policies and procedures surrounding the investigation, prosecution, and services for DV survivors are safe and effective.</p>	<p>identified stakeholders regarding the project and scheduling interviews and focus groups; and starting the stakeholder engagement process. Additionally, this group will work towards identifying participants and questions for interviews, focus groups and surveys; scheduling and completing interviews and focus groups and launching online surveys.</p> <p>Safety and Accountability Initiative (SAA) - DOW strategically partnered with organizations that served these marginalized populations to facilitate learning sessions on the topic. The SAA will also lay the foundation for the development of NJ's Domestic Violence State Plan.</p> <p>There are five phases of the SAA process and Phase 1 and 2 were completed by September 30, 2016</p> <ul style="list-style-type: none"> <li>•Phase I – Survey: Initial research to identify major themes and inform assessment topic. This phase will be done mostly during DOW's needs assessment and capacity building training. Each community will conduct needs assessments, environmental scans and stakeholder analyses. Participants will begin forging connections with groups serving marginalized populations and ensure necessary parties are included.</li> <li>•Phase II – Planning: Assessment Teams will form and meet to plan team objectives, roles, identify a topic and collect information. DOW will assist in coordinating meetings, taking meetings, taking minutes, and providing any other technical assistance and guidance as necessary.</li> </ul>
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# 2015-2019 CFSP Year Four Action Plan

**Core Strategy 1 – Strengthening the Case Practice Model**

The Case Practice Model (CPM) is the foundation of the work at the Department and is envisioned to be infused in all interactions with children, youth and families. The core of the CPM is partnerships with families through engagement of formal and informal supports, joint planning and teaming for desired outcomes, as well as individualized services to address the specific and unique needs of families. Over the next five years, the Department will build on the implementation of the CPM model to pilot initiatives aimed as refocusing staff attention on CPM core strategies like teaming and case planning. Through these efforts, it is expected that families will experience thorough joint planning and teaming will aid in providing supports for the family after child welfare involvement has ended.

Line #	Date Added	5 Year Intent	Year 4 Action Plan 10/1/16-9/30/17	Measures	Results (date)
1-1	14-Jun	<b>Families will experience collaborative service planning through timely completion of case plans and greater quality of case plans.</b>	Train staff in enhanced Case Plan	Will incorporated Enhanced Case Planning in New Worker pre-service training.	

1-2	14-Jun	<p><b>Teaming process will lead to positive permanency outcomes</b></p>			
			<p>Shift the focus to increasing the quality of family engagement in family teaming</p> <p>Ensure adequate staff are trained on teaming</p>	<p>Establish quality baseline</p> <p>Training and Distribution of carbonized FA to Area and Local Offices</p> <p>CPP to partner with Training Academy to increase capacity of Facilitators</p>	



1-3	15-Jun	<p><b>Families' needs and histories are understood and inform engagement strategies</b></p>	<p>adolescents, ages 14-21 who are in out of home placement.</p>	<p>Transitional Plans to assess quality.</p>	
			<p>Strategic phase in of case conferencing model Focus on Supervision</p> <p>PMA/CP&amp;P to formulate methodology to measure FOS outcomes</p>	<p>Will collaborate with PMA to develop a better way to collect FOS data</p> <p>Measureable tool is identified and initiated</p>	

**Core Strategy 2 - Refinement of the Service Array**

DCF will conduct a robust statewide assessment of the array of services available to children, youth and families. Services must be flexible and reflect current thinking on interventions as well as be nimble enough to respond to emerging needs for its service recipients. The statewide assessment process will result in better availability of services to address needs in the population; including prevention services and services to children in need of out of home placement.

Line #	Date Added	5 Year Intent	Year 4 Action Plan 10/1/16-9/30/17	Measures	Results (date)
2-1	15-Jun	<b>The needs of the children and families served by DCF are well understood and services are in alignment with identified needs</b>	Through the support of the ACYF Federal Planning Grant conduct data analysis, a needs assessment, and refine an intervention framework in order to address ongoing service gaps related to the need for evidence-based, trauma-informed, protective factor focused and	Create an intervention that works to prevent homelessness for youth in care, 14-21.  Continue Meta analysis of DCF Data such as NJS, CSOC, Census data,  additional Data set identified if needed	

		<p>comprehensive life skills and other critical program for adolescent and young adults being served through CP&amp;P. Initiate second phase of statewide needs assessment process</p> <p>Continue next steps in Focus Groups</p> <p>Utilize technology to determine greatest service need</p> <p>Continue CP&amp;P Statewide Needs Assessment</p> <p>Continue CP&amp;P</p>	<p>Conducted focus groups interviews of key stake holders both internal and external.</p> <p>Complete written report on Needs Assessment</p>	
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			Needs Assessment	Conduct Statewide survey on needs of children, youth and families involved with CP&P
2-2	15-Jun	<b>Families will have access to evidence supported services to address their needs</b>	<p>Draft Evidence-Based/Evidence-Informed Blueprint for the Department</p> <p>Apply implementation science-informed approach to identified programming including purchased CP&amp;P core services and one purchased prevention service.</p>	<p>Identify guidance strategies on the selection, adoption, implementation , evaluation and quality improvement practices for evidence-based/evidence-informed programs</p> <p>Infuse evidence-based methods to support quality implementation and scaling up of evidence based/evidence informed programs into our service</p>

			Provide Technical Assistance to New Initiatives	array.
2-3	14-Jun	<b>Children have family based settings that allows them to remain connected with their siblings in OOH placement</b>	Resource homes are available to serve larger sibling groups (SIBS homes).	Increase available homes for large sibling groups by 10%
			Siblings placed apart have regular contact with one another.	Children with 3 or more siblings able to be placed together is increased by 5%
			Continue to	Increase sibling visitation by 5%
				Increase kinship

			increase kinship placements	placements in target counties by 5%	
			Continue to reduce shelter placements for older youth	Reduction in shelter placement in target counties by 3%	

**Core Strategy 3 – Organizational Development**

Organizational development builds on the accomplishments made in training and development of its workforce; coupled with the increased availability of access to the tools necessary for staff to effectively and efficiently work with the children, youth and families we serve. This Core Strategy also includes steps to strengthen the technology available to staff to effectively and efficiently work with children, youth and families. The strengthening of the organization helps staff accomplish the broader positive outcomes for those it serves.

Line #	Date Added	5 Year Intent	Year 4 Action Plan 10/1/16-9/30/17	Measures	Results (date)
		<b>Families benefit from well trained staff who are competent in their ability to engage and team with families.</b>			
			Maintain support for certificate programs in specialty areas like domestic violence, managing by data, adolescent services  Domestic Violence (VAWC) Training: DCF staff are educate on the culture, how to deal with domestic violence and the understanding of domestic violence. Employees receive a certificate upon completion	Percentage of staff completing the program (total completion/total enrolled)  Domestic Violence (VAWC) Training: Percentage of staff completing the program (total completion/total enrolled)	

<p>3-1</p>	<p>14-Jun</p>	<p>DVL Training: DVLS are required to provide four DV related trainings to CP&amp;P staff in the local office per contract year.</p> <p>Provide SF Protective Factors Training- Improving Outcomes for families with Young Children ages Birth to Age 5 through Protective Factors training FCP to strengthen families in special needs</p> <p>Use educational incentive programs to recruit and retain social workers into the agency (BCWEP, MCWEP)</p>	<p>DVL: Total Number of CP&amp;P staff trained in the LOs</p> <p>Hire an additional ECS staff person to serve as the Cumberland County EC Liaison</p> <p>Increase MCWEP program to 5 cohorts/90 students</p> <p>Percentage of staff still employed 2 years post program (total retained/total graduated)</p>	
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3-2	15-Jun	Align staff training to critical or emerging areas of practice	<p>Medicaid training to all CP&amp;P LO Medicaid staff</p> <p>Youth Thrive training</p>	<p># of trainings held – yearly # of staff (per LO) attending Medicaid training; training attendance corresponds to Medicaid security designation</p> <p>CP&amp;P staff and contracted providers serving adolescent population will be afforded the opportunity to participate in the new Youth Thrive training/number of participants trained</p>	
3-3	14-Jun				



	<p>15-Jun</p>		<p>Train CQI staff on access and use of longitudinal data</p> <p>Increase access to county and case level outcome data</p> <p>Use available and accessible systems (NJS, SM) to accurately track and report on psychotropic medication use by children in out-of-home placement and compliance with best practice standards</p>	<p>Number of people trained, topics covered with access to local data</p> <p>OCFH to partner with RER to develop an electronic psychotropic medication report</p> <p>Implementation of automated report for monitoring psychotropic medication monitoring</p>	
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3-6	15-Jun		Continue technical assistance (TA) to further development of the information and data associated with the Systemic Factors	Employ monthly phone calls with CB Regional Office support  Monthly OPMA/CP&P Collaboration Meetings	
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**Core Strategy 4 – Continuous Quality Improvement**

Continuous Quality Improvement (CQI) at the Department includes the development of a fully functioning and sustainable system that has the organizational structure to support high quality data collection including case record review processes, data analysis, with stakeholder feedback processes as well as ways for public dissemination of information. Many of the component parts are present and with some refinements will form the basis for the CQI system.

Line #	Date Added	5 Year Intent	Year 4 Action Plan 10/1/16-9/30/17	Measures	Results (date)
4-1	14-Jun	<b>Develop a robust and fully functioning CQI system</b>	Gather understanding about current status of CQI activities  Build capacity of PMA staff to	Update accounting of CQI activities statewide  Developed and implemented CQI	

			<p>support CQI activities</p> <p>Review and approve Draft CQI policies</p> <p>Conduct a review of the documents/forms needed for the Independent Living Stipend.</p>	<p>training for staff designated CQI roles</p> <p>Results of the review and any follow up practice or policy guidance/changes</p>	
4-2	15-Jun		<p>Initiate draft CQI training</p>	<p>Development a Capacity Building and CQI training schedule for FCP / DOW new staff members</p>	
4-3	14-Jun				

4-4	14-Jun	Operate a quality data collection process	<p>Pilot accountability/quality control after a targeted review and follow next steps</p> <p>Launched the Caseload Verification Review Process</p>
		<p>Initiate process to build additional controls around data collection</p> <p>Continue work on the AFCARS PIP</p>	<p>Continue work of AFCARS PIP-enhancements during year 3 period</p>
		Operate a case record review process	# QRs completed 2017
		Continue implementation of the QR process and made modifications as needed	Annual summary report published

4-5	14-Jun		Complete targeted reviews on the quality of investigations as well as the quality of services to older adolescents for 2017	Results of the reviews and recommendation follow up	
4-6	14-Jun				
4-7	14-Jun		Provide data reports on key agency performance indicators to the public	# of reports posted publically	
4-8	14-Jun				
			Integrate feedback from stakeholders into processes and systems Counties with QRs during period have completed Program Improvement Plans from a systems perspective with input from stakeholders	Review of PIP participants and PIPs for statewide themes	

4-9	15-Jun		<p>PMA will provide technical assistance with CPP and onsite assistance with PIP development ion and monitoring</p> <p>Conduct CQI Summit will be held to review the QR data from the previous year, discuss opportunities for improvement to the QR process, and to set improvement goals for the QR process.</p>	<p>PIP's will be updated as needed and that the improvement practices identified are attainable and measurable.</p> <p>Was the summit held</p>	
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**Core Strategy 5 – Strengthening and Enhancing Partnerships**

DCF is committed to the process of collaboration with stakeholders and community partners to improve outcomes for those we serve. Accountability and transparency are two key components to enhancing partnerships. Additionally, partnership must reflect the voices and input of those served by the system. Formal systems of data collection and information gathering from stakeholders and partners must be in place and leveraged in decision-making and planning for true systems change.

Line #	Date Added	5 Year Intent	Year 4 Action Plan 10/1/16-9/30/17	Measures	Results (date)
5-1	14-Jun	<b>Partnerships are strengthened through transparency</b>			
5-2	14-Jun		Make data reports available to the public through the DCF webpage	CIACC reports and Data Dashboard are available monthly on the DCF website  Continue to post data to the Governor's Transparency Website	
5-3	14-Jun		Partner with entities in the research committee to disseminate knowledge	# of research projects approved	

				<p>CFN Pilot by JHU will provide a comprehensive outcomes-based evaluation of the CFN Pilot so as to inform program practices and improve resources for CP&amp;P.</p> <p>Evaluation actions will begin</p> <p>Interim results will be drafted and reviewed as part of a team process</p>	
5-4					
5-5	15-Jun	<p><b>Youth perspective is incorporated into the DCF system</b></p>	<p>Create a policy to provide and ensure a safe, healthy, and inclusive environment for all the youth and families we serve, including LGBTQI youth and families</p> <p>NJ Statewide Youth Advisory Boards (YABs) present concerns and recommendations</p>	<p>DCF reports back to YABs on progress twice per year.</p> <p>Publish policy/practice change</p>	

			<p>to DCF twice per year.</p> <p>DCF to update policy, practice, programming where appropriate in response to the YABs</p> <p>DCF presents updates and progress with Adolescent Service Providers.</p> <p>Restructure youth advisory boards to create a network of programming and culture in NJ that values youth leadership and voice (YAN).</p>	<p>Hold quarterly Provider Meetings</p> <p>Implementation of new programming.</p>	
5-6	15-Jun	<p><b>Mechanisms are available to receive stakeholder feedback and feedback is used to inform the system</b></p>			
			<p>DCF to engage stakeholders through the Youth At-Risk of</p>	<p>Focus groups, planning sessions and surveys are initiated</p>	

			<p>Homelessness Federal Planning Grant</p> <p>Reports information to the public through emails, newsletters, and the public website</p>	
			<p>Resource families are engaged have structured opportunities to provide input and feedback on the system</p> <p>Distribute a longitudinal survey</p>	
5-7	14-Jun		<p>Family surveys are completed by those engaged in the Teaming process</p> <p>Quarterly reports on FTM survey</p>	
			<p>State DV Plan Initiative: The Division on Women has embarked on the creation of a new and innovative plan that identifies and meets the needs of survivors and the communities NJ serves. The focus</p> <p>State DV Statewide Initiative: Schedule interviews/surveys, focus groups and starting stakeholder engagement in the process.</p>	

			<p>of this plan is inclusivity and accessibility</p> <p>Safety and Accountability Initiative (SAA): Pilot Project to assess cultural accessibility and inclusivity in Institutional Responses to DV.</p>	<p>Safety and Accountability Initiative (SAA): DOW will complete assessments on the local county and state level to ensure policies and procedures surrounding the investigation, prosecution, and services for DV survivors are safe and effective.</p>	
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# Section B

## Promoting Safe and Stable Families

The Promoting Safe and Stable Families (PSSF) Program is federally funded (Title IV-B, Subpart 2) grant program that focuses on helping families stay together, promotes family strength and stability, enhances parental functioning, and protects children. The federal government requires that at least 20% must be spent on programs in each of the following four funding categories: Family Preservation Services, Family Support Services, Time-Limited Family Reunification Services and Adoption Promotion and Support Services.

DCF maintains a comprehensive contract monitoring and execution process to ensure that:

- Purchased services meet the identified needs of the Department's Clients;
- Purchased services achieve identified performance objectives;
- Provider agencies and programs meet contracted levels of service;
- Programs comply with all applicable DCF contracting and all applicable program standards and policies;
- Agencies operate in a fiscally responsible manner and in compliance with agreed upon budgets;
- Agencies comply with applicable licensing requirements;
- DCF and provider agencies maintain open communication that encourages prompt problem identification and resolution; and
- Feedback regarding service needs from local DYFS staff, children and families, and other stakeholders is incorporated into negotiations for new contracts and renewals.

This monitoring process reviews all relevant program and service information, to include information contained within the PSSF update reports, during the monitoring process procedure which include:

- DCF Internal Check-in: DCF Contract Administrator meets with DCF Program Leads to review programmatic performance and contract compliance during the first contract quarter.
- On-Site Monitoring Visit: DCF Monitoring Team consisting of Contract Administrator, Program Lead and DCF Business Office supervisory staff completes program on-site visit during the second and third contract quarters to review programmatic performance, contract compliance as well as address any concerns or issues raised during check-in meeting. This visit includes an Administrative interview, program service interviews, record reviews, exit conference and written report.
- Coordinated Contract Review Meetings (CCRM): During the fourth contract quarter the DCF Business Office will conduct an internal meeting to review all relevant program information received during the monitoring process. The meeting is used for assessing if the provider agency is achieving contracted levels of service, meeting performance objectives, submitting required reports, and is in compliance with any applicable licensing standards. Its primary purpose is to support decision making concerning the contract renewal which will improve the services purchased through the contract. At the conclusion of the Coordinated Contract Review Meeting (CCRM), the Contract Administrator completes a Contract Monitoring Report which identifies the findings in all programmatic, administrative and fiscal areas, including any actions identified for follow-up. Recommendations to improve the contracts services, service availability and

accessibility, are included in the report, and are the basis for contract negotiations with the provider. Below is an example of a contract monitoring report.



State of New Jersey

DEPARTMENT OF CHILDREN AND FAMILIES  
SOUTHERN BUSINESS OFFICE - CN #720  
4 ECHELON PLAZA, 1<sup>ST</sup> FLOOR  
201 LAUREL ROAD  
VOORHEES, NJ 08043  
PHONE: (856) 772-0152  
FAX: (856) 770-1349

CHRIS CHRISTIE  
*Governor*

KIM GUADAGNO  
*Lt. Governor*

ALLISON BLAKE, PH.D., L.S.W.  
*Commissioner*

Ms. [Redacted], MSW  
Chief Executive Officer

Moorestown, NJ 08057

Re: Contract Monitoring  
Contract # [Redacted]

Dear [Redacted]:

Thank you for the courtesy and cooperation your agency extended to staff of the Southern Business Office during the contract monitoring visit on [Redacted]. Based on a review of your agency operations, we wish to report that [Redacted] is in satisfactory compliance with all of the items listed in the Contract Monitoring Tool Section Summary Report (attached). There were no issues identified that required corrective action.

Agency case records were reviewed and documented the attainment of required information. Overall program performance has met the service needs of DCP&P. Your Level of Service is above the CLOS, and program outcomes were positive. The Southern Business Office received positive feedback from the Local Offices attending the monitoring.

On behalf of Southern Business Office, I wish to thank you and your staff for the services provided to the residents of New Jersey. If you have any questions or wish additional information regarding the monitoring visit, please do not hesitate to contact me at (856) 772-0152 x143, Brian.Connolly@dcf.state.nj.us.

Sincerely,  
  
Brian J. Connolly  
Contract Administrator II  
Southern Business Office - Voorhees

Danielle Williams  
Supervising Contract Administrator  
Southern Business Office - Voorhees

1/2010

**Contract Monitoring Tool Section Summaries**

CONTRACT ADMINISTRATOR: Brian J. Connolly CONTRACT NUMBER: \_\_\_\_\_

NAME OF AGENCY: \_\_\_\_\_ CONTRACT PERIOD: \_\_\_\_\_

I. Agency Information			
A. Administration	Satisfactory	Corrective Action Needed	N/A
<p><b>1. Board of Directors Summary (a. through h.)</b></p> <p>Additional Comments:</p> <p>_____</p> <p>The Agency is governed by a Board of Directors that appears to operate in accordance with DCF policies and procedures.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>2. Required Documents Summary (a. and b.)</b></p> <p>Additional Comments:</p> <p>_____</p> <p>The Agency has the documents required by CPIM P1.01 and has access to the DCF Policy Manuals.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>3. Personnel Summary (a. through k.)</b></p> <p>Additional Comments:</p> <p>_____</p> <p>The Agency has staff, personnel, policies and procedures which support service delivery detailed in the Annex A.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Fiscal Monitoring	Satisfactory	Corrective Action Needed	N/A
<p><b>1. Expenditure Report Review Summary (a. through c.)</b></p> <p>Additional Comments:</p> <p>_____</p> <p>The Agency operates within DCF policy and submits timely fiscal reports in line with the Agency budget.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p><b>2. Fiscal Management System Summary (a. and b.)</b></p> <p>Additional Comments:</p> <p>_____</p> <p>The Agency appears to follow outlined accounting procedures and has internal financial controls in place.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>3. Audit Review Summary (a. and b.)</b></p> <p>Additional Comments:</p> <p>_____</p> <p>The Agency complies with CPIM P7.06 Audit Requirements.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>4. Equipment Summary (a.)</b></p> <p>Additional Comments:</p> <p>_____</p> <p>The Agency maintains an inventory of all equipment purchased with DCF funds, including vehicles owned or leased with a description and fair market value in compliance with CPIM policy.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>5. Medicaid Summary (a. and b.)</b></p> <p>Additional Comments:</p> <p>_____</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<p><b>C. Accreditation Organizations</b></p>	<p>Satisfactory</p>	<p>Corrective Action Needed</p>	<p>N/A</p>
<p><b>1. Accreditation Summary (1. through 3.)</b></p> <p>Additional Comments:</p> <p><u>COA: Expires 11/30/2018</u></p> <p>The agency maintains current accreditation(s).</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>II. Program Component Information</b>			
<b>A. Program Service Delivery System</b>	Satisfactory	Corrective Action Needed	N/A
<p><b>1. Goals and Objectives Summary (a. through d.)</b></p> <p>The program has policies and procedures that ensure that services provided to each client/consumer are coordinated so that specific outcomes can be achieved.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>2. Program Staff Summary (a. through c.)</b></p> <p>The program has staff sufficient to deliver services detailed in the Annex A.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>3. Feedback from Stakeholders Summary (a. through c.)</b></p> <p>Feedback from stakeholders reflects service delivery consistent with DCF contracting policies and the Annex A.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>4. Program Policies Summary (a. through f.)</b></p> <p>The Program maintains policies which support DCF contracting policies and the service delivery detailed in the Annex A.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>5. Level of Service Summary (a. through c.)</b></p> <p>The Agency is providing services in line with contracted service delivery detailed in the Annex A.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>6. Performance Based Outcomes Summary (a. and b.)</b></p> <p>The Agency is conforming to the contracted performance outcomes detailed in the Annex A.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p><b>7. Community Awareness Program (for non-DCF restricted programs) Summary (a. through c.)</b></p> <p>The Agency has a community awareness program designed to inform the public of its services.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>8. Compliance with DCF Residential Facilities Policies Summary (a. through e.)</b></p> <p>The Agency is complying with DCF residential facilities policies.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

<b>B. Program Component Compliance (On Site Review)</b>			
<b>Component:</b>	Satisfactory	Corrective Action Needed	N/A
<p><b>1. Program Observations Summary (a. through d.)</b></p> <p>The program site, staff, and activities observed appear appropriate for the services contracted to be provided.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>2. Client Records Summary (a. through l.)</b></p> <p>The Agency maintains established:</p> <ul style="list-style-type: none"> <li>• Intake procedures and/or an assessment process to ensure a timely response to the needs of clients/consumers;</li> <li>• Procedures for client/consumer termination, discharge, or transfer; and</li> <li>• A process and procedures to appeal service decisions.</li> </ul>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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### III. SUMMARY CONCLUSION

#### A. AREAS OF ACHIEVEMENT AND ACCOMPLISHMENTS

1. All programs have now switched over to electronic files. Files are well organized and easy to follow, all files have appropriate information. 2. LOS and Expendable Reports meet contracted levels and expectations. 3. Program services are meeting DCP&P needs.

#### B. AREAS THAT MAY NEED ENHANCEMENT

1. All DCP&P Referral Forms need to be scanned into the electronic record. 2. Ensure that all visitation notes are entered spirit within five business days. 3. Ensure that all records list the clients NJ Spirit number.

#### C. AREAS OF SUBSTANTIAL NONCOMPLIANCE AND THE NEED TO SUBMIT A CORRECTIVE ACTION PLAN

N/A

As a result of this review process all PSSF provider agency contracts were renewed.

<b>Family Preservation Services (FPS)</b>	<b>Family Support Services (FSS)</b>	<b>Time-Limited Family Reunification Services (TLFRS)</b>	<b>Adoption Promotion and Support Services (APSS)</b>
<p>Services are designed to help children and families who are at risk or in crisis including: services that are geared to:</p> <ul style="list-style-type: none"> <li>• Help children reunify with families</li> <li>• Help children be placed for adoption, or with legal guardian</li> <li>• Offer pre-placement preventive services</li> <li>• Provide post reunification follow-up</li> <li>• Offer respite care of children</li> <li>• Improve parenting skills</li> <li>• Infant Safe Haven programs</li> </ul>	<p>Community-based services are provided to promote the well-being of children and families by:</p> <ul style="list-style-type: none"> <li>• Increasing the strength and stability of families</li> <li>• Increasing competence in parenting abilities</li> <li>• Building a safe and stable environment</li> <li>• Strengthening parental relationships</li> <li>• Promoting healthy marriages</li> <li>• Enhancing child development</li> </ul>	<p>Services are provided to the parents or the primary caregiver and children in placement, in order to facilitate reunification.</p> <p>The services and activities include:</p> <ul style="list-style-type: none"> <li>• Counseling</li> <li>• Substance abuse treatment services</li> <li>• Mental health services</li> <li>• Assistance to address domestic violence</li> <li>• Temporary child care/therapeutic services</li> <li>• Crisis nurseries</li> <li>• Transportation to or from services and activities</li> <li>• Visitation</li> </ul>	<p>Services and activities are designed to encourage more adoptions out of the foster care system, when adoptions promote the best interests of children.</p> <p>This includes:</p> <ul style="list-style-type: none"> <li>• Pre and post-adoption counseling</li> <li>• Summary writers</li> <li>• Visitation and treatment</li> <li>• Behavioral Supports</li> <li>• Information and referrals</li> <li>• Advocacy and support services</li> </ul>
1,241,148	1,235,403	1,266,535	1,749,013
22.6%	22.5%	23.1%	31.8%



### 2017 PSSF Update Report

Section 1 – Identifying Information	
<b>1a</b>	<b>Provider:</b> Care Plus NJ
	<b>1b Program Name:</b> Adoption House
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, ___ FSS, ___TLFRS, <u>__X__</u> APSS
<b>1d</b>	<b>Program Address:</b> 1360 Morris Avenue Union, NJ 07083
<b>1e</b>	<b>Objective:</b> To expand and enhance the number and range of adoption and/or permanency services for children and families
<b>1f</b>	<b>Outcome(s) Addressed:</b> <u>__X__</u> Safety <u>__X__</u> Permanency ___ Well-Being
Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)	
<b>2a</b>	<p><b>Overview of Service:</b> Service Components of Adoption House include: <b>birth family/child visitation, sibling visitation, and preparatory groups.</b> All children attending Adoption House services also receive round-trip transportation.</p> <p>Adoption House provides three weekly supervised visitation sessions for <b>birth parents and children</b> under the supervision of DCP&amp;P. Children and families attending this service will participate in a sixty or ninety-minute supervised visitation session. The sessions are designed to provide families a structured therapeutic environment for parents to visit with their children. The goal of the program is to decrease the amount of time children spend in out of home placements and assist them in moving towards permanent placement either with their biological parents or in adoptive homes.</p> <p>Children attending the <b>sibling visitation</b> program participate in a 60-minute supervised visitation session, offered two evenings per week. The goal is to maintain meaningful relationships between siblings living in separate placements. During the sessions, staff introduce therapeutic activities that facilitate sibling interaction. The focus is to address underlying issues such as trauma, unresolved grief, and depression. Additionally, staff strives to promote healthy self-esteem, support self-worth, and acknowledge any feelings of loss, grief, or rejection.</p> <p>The 60-minute <b>preparatory groups</b> assist school-age children in addressing issues that they experience while residing in foster care and being removed from the care of their biological family. The groups provide children with support and allow open discussion among children sharing a common life event. The groups address underlying issues such as trauma, loss and unresolved grief, as well as feelings of isolation, rejection, shame, guilt, depression, and anger. Further, our staff strives to promote healthy self-esteem and support self-worth through the use of group discussion and therapeutic activities. Preparatory groups are held three times a year for eight week sessions, each.</p>

	It should be noted that all staff working with the Adoption House Program have completed the Certificate Program in Adoption through Rutgers University, School of Social Work.
<b>2b</b>	<b>Population Served:</b> Children ages newborn to 17 years of age and families, who are affiliated with the Division of Child Protection and Permanency. Primary recipients are children and families from the surrounding counties such as; Union, Essex, Bergen, Passaic, Hudson, Somerset, and Monmouth. All children and families under the supervision of DCP&P Local/Area Offices will be eligible for services with the Adoption House Program.
<b>2c</b>	<b>Geographical Area of Services:</b> Statewide, with the primary recipients being from the Metropolitan Region.
<b>2d</b>	<b>Referral Sources:</b> Division of Child Protection and Permanency Local/Area Offices
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b></p> <p><b>Include data where available:</b> Program accomplishments and goals will be broken down by the three service components:</p> <p><b>Birth Family/Child Visitation</b>  This service decreased the amount of time children spent in out of home placements and assisted families in moving towards permanent placement, either with their biological parents or in adoptive homes. This outcome was measured by the documentation of the family’s goals/progress in the weekly/biweekly observational summaries as well as outlined in the initial service planning meetings. As a result, 65% of families served between 10/1/15 and 9/30/16, achieved permanency by being either reunified or finalizing adoption. The remaining families continue to receive ongoing services by Adoption House to facilitate permanency.</p> <p><b>Sibling Visitation:</b> This service assisted children in improving the relationships they share with their siblings. This outcome was measured by the documentation of the siblings’ goals/progress in the weekly/biweekly observational summaries. As a result, 100% of sibling sets exhibited significant improvement in their interactions with one another. Further, during this reporting year 26 % of the served sibling sets graduated from the Adoption House program. This was due to the program’s ability to collaborate with the Division to assist the caretaker’s facilitation of bonding time outside of the program. The children reported their satisfaction in being able to maintain visits with one another outside of the parameters of Adoption House which in turns provides the program the ability to service more families. It should also be noted that 50% of the served sibling sets during the identified time period continue to be engaged in therapeutic visitations and continue to visit with one another consistently.</p> <p><b>Adoption Preparatory Groups:</b>  This service facilitated open discussion regarding children’s feelings of foster and adoptive placement in a group setting. The specific goal of increased awareness of the adoption process as measured by pre and post tests resulted in 100% of participating children demonstrating increased awareness. Upon completion of the program children felt they knew what it meant to be adopted, had become increasingly aware of the feelings, and emotions associated with adoption, and were better able to discuss these feelings openly with someone they trusted.</p>

<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b></p> <p><b>Birth Family Visitation:</b> Participants were able to improve communication and address sources of conflict. Parents were educated on appropriate parenting techniques and encouraged to engage in positive interaction with their child(ren). This expedited the permanency planning process with all parties effectively communicating and working together to achieve this goal.</p> <p><b>Sibling Visitation:</b> Siblings utilized therapeutically oriented activities designed and implemented by professional staff to increase positive interaction, improve supportive relationships and elicit effective communication amongst the siblings. This process provided the siblings with the opportunity to engage in open dialogue concerning events leading up to their removal from their biological families and their experiences in the foster care system. The children demonstrated a positive change in their emotional reaction to their transition to permanency planning and displayed a decrease in feelings of isolation, as well as improve their self-esteem.</p> <p><b>Preparatory Groups:</b> The groups provided children with support and allowed open discussion among children sharing their common experiences. The groups addressed issues of loss and unresolved grief, self-esteem, as well as feelings of isolation, rejection, shame, guilt, depression, and anger.</p>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement:</b> The implementation of the Case Practice Model has ensured better communication and synergy in service planning. In addition, Care Plus NJ was awarded funding to partner with several Local Offices for the roll out of the Case Conference Model for Focus on Supervision. This partnership has provided our teams with more access to Resource Development Specialists, Case Work Supervisors and their teams. As a result, we have seen an increase in awareness about the valuable services that the Adoption House Program provides, as evidenced by more referrals forwarded by Local Offices. Further, the Adoption House Program Coordinator invites Division Case Workers to attend the intake session with each family, in order to increase participation and achievement of established goals with the Adoption House Program.</p>
<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment:</b></p> <p>All referrals made to the Adoption House Program have a case plan of Termination of Parental Rights. Adoption House staff often encounters families who are inconsistent with participating in the program. Many of the families present with a history of untreated mental health and substance abuse. Some families present with consistent legal involvement that inhibits their ability to participate (i.e. incarceration). When families are not in treatment it is challenging to engage them in services. The program collaborates directly with families and the Division to identify appropriate services to address the aforementioned service needs.</p> <p>In addition, Adoption House continues to struggle with the great distances required to travel to transport children to the program. A number of children who attend services at Adoption House reside a significant distance from the location of the program and therefore may spend up to two hours in a vehicle. These are less than desirable circumstances for children. Unfortunately, given children are at times separated into foster homes across the</p>

	<p>state, we are aware there is not a simple remedy to this challenge. Since the Adoption House program is unable to transport parents to the visitation sessions, there are many instances in which parents do not participate in services due to the unavailability of transportation. Adoption House staff communicate with the parents, as well as the DCP&amp;P caseworkers in order to advocate for public transportation fare and give detailed scheduling/availability of the public transportation outlets in the area.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> A Unit of Service is defined as – <b>number of services days (5 per week)</b>, which includes birth parent/child visitation, sibling visitation, and preparatory groups (including round trip transportation of the child for all services).</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b></p> <p><b>The <u>contracted</u> number of units of service, which includes birth parent/child visitation, sibling visitation, and preparatory groups: <u>251 service days</u></b></p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b></p> <p><b>The <u>actual</u> number of units of service, which includes birth parent/child visitation, sibling visitation, and preparatory groups: <u>199 service days or 80%</u></b></p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p>Adoption House served unduplicated individuals/ unduplicated families during this time period.</p> <p><b># of unduplicated individuals: 86</b> <b># of unduplicated families: 34</b></p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <p>Care Plus NJ participates annually in the National Mental Health Association Consumer Satisfaction Survey and all clients are invited to participate. Adoption House distributed surveys to participating families during the month of October. Results yielded that clients served by Care Plus were more satisfied in every category compared to the national database of other mental health centers. Professionalism of staff was the highest rated item following confidentiality. Overall, Outcome and Reputation at Care Plus NJ scored higher than the national database of other mental health centers. It is important to note that Care Plus NJ has been ranked number one, nationally overall in staff satisfaction for agencies that have five or more programs.</p>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>Services will remain the same.</p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p>

	Care Plus NJ received positive feedback from stakeholders. Unless a needed change is identified, we will continue to maintain our standards of excellence.
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p> <p>The estimated number of units served will be: <u>251</u></p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p><b># of unduplicated individuals:</b></p> <p><b># of unduplicated families:</b></p> <p><b>Birth Visit: # of unduplicated individuals: <u>48</u></b></p> <p><b>Birth Visit: # of unduplicated families: <u>24</u></b></p> <p><b>Sibling Visit: # of unduplicated individuals: <u>39</u></b></p> <p><b>Sibling Visit: # of unduplicated families: <u>12</u></b></p> <p><b>Prep group: # of unduplicated individuals: <u>9</u></b></p> <p><b>Prep group: # of unduplicated families: <u>N/A</u></b></p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b></p> <p>A case file is created for every family and child referred to and accepted to any of the services provided by the Adoption House Program. Staff complete weekly summary reports concerning each child’s and/or family’s participation in services. An initial service plan is developed between the Case Manager, the DCP&amp;P caseworker and/or the biological parents. The Case Manager maintains weekly contact with the family’s DCP&amp;P caseworker via telephone. Case Manager is able to attend and encourage quarterly meetings with the family and the DCP&amp;P case worker. A final meeting is held with the caseworker to develop a discharge plan. The service plans as well as the discharge plan will be maintained in child/family’s case file. The DCP&amp;P Caseworkers will receive a copy of the weekly/bi-weekly summaries by the 10<sup>th</sup> of the following month. All the Weekly/Biweekly summaries document the family’s progress.</p> <p>Preparatory Groups complete a questionnaire to measure progress. The questionnaire evaluates twenty areas that address feelings that surround the adoption process. The rating scale was designed to be child friendly. Responses include: Never, A little bit, Sometimes, A lot, and Always. The participants complete a questionnaire during the first group which serves as a pre-test. Participants also complete a questionnaire during their final group, which serves as a post-test. This has been successful with measuring increased knowledge of the adoption process as well as feelings surrounding adoption.</p> <p>All communication (verbal and written) to and from DCP&amp;P offices, families, foster parents, adoptive parents, and other service providers are maintained in the case file. All the documentation provided by DCP&amp;P, birth, foster, and adoptive parents will also be maintained in the case file. When a family’s involvement in any of the services ends, a termination summary will be completed, maintained in the case record and a copy will be forwarded to the assigned DCP&amp;P caseworker. Adoption House also tracks children and</p>

	<p>families participation/attendance in services using the DCP&amp;P network database, NJ Spirit.</p> <p>As per the request of DCP, beginning July 1, 2014 the Adoption House Program started reporting new performance based outcomes for birth family/child visitation. They are as follows:</p> <p>In TPR cases, parents will attend visit 65% of the time. Of those parents that do attend visits, they will demonstrate appropriate interaction with their children:</p> <ul style="list-style-type: none"> <li>-25% of cases at 90 days post intake</li> <li>-50% of cases at 6 months post intake</li> <li>-50% or more of cases thereafter as measured at 90 day intervals</li> </ul> <p>These outcomes continue to be measured using a parent/child interaction checklist.</p>
<p><b>5b</b></p>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <p>Care Plus NJ will continue to participate annually in the National Mental Health Association Consumer Satisfaction Survey. We will continue to encourage families to participate in this process as we value their feedback and depend on it to enhance the Adoption House program. In addition, staff will continue to take advantage of the depth of training and consultation offered by Care Plus NJ and the Care Plus Foundation. This ensures that staff is staying abreast of the most current methods and treatments for the families we serve. Any new Adoption House staff will attend and complete the Adoption Certificate Program through Rutgers University School of Social Work as well as attend the annual “Let’s Talk Adoption” conference.</p>
<p><b>5c</b></p>	<p><b>How do you collaborate with community partners?</b> The Program Director and Director of Program Coordinator have held meetings with the Local/Area DCP&amp;P offices in an effort to educate DCP&amp;P staff on the services that the Adoption House program offers. Further, as mentioned in sections above, Care Plus NJ was awarded funding to partner with several Local Offices for the roll out of the Case Conference Model for Focus on Supervision. This partnership has provided our teams with more access to Resource Development Specialists, Case Work Supervisors and their teams. Adoption House has collaborated and facilitated meetings with outside service providers such as; individual therapists, Child Advocate Caseworkers, and extended family members to ensure the goals for the family are attainable and achieved while they are engaged in the Adoption House Program. In addition, upper administration, such as the VP and the President/CEO participate in many community meetings (such as CIACC, NJAMHA, Rotary, etc.) to ensure that community partners are aware of the services provided by Adoption House and the agency at large.</p>

### 2017 PSSF Update Report

Section 1 – Identifying Information	
<b>1a</b>	<b>Provider:</b> The Children’s Home Society <b>1b Program Name:</b> PACS
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, ___ FSS, ___TLFRS, <u>X</u> APSS
<b>1d</b>	<b>Program Address:</b> 635 S Clinton Ave Trenton NJ 08611
<b>1e</b>	<b>Objective:</b> The objective of the program is to provide services which strengthen family functioning, stabilize adoptive or kinship placements, increase the likelihood of successful adoptions/KLG, and minimize the possibility of disruptions or dissolution
<b>1f</b>	<b>Outcome(s) Addressed:</b> ___Safety <u>X</u> Permanency ___Well-Being
Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)	
<b>2a</b>	<p><b>Overview of Service:</b></p> <p>The Pre- and Post-Adoption/Kinship Counseling program (PACS) provides services to stabilize adoptive and relative placements and enable caregivers to meet the unique needs of children who have been exposed to abuse/neglect and removed from their birth families. Services are provided pre- and/or post finalized adoption and Kinship Legal Guardianship (KLG). These services include individual, group and/or family therapy, life story/life book work, parent support, respite services, advocacy, and follow-up. The therapist utilizes a variety of techniques, including talk, book, play and art therapy, as well as behavior modification, EMDR (for those trained in this technique), Sandplay, and Cognitive-Behavioral Therapy. The therapist also educates the parents about the traumatic and difficult issues foster children face and how the parents can better help the child(ren) cope through understanding, patience, nurturance and structure. Clinicians also implement the skills learned in the ARC training as well as trainings provide by the Attachment and Trauma Center of Nebraska and assist parents in learning to regulate their own emotions, set consistent boundaries and increase their attunement to children.</p>
<b>2b</b>	<p><b>Population Served:</b></p> <p>The target population is children up to the age of 21 who are preparing for or have achieved permanency in an adoptive or relative placement. Pre- and post- finalization services are provided to children and families in DCF placements. The target population is fully blended (pre and post adopt/KLG) for all geographic locations covered in the contract. Post adoption services are offered to families who were not involved with DCF.</p>

<p><b>2c</b></p>	<p><b>Geographical Area of Services:</b></p> <p>The geographic areas to be served are Mercer, Monmouth, Middlesex, Ocean, Somerset, and Hunterdon Counties.</p>
<p><b>2d</b></p>	<p><b>Referral Sources:</b></p> <p>All referrals for DCF-involved children are transmitted through CP&amp;P Local Office Adoption staff or Resource Development Specialists (RDS). For Post Adoption/ KLG Families, the parent or guardian may contact CHS directly and request PACS services.</p>
<p><b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b></p>	
<p><b>3a</b></p>	<p><b>Provide a summary of program accomplishments on goals. Include data where available:</b></p> <p>There were three identified goals for the PACS program during the identified time period. The first goal was that 80% of children will maintain placement at 3 months and 6 months as measured by follow-up call. A total of 62 post discharge follow up calls were made at three months after discharge. Of the 62 attempts to contact, 19 families did not respond to phone calls or a letter sent. Out of 43 families in which contact was made, 41 families reported that the children remained in the home (95%). A total of 55 post discharge follow up calls were made at six months. Of the 55 attempts to contact, 18 families did not respond to the phone calls or a letter mailed. Out of the 37 families in which contact was made, 32 families reported that the children remained in the home (86%), with 2 additional children placed in Select Home Placements. Two children were reported to be placed in residential placements and 2 placements disrupted.</p> <p>The next goal identified was that 85% of children will show improvement through measurement by an objective tool. The PACS Program currently uses the Trauma Symptom Checklist and the Trauma Symptom Checklist for Young Children as a tool in which we can measure improvement in symptoms of trauma such as anxiety, depression, anger, and dissociation. 75% of the children discharged during this contract year showed improvement in their trauma related symptoms. This represents 21 out of the 28 children in which both pre-test and post-tests were given. Of the 7 remaining children, 5 (17.85%) of them did not present with clinical symptoms at the time of the pre-test and therefore remained the same or reported slight increases in some areas. The percentage of children where a pre/posttest was completed was low due to the following factors: unplanned discharges which did not allow staff to administer the posttest, invalid tests results due to over reporting or underreporting of symptoms, unplanned discharges which did not allow staff to administer the post test, and staff turnover rate which required new staff to be trained in the use of the TSCC/TSCYC prior to them using this assessment tool. This reduced the sample size which may have affected the outcome.</p> <p>The last goal is that PACS will provide services to 74 unduplicated children within the contract year. The PACS program exceeded this expectation by providing services to 95 unduplicated children.</p>

<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b>  PACS services improved outcomes for children and families by providing clinical interventions which resulted in more than 80% of the placements either lead to successful adoption or prevent dissolution or disruption of placement. Children and families who participated in PACS services showed an increase in the level of attachment, an increase in trust and relationship building and a decrease in symptoms related to trauma. Children also showed an increase in their ability to express and identify their feelings.</p> <p>The children, who accomplished their goals, felt safe and stable at the conclusion of therapy, were happy in their homes and negative behaviors were decreased or eliminated. Caregivers were better able to provide the structure, nurturance and understanding needed to help the child(ren), feel a sense of belonging and improved well-being, better understand the adoption process, cope with the separation and loss from the birth family and feel more connected to the resource or kinship family. The children were also better able to cope with other changes in their lives, such as school, friends, and new family members. Acting-out behaviors were decreased or eliminated.</p>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement:</b>  Specific factors which contributed to this improvement included having trauma informed staff and a trauma specific assessment tool which allowed staff to accurately identify the impact that trauma had on a child and their ability to function in their home environment. Staff were then able to provide psycho-education to the child and family on how the trauma impacted them and identify behavioral plans and parenting interventions which were individualized to the families’ needs and effective in minimizing behaviors over time. Trainings received on the ARC Framework and Integrative Parenting allowed staff to provide competent and effective services.</p> <p>The staff in the PACS Program offer a flexible schedule including evening and weekends. This maximizes potential for family engagement. All staff are either working towards or have completed the Adoption Certification training at Rutgers University which provides them with basic knowledge about defense mechanisms and common behaviors of foster children and effective ways to address them in the home.</p>
<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment:</b>  Significant barriers to goal accomplishment have been identified as a lack of trauma training for foster parents prior to having a traumatized child move into their home; parent unwillingness to engage in psycho-education or family counseling as they do not identify themselves as the “client;” unprocessed grief of pre-adoptive parents or unrealistic expectations of what fostering/adopting a child entails; and parents’ ability, or lack of, to implement recommended interventions into their daily routine. Sometimes caregivers are inconsistent in putting therapist recommendations in place to make needed behavioral changes and to help the child feel safe and accepted. It often takes time for them to realize how important consistency of response is to the process of change for the better. The therapists spend a great deal of time with the caregivers to educate them about trauma and its effects on the brain, behavior and emotions. The act of attuning to a child’s needs requires a level of self-awareness which takes time to cultivate.</p>

	<p>Working with this population, children who have experienced at times significant abuse and neglect, also presents a challenge. These children have complex trauma histories which impact their ability to trust their care takers and service providers. This results in services being provided for longer periods of time as it is more difficult to build a therapeutic relationship with these children.</p> <p>Concurrent planning is also a barrier at times. Children are often in their homes for over two years by the time that Termination of Parental Rights is determined and the birth parent exhausts all appeals. If services are requested prior to this taking place, it impacts a child's ability to understand what permanency means to them as they often feel like they will not have it. These children also continue to have ambivalent feelings about adoption or their relationship with their birth parents and care takers as they typically continue with visitation during this period and may get mixed messages about their permanency. There are also loyalty issues which present themselves as the child can get confused about whether they align with their birth parents or foster parents.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b></p> <p>Contracted units of service are defined as the number of children in adoptive or relative care placements who are served by the program. A separate case is opened for each child in placement. Siblings that are placed together are counted as separate cases. Each child will count towards one level of services even if they discharge and re-enter during the contracted year.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b></p> <p>The contracted Level of Service for this program is 74 children.</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b></p> <p>The PACS Program serviced 118 unique children during this funding period.</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:</b> 118  <b># of unduplicated families:</b> 96</p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <p>The Consumer Satisfaction Survey Version 8 (CSQ8) was sent to all 69 families that were</p>

	<p>discharged during this period. Of those, 16 responded. Of the 16 respondents, 15 (94%) rated the services as excellent and 1(6%) rated them as good;11 (69%) indicated they definitely received the type of services they wanted and 5 (31%) indicated that they generally received the services they wanted; 12 (75%) indicated the services helped a great deal and 4 (25%) indicated that the services helped somewhat; 14 (88%) indicated that they were very satisfied with the overall services received, while 2 (13%) were mostly satisfied.</p> <p>Overall these are positive responses and indicate a general satisfaction with the services.</p>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>There are no planned changes to the program for the FFY 10/1/16-9/30/17.</p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>As there was no stakeholder feedback indicating that services were ineffective or that families believed that they would benefit from additional services, no changes will be made at this time. Staff will continue to receive training in the area of trauma and foster care/adoption related issues in order to continue to provide the quality of services in which they currently provide.</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p> <p>It is expected that the PACS Program will provide 120 units of service during the contracted period of 10/1/2016 to 9/30/2017.</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p><b># of unduplicated individuals:</b> 120  <b># of unduplicated families:</b> 100</p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b></p> <p>CHS will continue to measure progress using the TSCYC and TSCC for an objective assessment tool, Consumer Satisfaction Surveys, stabilization of placements, and client report on treatment plans.</p>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <p>CHS will continue to provide the families that we work with with Consumer Satisfaction Survey Version 8 (CSQ8) upon discharge from the program. Feedback from these services will allow us to be more aware if modifications to the program are needed in order to further facilitate success. We will also follow up with families through phone calls or mail at 3 and 6 months post discharge to discuss if the family continues to make progress on the identified treatment goals. An internal review of treatment plans will be done every 90 days to insure</p>

	that families are reporting improvement in their homes.
<b>5c</b>	<p><b>How do you collaborate with community partners?</b>            Currently all staff from the PACS Program meets with the DCP&amp;P case workers and Adoption Operations Liaison on a monthly basis to discuss services rendered and we will continue to do so. In addition to working closely with DCP&amp;P, PACS staff members also attend family team meetings, school meetings, and treatment team meetings with the other providers who work with the families we provide services to. Staff are encouraged to make collateral contacts with all community partners involved with a family one time per month in order to coordinate effective services. CHS of NJ maintains a directory of services in our offices, based on the counties within which we work. We also have a variety of child and family-centered programs within our agency that could prove helpful to families, depending on their needs and where the family is located. Releases of Information are signed in order to maintain professional and ethical standards.</p>

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> The Children’s Home Society of NJ</p> <p><b>1b Program Name:</b> Child Summary Writers</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <u>  X  </u> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 635 South Clinton Avenue, Trenton, New Jersey 08611
<b>1e</b>	<b>Objective:</b> The objective of the Child Summary Writers program is for The Children’s Home Society of New Jersey to provide support to the Division of Child Protection and Permanency to complete Child Summaries which helps to facilitate the adoption process for children under the care of the Division whose parental rights have been terminated.
<b>1f</b>	<b>Outcome(s) Addressed:</b> ___Safety <u>  X  </u> Permanency ___Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Child Summary Writers work in the various DCP&P local offices. They are assigned children for whom to write summaries by the Concurrent Planning Specialists and are given access to the necessary case files. From the information in the case files, the Child Summary Writers create the child summary, which is used as a part of the adoption process.
<b>2b</b>	<b>Population Served:</b> This service ultimately serves children in the care of the Division of Child Protection and Permanency who are free for adoption and who require a Child Summary to be completed. However, the work done in the program is with the Division of Child Protection and permanency staff and not directly with the children themselves.

2c	<b>Geographical Area of Services:</b> There are Child Summary Writers who serve all 21 counties in New Jersey. The Child Summary writers are based in the local Division of Child of Protection and Permanency offices.
2d	<b>Referral Sources:</b> Children are referred to the Child Summary Writers by the Concurrent Planning Specialists in the local Division of Child Protection and Permanency offices.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
3a	<b>Provide a summary of program accomplishments on goals.</b> N/A – Please refer to 3b <b>Include data where available:</b> N/A – Please refer to 3b
3b	<b>How did this improve outcomes for children and families?</b> As this is not a counseling program and there is no client contact, it is difficult to determine the impact this service directly has on the children for whom child summaries are written. However, the completion of the child summaries does help to facilitate the adoption process for these children.
3c	<b>Identify specific factors that contributed to this improvement:</b> N/A – Please refer to 3b
3d	<b>Identify significant barriers to goal accomplishment:</b> N/A – Please refer to 3b
3e	<b>Definition of Level of Service as per contract:</b> The definition of level of service for this contract is 7 child summaries per child summary writer per month. There are currently 21 child summary writers associated with this contract. Therefore there is a monthly level of service of 147 child summaries per month, and 1764 per year.
3f	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> The contracted level of service for this time period is 1764 child summaries.
3g	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> The number of Part B summaries that were completed from 10/1/15 through 9/30/16 was 1157.
3h	<b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b> There is no client contact for this program.  # of unduplicated individuals: # of unduplicated families:

3i	Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results. N/A – Please refer to 3b
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
4a	Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program. There are currently no planned changes to the program.
4b	Identify changes you will make that stem from stakeholder feedback. There are no planned changes to the program.
4c	How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17? Based on the level of service for the program we are expecting 1764 Child Summaries to be completed.
4d	Indicate how many unduplicated individuals and unduplicated families you expect to serve. There is no client contact for this program. # of unduplicated individuals: # of unduplicated families:
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
5a	How will you measure progress? N/A – Please refer to 3b
5b	Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods. While there is no direct client contact for this program the quality of the Child Summaries is monitored by both the Concurrent Planning Specialists at the Division of Child Behavioral Health Services and the Administrator for Adoption Services at The Children’s Home Society of New Jersey. When there is an identified quality issue additional training is given to the Child Summary Writer to help improve his or her skills.
5c	How do you collaborate with community partners? N/A – Please refer to 3b

### 2017 PSSF Update Report

Section 1 – Identifying Information	
<b>1a</b>	<b>Provider:</b> Volunteers of America - Northern NJ Sector
<b>1b</b>	<b>Program Name:</b> Parenting Skills Partnership Program – Adoption Support
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, ___ FSS, ___TLFRS, __X_APSS
<b>1d</b>	<b>Program Address:</b> 205 West Milton Ave., Rahway, NJ 07065
<b>1e</b>	<b>Objective:</b> The objective of the Parenting Skills Partnership Program is to stabilize and preserve the family unit. The program provides tools for caring parents of adoptive children to effectively work with children to stabilize the family, increase adaptive behaviors, and decrease inappropriate behaviors in order to achieve a successful adoption.
<b>1f</b>	<b>Outcome(s) Addressed:</b> ___Safety __X__Permanency ___Well-Being
Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)	
<b>2a</b>	<b>Overview of Service:</b> The objective of the Parenting Skills Partnership Program is to stabilize and preserve the family unit. The program provides tools for caring parents of adoptive children to effectively work with children to stabilize the family, increase adaptive behaviors, and decrease inappropriate behaviors in order to achieve a successful adoption.
<b>2b</b>	<b>Population Served:</b> Pre and post adoptive families
<b>2c</b>	<b>Geographical Area of Services:</b> Northern New Jersey including Bergen, Hudson, Morris, Passaic, Sussex, and Warren counties.
<b>2d</b>	<b>Referral Sources:</b> Department of Children and Families, Division of Child Protection and Permanency (DCP&P) District Office’s, Foster and Adoptive Family Services of New Jersey, and self-referral.
Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)	
<b>3a</b>	<b>Provide a summary of program accomplishments on goals.</b> <b>Include data where available:</b> The overall goals and objectives of the program were for parents to learn effective parenting techniques, implement these effective parenting techniques, and sustain effective parenting skills in order to stabilize placement, promote permanency, and assist in adoption finalization when appropriate. Pre and post family assessments are completed with the families. The data demonstrates that families report a reduction in child negative behaviors both in school and at home as well as experiencing an increased feeling of parenting competency. On several occasions families have requested an extension in service as they have become bonded to the Parent Educator and look to

	<p>them for support. The DCP&amp;P workers have recognized the need for continuing service and have approved the extensions. Our bilingual clinician is able to accommodate Spanish speaking families.</p>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Feedback from caregivers included,          “It showed me real life scenarios and potential ways to resolve conflict”.</p>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> The Parenting Skills Partnership Program closely coordinates with individual families and their DCP&amp;P representatives. The program utilizes an evidence supported model to improve parenting practices. Presentations were offered to all referring agencies and completed at all referring DCP&amp;P offices at multiple times throughout the year. Staff conducted outreach such as presenting at PRIDE trainings, reaching out to hospital staff, reaching out to Head Start, CIACC/HSACs, SPAN Resources training, etc. The utilization of bilingual staff also provided the program an opportunity to provide services/presentations to an additional population as identified by DCP&amp;P.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b> Barriers to goal accomplishment was not a factor during this period.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> A unit of service is one referral.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> The contracted level of service was 24 referrals.</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 2</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals: 7</b>  <b># of unduplicated families: 2</b></p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>          Feedback from stakeholders includes an annual client satisfaction survey and quarterly meetings with the referral source. The feedback received from our referral source in</p>

	<p>quarterly meetings is overall positive. The client satisfaction survey indicates that the parents who responded are overall satisfied with all aspects of the program. Feedback from caregiver clients included having new ways to change their attitude and the attitude of the children in their care and feeling staff is knowledgeable and professional. The overall average score for the program was 6.96 on a seven point Likert scale.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
4a	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> During upcoming DCF Quarterly, will inquire of funding sources on a need for services in other counties.</p>
4b	<p><b>Identify changes you will make that stem from stakeholder feedback.</b> Stakeholders continue to report they are pleased with the service provided. We plan to continue to offer parenting support in English and Spanish. Marketing and outreach strategies have been increased to include hospitals, adoption agencies, head start and schools to increase referral sources.</p>
4c	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> In the report year 10/1/16-9/30/17, we plan to deliver 36 units of service.</p>
4d	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>  <b># of unduplicated individuals: 68</b>  <b># of unduplicated families: 36</b></p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
5a	<p><b>How will you measure progress?</b> In FY ‘17 Volunteers of America will continue to measure progress through program evaluations, feedback from funder and referral sources, consumer satisfaction, outcome measures, family assessments, and the continued permanency of adoptive families served.</p>
5b	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> Our Sector has a quality department that reviews program outcomes, safety issues, incident reporting, and performance improvement initiatives. Program outcomes are tracked monthly and reported to the Assistant Vice President and the Executive Office. Each year a consumer satisfaction survey is distributed to all participating families. The scores and comments are reviewed by Quality, Program Director, and Assistant Vice President. Any suggestions for improvements to the program are reviewed and implemented when appropriate. Community organizations, families, and DCP&amp;P outreaches will continue to provide feedback through our satisfaction surveys, treatment team meetings, and quarterly meetings.</p>

<b>5c</b>	<p><b>How do you collaborate with community partners?</b> The program staff works closely with the individual DCP&amp;P caseworkers and with the DCP&amp;P Resource Development Specialists. We make recommendations to the caseworkers for specialized assessments and additional identified services that may be necessary for family stabilization. We advocate on our clients' behalf in order to expedite recommended services. Staff will continue to connect families to community resources for physical and mental health services, school child study teams for educational support, and social welfare providers as needed. The bilingual parent educator collaborates with adoption agencies in the counties we serve. One parent educator is trained as a Parents Anonymous trainer and will assist any family who would like to start a group. VOA also continues to attend various staff, team leader, RDS, and Practice Forums through DCF to educate the workers on the services available.</p>
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**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Catholic Charities, Diocese of Metuchen</p> <p><b>1b Program Name:</b> Adoption Support and Advocacy Program (ASAP)</p>
<b>1c</b>	<p><b>Relevant PSSF Program:</b> ___FPS, ___ FSS, ___TLFRS, <u>x</u>APSS</p>
<b>1d</b>	<p><b>Program Address:</b> 319 Maple Street, Perth Amboy, NJ 08861</p>
<b>1e</b>	<p><b>Objective:</b> To provide behavior management, play therapy, and parent skill-building services designed to support adoptive families, enhance family functioning and prevent disruptions, thus promoting permanency.</p>
<b>1f</b>	<p><b>Outcome(s) Addressed:</b> ___Safety <u>x</u>Permanency ___Well-Being</p>
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b> Catholic Charities, Diocese of Metuchen provides in-home behavioral supports for adoptive and pre-adoptive families via the Adoption Support and Advocacy Program (ASAP). ASAP serves children in out-of-home placements and the majority of these children cannot or have not benefited from traditional psychotherapy. The children's behavioral and emotional difficulties are causing significant stress on the adoptive or pre-adoptive family functioning to the point where placement disruption is possible.</p>

	<p>It is the philosophy of ASAP that a comprehensive behavioral approach to serving this population is beneficial in preventing disruption of the child’s permanency plan. The overall goal of ASAP is to provide in-home behavioral support services to strengthen family functioning and increase parental ability and effectiveness, to facilitate adoption finalization plans and prevent adoption disruption/dissolution.</p> <p>ASAP uses a family therapy approach focusing on behavior management and adoption preparation. When clinically appropriate, clients and foster/adoptive parents are seen individually.</p>
<b>2b</b>	<p><b>Population Served:</b> The Adoption Support and Advocacy Program is available to children of any age who are in need of in-home behavioral support services to strengthen family functioning in order to prevent placement disruption, facilitate adoption finalization plans, and assist DCP&amp;P with permanency achievement.</p>
<b>2c</b>	<p><b>Geographical Area of Services:</b> These children are under the supervision of the DCP&amp;P Local Offices in Essex, Middlesex, and Union counties.</p>
<b>2d</b>	<p><b>Referral Sources:</b> Referrals are accepted from the DCP&amp;P Local Offices in Essex, Middlesex, and Union counties as well as directly from adoptive families identified through DCP&amp;P and Foster and Adoptive Family Services</p>
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b>  <b>Include data where available:</b> During the course of treatment, 85% of clients served were stabilized and had improved at the conclusion of treatment.</p>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b>  The clinical and behavioral interventions provided to the children and families were able to support and help facilitate adoption finalization and prevent adoptive placement disruption.</p>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b>  It is believed that the quick response to providing services when first requested contributes to assisting the family at a difficult time, and provides key insight to the nature of the issues. The agency also has a strong commitment to focusing on the family unit as a whole to assure all members are able to learn and support each other.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b>  To enhance awareness of the program and generate referrals, recruitment efforts are</p>

	<p>facilitated on a regular basis. For example, regular emails and phone calls are facilitated to the Resource Development Specialists in each of the contracted DCP&amp;P Local Offices as well as to DCP&amp;P Caseworkers who have provided previous referrals to the program. Of the appropriate referrals received, 100% were provided services.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> The Adoption Support and Advocacy Program is contracted to serve 108 unduplicated individuals per year. Each client is provided with 10 weeks of in-home therapy for a minimum of one hour per week.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> The contracted Level of Service for the ASAP Program is 108 unduplicated individuals.</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16: 41</b></p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals: 41</b> <b># of unduplicated families:</b></p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> The program conducted Consumer Satisfaction Surveys at the conclusion of treatment. Out of 41 surveys requested, 21 were completed. Out of those returned, 81% agreed or strongly agreed that they were helped by the program.</p>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> There are no planned changes to this program</p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b> The program will continue to work with stakeholders to identify additional avenues to</p>

	generate referrals.
<b>4c</b>	<b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> 108 units of service will be delivered between 10/1/16 – 9/30/17
<b>4d</b>	<b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> <b># of unduplicated individuals:</b> 108 <b># of unduplicated families:</b>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<b>How will you measure progress?</b> Monitoring of the program for customer satisfaction, discharge and post-discharge status will be done through paper or phone surveys. Customer Satisfaction Surveys are forwarded to all clients upon termination of services either in person at the last home visit or via mail along with a self-addressed stamped envelope to aide in the return of the surveys. Upon receipt of the completed surveys, the Catholic Charities Performance Improvement Department aggregates the data.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> To ensure consumer focused feedback, satisfaction surveys are disseminated at the conclusion of treatment. This information is aggregated on a quarterly basis and annually. Any areas that fall below an 80% approval rating will be targeted for improvement. During contract renewal and at various times throughout the year, communication with DCP&P is paramount to continued program quality initiatives.
<b>5c</b>	<b>How do you collaborate with community partners?</b> During the initial and on-going assessment process Behavioral Specialists are working with other community providers to ensure all client needs are being met. Recommendations are also indicated during the discharge planning process.

### 2017 PSSF Update Report

Section 1 – Identifying Information	
<b>1a</b>	<p><b>Provider:</b> Robins’ Nest, Inc.</p> <p><b>1b Program Name:</b> PACS (Pre and Post Adoption and Kinship Counseling Services)</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, ___ FSS, ___TLFRS, <u>X</u> APSS
<b>1d</b>	<b>Program Address:</b> 42 South Delsea Drive, Glassboro, NJ 08028
<b>1e</b>	<b>Objective:</b> To help the child and family negotiate the transition created by the adoption and to build positive family interaction in order to strengthen and stabilize the pre or post adoptive placement.
<b>1f</b>	<b>Outcome(s) Addressed:</b> ___Safety <u>X</u> Permanency <u>X</u> Well-Being
Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)	
<b>2a</b>	<p><b>Overview of Service:</b> Pre and Post Adoption and Kinship Counseling programs (PACS) provide services to stabilize adoptive and relative placements and enable caregivers to meet the unique needs of children who have been exposed to abuse/neglect and removed from their birth families. Services are provided pre- and/or post finalized adoption and Kinship Legal Guardianship (KLG) including: Individual, Group and/or Family Therapy, Parent Education, Respite Services, Life Book Work, Educational Support, Advocacy and Follow Up.</p>
<b>2b</b>	<p><b>Population Served:</b> All pre and post adoptive families (children twenty one years and younger).</p>
<b>2c</b>	<p><b>Geographical Area of Services:</b> Burlington, Camden, Gloucester, Cumberland, Salem, Cape May and Atlantic Counties.</p>
<b>2d</b>	<p><b>Referral Sources:</b> Referrals come from DCP&amp;P caseworkers and adoption and permanency workers if the child is DCP&amp;P involved. Non-DCP&amp;P involved families self refer.</p>
Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b> <b>Include data where available:</b></p> <ol style="list-style-type: none"> <li>1. 19/19 (100%) children’s cases closed having made progress.</li> <li>2. 49/52 (94%) case goals were achieved or partially achieved.</li> <li>3. 6/7 (86%) families improved their functioning and familial relationships by the end of in-home intervention as measured by the Child Well Being Scale.</li> <li>4. 10/10 (100%) children remained stable in their pre/post adoptive home three months post treatment.</li> <li>5. 10/10 (100%) children remained stable in their pre/post adoptive home six months post treatment.</li> </ol>

<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b>                  Our model of providing adoption education and attachment focused parenting strategies to parents in addition to family therapy, increases family success. By increasing empathy and effective parenting and communication amongst family members children remain stable in their pre/post adoptive homes.</p>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement:</b>                  Specialization in adoption work is not common and due to extensive training through Rutgers’ Adoption Certificate Program, staff are competent in providing adoption related individual and family therapy. Staff are also trained on the ARC Model- Attachment, Self-Regulation and Competency, a model designed to increase resiliency amongst children with complex trauma.</p> <p>Staff also utilize a Parent Awareness Curriculum, based off of the Adoption Certificate Program, and a Trauma Curriculum, based off information from the National Child Traumatic Stress Network (NCTSN). This education on separation, attachment and loss in addition to the elements on trauma are a critical part of our work to increase parental empathy and effective parenting. This curriculum is being updated for the next reporting period to strengthen its content and delivery.</p> <p>Utilizing knowledge from the Adoption Certificate the ARC model amongst other modalities allows our clinicians to provide timely, appropriate and effective treatment, bringing felt success to the family and thereby better outcomes.</p>
<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment:</b>                  As children remain in the system for long periods of time, it remains challenging to address loss and trauma in a timely manner. Children lack a solid understanding of the reasons for placement and desire greater communication. Therapists are tasked with both supporting caseworkers and assisting in the telling of a child’s story in a manner they can understand.</p> <p>Complex factors such as concurrent planning, appeal of TPR and delay of court hearings all create challenges for both children and pre-adoptive parents in feeling stable and require sensitivity and forthrightness in addressing by therapists.</p> <p>In addition, the need for services is significantly greater than the services available, leading to extensive wait times for children and their pre-adopt families. As a result of improved reporting practices, services were expanded in July 2016 with staff hired and starting in September 2016. This expansion will allow us to more effectively meet the needs of families in a timely manner without any or minimal waiting time prior to services starting.</p>
<p><b>3e</b></p>	<p><b>Definition of Level of Service as per contract:</b>                  The level of service is based on number of children served.</p>
<p><b>3f</b></p>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/14 – 9/30/15:</b>                  Based on the DCP&amp;P Contract, 16% is Title IV-B funded. 16% = 22 children.</p>
<p><b>3g</b></p>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the</b></p>

	<p><b>period of 10/1/14 – 9/30/15:</b> 19 children (85%) served.</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b> # of unduplicated individuals: 19 # of unduplicated families: 11</p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> 100% (N=25) of clients surveyed reported being satisfied or very satisfied with services and staff. 100% (N=2) referral sources surveyed reported being satisfied or very satisfied with services and staff.</p>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>During the coming year, we are revising and combining our Parent Awareness and Trauma Curriculums in order to streamline our approach with our families. As we have learned how critical education is to being effective, we desire to ensure that we are as efficient and effective as possible in delivering pertinent information. Creating a more clear and succinct version of the materials we currently use will allow us to continue educating families while also recognizing their need to feel as though they are ‘doing’ something to address various behavioral concerns.</p> <p>Due to the ongoing concerns with our wait list for services and improved reporting practices, services were expanded in July 2016 with staff hired and starting in September 2016. Half of the expansion staff were hired at that time and we continue to work to hire the remaining staff. This expansion will allow us to eliminate our wait time for families seeking services and ideally stabilize placements more quickly.</p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b> Feedback from our stakeholders has led to many of the changes we are making. The merge of the Parent Awareness and Trauma curriculums streamlines our education component; implementing the ARC model formalizes and provides additional structure and understanding to the work being done; and finally, expansion of PACS services to meet the needs of the community in a more timely and effective manner.</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/15 – 9/30/16?</b> 16 % or 22 Children</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: 19 # of unduplicated families: 11</p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	

<p><b>5a</b></p>	<p><b>How will you measure progress?</b>          The program uses pre and post measurement tools such as the Attachment Symptom Checklist and the Child Well Being Scale. In addition to these pre and post scales, therapists assess case disposition and progress made towards goals. Follow up phone calls with the families at three and six months post treatment allows us to assess stabilization of the family unit. In addition, mail, phone and referral source surveys provide additional subjective feedback on the provision of our services.</p>
<p><b>5b</b></p>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b>          The agency randomly conducts client satisfaction phone interviews during the intervention. Obtaining feedback on services and staff gives the agency an opportunity to improve customer satisfaction and services while the case is still active. All clients also receive, at closing, a self-administered mail survey giving clients another opportunity to provide feedback. This includes questions specific to participation in the teen adoption support group to obtain feedback about its effectiveness. A referral source survey is emailed to the referent, giving them the opportunity to assess service quality and to offer input for program improvement.</p> <p>The agency was re-accredited by the Council on Accreditation for Children and Families in 2016, carrying us through to 2020. Adhering to best practice COA standards and incorporating feedback from our PAC liaison and annual DCP&amp;P monitoring reviews, helps us to maintain our quality provision of service.</p>
<p><b>5c</b></p>	<p><b>How do you collaborate with community partners?</b>          Partnering with our community providers is an essential component to providing quality services. Program director and program supervisors participate in the Post Adoption Counseling Providers meetings, presents the program and promote the support group component to DCP&amp;P resource fairs, DCP&amp;P staff meetings, DCP&amp;P new employee trainings, foster parent meetings and PRIDE trainings as well as participates in Family Court Adoption Resource events and other community resource events. In addition, program director and supervisors participate in regular meetings with Local Office staff to discuss specific cases, address services needed and identify ways in which various supports can help the child succeed. When given the opportunity, program director conducts adoption loss trainings as well as promotes the need for adoption counseling to DCP&amp;P adoption workers and supervisors, Mobile Response, Traumatic Loss Coalitions, medical intern students and school personnel. Program director has consistent and frequent communication with adoption liaisons, Jill Carmody-Burns and Beth Ann Tarver, to ensure a close collaboration with the Division, exploring obstacles, case updates and the delivery of services. Program director, supervisors and therapists maintain ongoing phone and face to face contact with caseworkers, supervisors and RDS' to discuss concerns and progress.</p>

### 2017 PSSF Update Report

Section 1 – Identifying Information	
<b>1a</b>	<p><b>Provider:</b> The Bridge</p> <p><b>1b Program Name:</b> FPS Boarder Baby Program</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> <input checked="" type="checkbox"/> FPS, <input type="checkbox"/> FSS, <input type="checkbox"/> TLFRS, <input type="checkbox"/> APSS
<b>1d</b>	<b>Program Address:</b> 50 Union Avenue, Suite 305 - 306 Irvington, NJ 07111
<b>1e</b>	<b>Objective:</b> The purpose of the FPS Boarder Baby Program is to work with the family with whom the infant/child has been placed and to provide intensive in-home counseling in order to stabilize the family and prevent placement.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)	
<b>2a</b>	<p><b>Overview of Service:</b> The Bridge provides Family Preservation Services in Essex and Union Counties, which consists of short-term intensive in-home counseling services. Services are designed to stabilize the family’s crisis, facilitate child safety, reduce the risk of child abuse and neglect, &amp; avoid the unnecessary out-of-home placement of a child or lengthy stay in hospital. Services are responsive (within 72 hours of referral), intensive (5 -20 hrs of direct time per week), accessible (24 hours/7 days a week), focused on family strengths, goal oriented (2 -4 goals developed with the family to address problems that led to the crisis), family centered, and focused on skill building and problem resolution.</p>
<b>2b</b>	<p><b>Population Served:</b> Newborn infants who are medically cleared for discharge but not released because they are identified as being at risk of abuse, neglect or abandonment.</p>
<b>2c</b>	<p><b>Geographical Area of Services:</b> Essex County and Union County</p>
<b>2d</b>	<p><b>Referral Sources:</b> Child Protection and Permanency</p>
Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b> <b>Include data where available:</b></p> <p>1. <u>3</u> Families and <u>8</u> Children received services from the FPS Boarder Baby program. The average length of service that families received was <u>30</u> days. The average direct hours of service that families received were <u>35</u> hours.</p> <p>2. Placement disposition of children at the end of FPS intervention was <u>100</u> %.</p>

	The placement prevention rate at six months post termination of FPS averaged <u>100%</u> for the FFY 2016.
<b>3b</b>	<b>How did this improve outcomes for children and families?</b> Children were able to remain in a safe and stable home environment.
<b>3c</b>	<b>Identify specific factors that contributed to this improvement:</b> The provision of in-home therapeutic services in a strength based, family focused manner that empowers a family to move toward health and stability were factors that contributed towards the accomplishments.
<b>3d</b>	<b>Identify significant barriers to goal accomplishment:</b> No barriers to service were identified.
<b>3e</b>	<b>Definition of Level of Service as per contract:</b> One family equals one unit of service.
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> Up to 14 families as needed.
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b>  3 families received FPS Boarder Baby Services
<b>3h</b>	<b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  # of unduplicated individuals: <u>8 Children</u> # of unduplicated families: <u>3 Families</u>
<b>3i</b>	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>  Satisfaction surveys are distributed towards the end of the intervention. The family is provided with a self-addressed stamped envelope. <u>3</u> surveys were submitted to the families. <u>3</u> out of the <u>3</u> surveys were returned by the families.  The surveys indicated that the families were satisfied with the services rendered. Verbal feedback received from the referral source, CP&P, indicates that they are satisfied with the provision of services rendered to the families. Some comments from the families are as follows: <ul style="list-style-type: none"> <li>“Yes, she was very helpful indeed. My thought process towards stress is different.”</li> <li>“Yes, our parenting skills is better and we are able to communicate more as co-parents.”</li> <li>“My worker was very helpful and a good worker who helped our family a lot.”</li> </ul>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<b>Identify any changes you are making to the services described in Section II and why.</b>

	<p><b>This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>The Bridge’s Boarder Baby Program (BBP) was formally concluded in SFY 2016 as a result of the State’s previous conclusion of the Boarder Baby Program. As a result, CP&amp;P will no longer make referrals to the BBP. For those cases where infants are in the hospital and the families are identified as needing an FPS intervention, then the CP&amp;P Caseworkers will refer those families through the Essex County or Union County FPS program.</p> <p>On June 9, 2016, a Provider Meeting was held with The Bridge and facilitated by DCF. Those in attendance were: Judith Caffiero, Everett Spann, Juanita Pridgen - Office of Contract Administration; Debra Lancaster, KerryAnne Henry - Office of Strategic Development; Nancy Carre-Lee, Lori Sanders - Child Protection &amp; Permanency; Inya Chehadé, Darlene Wong, Allison Reynolds, Lisa Parks, Key-Tora Love - The Bridge. During this meeting, clarification about the Boarder Baby Program was provided. It was expressed that there is no longer a Boarder Baby population in New Jersey and as such, The Bridge should no longer track / report cases as Boarder Baby cases. The population of hospitalized infants who are medically cleared for discharge and are identified as at risk of abuse or neglect will be referred by CP&amp;P through the Essex or Union FPS program.</p>
<p><b>4b</b></p>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>The Bridge will no longer track Boarder Baby cases and no further PSSF Reports will be completed for this population.</p>
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p> <p>Zero</p>
<p><b>4d</b></p>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p><b># of unduplicated individuals:</b> Not Applicable  <b># of unduplicated families:</b> Not Applicable</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>5a</b></p>	<p><b>How will you measure progress?</b></p> <p>No Longer Applicable for the Boarder Baby population</p>
<p><b>5b</b></p>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <p>No Longer Applicable for the Boarder Baby population</p>
<p><b>5c</b></p>	<p><b>How do you collaborate with community partners?</b></p> <p>No Longer Applicable for the Boarder Baby population</p>

### 2017 PSSF Update Report

Section 1 – Identifying Information	
<b>1a</b>	<b>Provider:</b> Oaks Integrated Care
	<b>1b Program Name:</b> FOCUS
<b>1c</b>	<b>Relevant PSSF Program:</b> <input checked="" type="checkbox"/> FPS, <input type="checkbox"/> FSS, <input type="checkbox"/> TLFRS, <input type="checkbox"/> APSS,
<b>1d</b>	<b>Program Address:</b> 79 Chestnut Street Lumberton, NJ
<b>1e</b>	<b>Objective:</b> To prevent hospitalization and/or residential placement in order to maintain children in their own homes and attain or improve child and family well-being.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input type="checkbox"/> Safety <input type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)	
<b>2a</b>	<p><b>Overview of Service:</b> The FOCUS program provides intensive in-home, family therapy to children and families involved in the children’s acute mental health system. Master’s level therapists work with each family for up to 3hours per week for a period of up to 6 months.</p> <p>The primary goal of the program is to prevent hospitalization and/or placement in a residential treatment setting.</p>
<b>2b</b>	<b>Population Served:</b> Youth ages 5-21 and their families.
<b>2c</b>	<b>Geographical Area of Services:</b> Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem Counties
<b>2d</b>	<b>Referral Sources:</b> DCP&P; CMO; Mobile Response; Performcare
Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b> <b>Include data where available:</b></p> <ul style="list-style-type: none"> <li>• Goal: to prevent hospitalization for at least 75% of active clients. The program achieved 100%.</li> <li>• Goal: to prevent residential placement for at least 75% of active clients. The program achieved 100%.</li> <li>• Goal: to prevent hospitalization of at least 75% of discharged clients for up to 6 months post discharge. The program achieved 100%.</li> </ul>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> By helping children and families increase their understanding, acquire or enhance their skills for managing illness and improve overall family functioning, children are able to remain in their communities with their families.</p>

<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b>                  The program utilizes qualified professionals (master’s level therapist) to provide individual case management services and address the therapeutic issues at hand. The involvement of family members in each child’s therapy also contributes to the program’s success. Because the program is community rather than center based, the therapist is able to collaborate with the entire team serving the family and child.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b>                  The scarcity of psychiatric services for children and the financial instability of families pose challenges to making and/or maintaining progress in therapy. These are addressed by collaboration with other entities in the community serving children and families.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> One individual or family equals one unit of service.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 2 units</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 2</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p># of unduplicated individuals: 2                  # of unduplicated families: 2</p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>                  Surveys were sent to all individuals served and were returned. Results were positive.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b>                  No planned program changes</p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b>                  Positive feedback indicates that programming should remain unchanged.</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b>                  2 Units</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>                  # of unduplicated individuals: 2                  # of unduplicated families: 2</p>

<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<b>How will you measure progress?</b> The program will continue to track outcome data collected and feedback from surveys. Progress is measured by both aggregate outcome and survey data as well as individual progress made on treatment goals
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> The system employed includes intensive case supervision – group and individual; a review of each client’s clinical records by the Director, Vice President, and Agency Quality Treatment and Review Committee; outcome reporting; and ongoing communication between the program Director, families served, and referral sources.
<b>5c</b>	<b>How do you collaborate with community partners?</b> Collaboration is accomplished both formally and informally. The Vice President serves on the Southern Region Children’s Coordinating Council, Burlington County CIACC, and the Human Services Advisory Council of Burlington County. Program management attends CIACC meetings in Burlington, Camden, and Cumberland Counties in addition to the Children’s Systems Review Meetings in Burlington County. Therapists collaborate on an individual basis with the entire treatment team providing services to the families. Community partners include all levels of case/care management, DCF partners (DCPP), child study teams, schools, medical providers, and human services agencies.

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> SAFE in Hunterdon, Inc. <b>1b Program Name:</b> PRS Case Management Outreach and Counseling
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, ___ FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 47 East Main Street, Flemington, NJ 08822
<b>1e</b>	<b>Objective:</b> Reduce barriers to services and provide counseling services
<b>1f</b>	<b>Outcome(s) Addressed:</b> X Safety X Permanency X Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> During this reporting period of October 1, 2015 – September 30, 2016, four counselors had part-time hours on this grant to provide on and offsite counseling to victims of domestic violence and sexual assault. Onsite is considered at the SAFE House or at our main office, offsite was at one of four community-based locations that exist with MOUs. These sites were chosen because they were outside of the Flemington location,

	which is widely known, and some are walkable to high schools and/or convenient for transportation. Our county is large and rural so this reduces barriers.
<b>2b</b>	<b>Population Served:</b> Adult and teen clients in need of counseling
<b>2c</b>	<b>Geographical Area of Services:</b> Hunterdon County residents, those that work in Hunterdon or who are relocated from other counties for safety reasons.
<b>2d</b>	<b>Referral Sources:</b> Hotline staff, adult counselors, community organizations, DVRT/SART
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<b>Provide a summary of program accomplishments on goals.</b> <b>Include data where available:</b> During the period of the grant, we were especially grateful to have had active safe sites in the community since our main office experienced interruptions in service due to a renovation. We utilized those sites more heavily for months, which actually made it convenient for clients to be seen closer to their homes. In addition, we started to see teens request to be seen offsite more frequently as they viewed coming to the main office as more stigmatizing or did not have transportation from a parent available.  During this period, 290 client sessions of one therapist hour were held, 110 offsite sessions were held.
<b>3b</b>	<b>How did this improve outcomes for children and families?</b> Children and adults receiving counseling were all moved into our main office building in early 2016, which made it easier for parents of children to attend counseling. In addition, as mentioned above, the community-based safe sites made it more convenient for clients to be seen closer to their homes.
<b>3c</b>	<b>Identify specific factors that contributed to this improvement:</b> We researched and created MOUs with churches and other community agencies to use their sites as another option to overcome the barriers of a lack of transportation in our county. We are now writing these MOUs to include offering cross training with these agencies so it is mutually beneficial in also getting referrals of appropriate clients.
<b>3d</b>	<b>Identify significant barriers to goal accomplishment:</b>

	While we heavily utilized the safe sites in the first half of the grant period, it has dwindled for two reasons, i.e., safety concerns as two of the locations have poor lighting, parking issues and access issues (doors that don't and do lock), and we have reduced some staff hours offsite due to time for travel and mileage reimbursement.
<b>3e</b>	<b>Definition of Level of Service as per contract:</b> Unit is defined as one therapeutic hour of 50 minutes
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 250 units or hours in total ranging from 15-30 monthly
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 292 units or counseling hours were actually performed.
<b>3h</b>	<b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  # of unduplicated individuals: 113 individuals unduplicated # of unduplicated families:
<b>3i</b>	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> Eleven surveys were completed. Surveys are provided as an option to submit. All but one client was fully satisfied with their services. Since the time of this reporting period expiration, we have instituted a new policy to try to obtain client feedback more frequently.
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> We are now requesting client feedback between sessions 6-12 and at exit and no longer just at exit. We are also planning to reduce the number of safe sites down to 2-3 and designate 1-2 counselors as mobile.

<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b>                  The only change based on client feedback is to be mindful that clients may prefer offsite counseling for convenience but may feel less safe, for the security and lighting are not adequate.</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> Same</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>                  # of unduplicated individuals: Same                  # of unduplicated families:</p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b>                  Progress is assessed based on individual client goal progress, completion of safety plans and satisfactory surveys.</p>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b>                  A Likert scale response is used for all question responses and there is space for written narrative as well.</p>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b>                  We formally collaborate via signed MOU agreements, which are renewed each year.</p>

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>		
<b>1a</b>	<b>Provider:</b> Center for Family Services	<b>1b Program Name:</b> Services Empowering Rights of Victims (SERV) Cumberland
<b>1c</b>	<b>Relevant PSSF Program:</b> <input checked="" type="checkbox"/> FPS, <input type="checkbox"/> FSS, <input type="checkbox"/> TLFRS, <input type="checkbox"/> APSS	

<b>1d</b>	<b>Program Address:</b> PO Box 1149 Vineland, NJ 08360
<b>1e</b>	<b>Objective:</b> To reduce/eliminate the psychological and emotional trauma of family violence experienced by child victims.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input type="checkbox"/> Permanency <input type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b>  <b>SERV Child Advocacy</b> program provides advocacy and support services for child victims of domestic violence. Advocacy includes basic needs assessments, education advocacy, and special needs advocacy. Support services include individual and group counseling, age-appropriate safety planning, and recreational activities. The children’s group meets weekly during the same time as the adult support group and their individual counseling sessions are scheduled at a convenient time for both the parent and the child.  SERV provides a holistic healing environment to help children feel safe and comfortable. As part of the counseling process, all participants are encouraged to explore and express their emotions that often accompany exposure to violence in the home. Role playing, art, music, games, toys, and stories are used by the children to help express their emotions. The child’s age, previous level of adjustment and coping ability, plus the current level of environmental support all shape the specific child’s response to stressful events. The appropriate counseling activities will be individualized and provided in accordance with the outcomes of the intake assessment and observations, with a heightened sensitivity to each child’s preferred method of engagement.  Recreational activities are coordinated through the child counselor and involve celebrations of holidays, birthdays, seasons, and community events. Some activities include trips to the library, movie night, decorating for the seasons, learning about another culture, and ideas from the children. The child’s parent is encouraged to get involved in the activities in hopes the parent will continue this special time with their child once they have left the program.</p>
<b>2b</b>	<b>Population Served:</b> Child victims of domestic violence
<b>2c</b>	<b>Geographical Area of Services:</b> Cumberland County
<b>2d</b>	<b>Referral Sources:</b> Open-SERV receives referrals from CPP, law enforcement, schools, social services, other programs and our hotline.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals. Include data where available:</b>  Domestic violence poses a serious threat to children's emotional, psychological, and physical well-being. SERV provides counseling to decrease children’s generalized anxiety, nightmares, difficulty concentrating, increased aggression, increased anxiety about being separated from a parent and intense worry about their safety or their family’s safety. In this</p>

	reporting period, SERV provided services to 68 children with 95 individual counseling sessions and 22 group sessions.
<b>3b</b>	<b>How did this improve outcomes for children and families?</b> SERV assisted our children in learning how to deal effectively with the effects of their traumatic experience. In some cases, the experience will never be forgotten, but they can learn to overcome the effects to hopefully lead a fulfilling life.
<b>3c</b>	<b>Identify specific factors that contributed to this improvement:</b> Primarily the therapeutic relationship that the child counselor establishes and maintains with the child. This was accomplished through the use of various mediums in counseling including play, art, and music. The consistency of the Child Counselor in using techniques and activities designed to address the individual needs of the children also contributed to the improvement. Beyond that, gradually introducing the topic of DV and letting them disclose as much or as little as they feel comfortable disclosing.
<b>3d</b>	<b>Identify significant barriers to goal accomplishment:</b> The biggest barrier is the child's desire to avoid the topic of the DV they witnessed/experienced. It is a painful process for them and has to be approached gently and only as they can tolerate it. It is imperative for the child to consistently attend sessions in order get through this process. But an additional challenge many of the residents in Cumberland County have is transportation. Although the Cumberland County outreach office has a bus stop nearby, it is difficult for clients who do not live near any transportation service to get to their appointments. Many clients rely on friends or family to bring them to appointments which may not always be a consistent transportation method for the client.
<b>3e</b>	<b>Definition of Level of Service as per contract:</b> A unit of service equals 1 hour of counseling or related program activity.
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16: N/A</b>
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16: 117</b>
<b>3h</b>	<b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  # of unduplicated individuals: 68 # of unduplicated families: 148
<b>3i</b>	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> Non offending parents complete a survey that measures if they are more knowledgeable after meeting with a SERV advocate/counselor about safety planning and community resource. During this reporting period, 256 non offending parents completed a survey with 228

	responding they were more aware of safety planning and 210 were more aware of how to access community resources. Some parents had not attended the safety planning/community resource workshop prior to taking the survey.
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> There are no planned changes to the program at this time.
<b>4b</b>	<b>Identify changes you will make that stem from stakeholder feedback.</b> There are no planned changes to the program at this time.
<b>4c</b>	<b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> 120
<b>4d</b>	<b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: 70 # of unduplicated families: 150
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<b>How will you measure progress?</b> The child counselor works with the child's parent to understand the DV effects they are observing, to understand the outcome they are hoping to see, and to determine the changes in behavior that they have noticed. The child counselor also looks to see any changes in the child's willingness to discuss their feelings regarding their experiences, their openness and improvements in their demeanor and utilizes a victim assistance outcomes forms. Every client establishes short and long-term goals and is re-evaluated on a monthly basis. Follow-up is conducted with permission from the client to determine if their goals have been met, and whether any additional referrals/references are needed.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> Evaluation surveys are used in the first 30 days and then a 3-month and 6-month intervals and upon exit from the program to obtain consumer feedback and measure their progress.
<b>5c</b>	<b>How do you collaborate with community partners?</b> SERV participates in community events, meetings and workgroups to stay connected and collaborate with community partners. SERV participates in the Cumberland County Positive Youth Development Coalition and serves on the Executive Committee to the coalition; this coalition addresses the needs of the children in Cumberland County. SERV provides prevention and awareness presentations to community service providers throughout the county on services available and domestic violence. SERV is actively involved in events on the Cumberland County College (CCC) campus and partners with the college for domestic violence awareness month and sexual assault awareness month. For children residing in our safe house, SERV coordinates with McKinney Vento Homeless Services to provide tutoring and recreational activities. SERV is an active member of the New Jersey Coalition to End Domestic Violence, New Jersey Coalition Against Sexual Assault, and routinely works in collaboration with the local DCCP offices, law enforcement, and superior courts to meet the

	needs of our clients. In addition, SERV will provide referrals/resources to participants of the program to assist with any services that would help the family move toward a non-violent environment.
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### 2017 PSSF Update Report

Section 1 – Identifying Information	
<b>1a</b>	<b>Provider:</b> Family Connections, Inc.
	<b>1b Program Name:</b> Reunity House South Orange
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, ___ FSS, <u>X</u> TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 122 Irvington Avenue South Orange, NJ 07079
<b>1e</b>	<b>Objective:</b> To expand and enhance the number and range of services to families and children in order to support family reunification and permanency.
<b>1f</b>	<b>Outcome(s) Addressed:</b> ___Safety <u>X</u> Permanency ___Well-Being
Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)	
<b>2a</b>	<p><b>Overview of Service:</b></p> <p>This program facilitates permanency planning for children in a manner that is consistent with the requirements of the Adoption and Safe Families Act (ASFA). The program provides services that address the goals of: maintaining family bonds; supporting the parent/child relationship; improving parenting skills; decreasing the length of time children remain in foster care; successfully reunifying children with parents or relatives; and providing documentation to support case goals.</p> <p>Services include: supervised visitation, transportation, parenting skills training, parent support groups, and information and referral. The benchmark timeframe for services is six months with additional aftercare services available for up to one year. Program activities focus on supporting the parent-child relationship and on providing the parent with opportunities to learn and practice new skills. The program model builds on current skills and practices, and reflects a family-focused and community-based collaboration.</p>
<b>2b</b>	<b>Population Served:</b> Serves families with children in out of home placement
<b>2c</b>	<b>Geographical Area of Services:</b> Essex, Union and Middlesex Counties in New Jersey
<b>2d</b>	<b>Referral Sources:</b>

	<p>All referrals are received from the Division of Child Protection and Permanency. The DCP&amp;P case manager makes the referral for a family whose case goal is family reunification.</p>
<p><b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b></p>	
<p><b>3a</b></p>	<p><b>Provide a summary of program accomplishments on goals.</b>  <b>Include data where available:</b>                  During the reporting period of October 1, 2015 to September 30, 2016, a total of 80 families received services. Forty families were enrolled in the program at the start of the reporting period. Forty new families were referred, and 9 families were reunified.</p> <p>A total of one hundred and sixty-two (162) families have been reunified since the program’s inception in April 2002. One hundred fifty-one of those families (94%) have remained intact for at least twelve (12) months following family reunification. Nine (9) of ten (10) families that were reunified during the prior reporting period of October 1, 2014 to September 30, 2015, have remained reunified.</p>
<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b>                  Given the complexity and chronic challenges that families should address, the program’s ability to provide a continuum of services positively impacts outcomes in achieving desired goals. In addition to the services provided within the Reunity House Program, additional Family Connections’ services enhance reunification for many of our families. Within Reunity House, the combination of therapeutic visitation and group treatment, supervised overnight visitation, and in-home aftercare services enhance each family’s ability to sustain long-term successful reunification. Collaboration with Family Connections’ Reunity House Program in East Orange has also provided opportunities for increased case management services, and access to specialized parent-child bonding activities, such as Infant Massage and Music Together.</p> <p>Reunification opportunities for families with substance abuse issues are improved with Family Connections’ intensive outpatient program for both mothers (Strong Mothers Program) and fathers (Strong Fathers Program). Due to the large percentage of clients with substance abuse histories, collaboration related to substance abuse treatment is a crucial part of assessing for reunification readiness.</p> <p>Reunity House also utilizes a trauma based framework with families, the Attachment, Self-Regulation and Competency (ARC) model. This model helps to build parental capacity to regulate self as well as provide a structured environment for their children, as there is multigenerational trauma experience for families involved with child welfare.</p>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement:</b>                  The ability to collaborate with intensive outpatient (Strong Mothers and Strong Fathers) substance abuse and mental health services affords clients immediate access to treatment at the same agency.</p> <p>Reunity House, a completely renovated three-story house, is centrally located within Essex</p>

	<p>County. It affords a homelike environment that includes a large reception area, private visitation rooms, a large room for group meetings, and two family suites each with a kitchen, living room with fold-out couch, and a bedroom with a twin bed and a crib. The suites provide for the availability of overnight visitations. The third-floor visitation area was designed and decorated for families with adolescents to have visitations and includes a kitchen area, comfortable living room area with a couch, chairs and a couple of desks. The flexible design of the house enhances the program’s ability to provide individualized services to the children and their families in a comfortable and pleasant environment.</p> <p>Utilizing a trauma lens with families at Reunity House allows the Clinician to join with the family at a place of understanding that they are partners in moving forward from the trauma, and not blaming them for their maladaptive coping.</p>
<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment:</b>          Difficulties associated with transportation costs for the program continued to be challenging, as bus fares and gas prices continue to escalate. The costs of maintaining the safety and effectiveness of program vehicles have also continued to increase. Transportation is time-consuming, with parking, scheduling, and logistical challenges. However, children residing in foster placements within their community have significantly increased; this improves the number of children able to remain in their own community, and decreases some of the program’s transportation challenges.</p> <p>Services at Reunity House South Orange are primarily delivered in English. Therapeutic visitation services as well as case management services are also able to be delivered in Haitian-Creole as Reunity House South Orange has a Haitian-Creole speaking Clinician and Case Manager. This continues to expand the capacity for Reunity House to serve Haitian-Creole speaking families. A Spanish speaking Clinician at the East Orange site provides services to Spanish-speaking families who are referred there. This has improved service delivery, as the program works toward meeting the community’s diverse language needs. There is a Case Manager/Driver who speaks Haitian-Creole to meet the language needs of our Haitian families. The Family Connections’ Cultural Competence Committee collects data on the language capacities of all Family Connections’ staff, which can then be utilized for clinical support and referral resources for other languages. Reunity House is committed to hiring bilingual staff to address the needs of population referred. Language needs will continue to be tracked through the Cultural Competence Committee, and shared with the Quality Improvement Program.</p> <p>Reunity House South Orange continues to have two Bachelor’s level Case Manager/Drivers who have been able to increase the Case Management services provided to the families served at Reunity House South Orange.</p>
<p><b>3e</b></p>	<p><b>Definition of Level of Service as per contract:</b>          A “unit” of service is identified as a family of up to five children. Families that have more than five children are considered two units.</p>
<p><b>3f</b></p>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period</b></p>

	<p><b>of 10/1/15 – 9/30/16:</b>          For the reporting period October 1, 2015 to September 30, 2016, Reunity House is expected to serve eighty (80) families/units of service. Families with more than five children will be counted as two units of service.</p>
<p><b>3g</b></p>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b>          80 units of service were delivered.</p>
<p><b>3h</b></p>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:</b> 218  <b># of unduplicated families:</b> 80</p>
<p><b>3i</b></p>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>          Family Connections’ Quality Improvement Committee (QIC) typically conducts a yearly consumer satisfaction survey or focus group. Outcomes are identified and utilized to make improvements in services to clients. A Consumer Satisfaction Survey was conducted in April 2016 for each Family Connections’ programs. Results were compiled, and Reunity House South Orange’s top 3 positively rated items included the following:</p> <ol style="list-style-type: none"> <li>1. “Staff speaks to me in a way that I understand.” 94% indicated they strongly agreed or agreed.</li> <li>2. “I was given information about my rights.” 94% indicated they strongly agreed or agreed.</li> <li>3. “I am able to read and understand paperwork that I sign here.” 96% indicated they strongly agreed or agreed.</li> </ol> <p>Reunity House South Orange’s 3 lowest percentages for items included the following:</p> <ol style="list-style-type: none"> <li>1. “The location of services is convenient.” 76% indicated they strongly agreed or agreed, 17% indicated they were neutral and 6% indicated they strongly disagreed or disagreed. In response to this item, the Program Manager will discuss with referring agency, DCP&amp;P, the best Reunity House location for clients considering their communities and the Reunity House team will have on-going conversations with clients about ways to make travel to and from Reunity House South Orange more convenient (e.g. review best bus routes and consider the time of visits).</li> <li>2. “I have a better understanding of how my thoughts, feelings and behaviors are related to negative or bad things that have happened in my life.” 73% indicated they strongly agreed or agreed. 7% indicated they were neutral. 6% indicated they strongly disagreed or disagreed. 13% indicated “N/A: I have not had any negative or bad things happen in my life.” In response to this item, the Reunity House South Orange team will work to create an environment that provides some degree of felt safety for clients by naming the negative event with clients; validating the behaviors and roles the behaviors may have played in clients’ lives and educating parents about the trauma response, triggers and links between past experiences and current</li> </ol>

	<p>response. Additionally, the Program Manager will support Clinicians to work with Parents on using attunement skills to mirror and reflect the Parent’s experience. Program Manager will support Clinicians in increasing a sense of safety by providing consistence responses and routines for Parents and their Children in visits. Clinicians will teach modulation skills (be a resource) and model effective self-regulation and support the Parents and Children in their use of modulation skills.</p> <p>3. “The staff here have helped me improve my support system.” 76% indicated they strongly agreed or agreed. 17% indicated they were neutral. 6% indicated they strongly disagreed or disagreed. In response to this item, the Reunity House South Orange team will consider that our parents have trauma histories and will assist Parents in connecting/linking to resources as needed. Manager will support Clinicians in talking to Parents about the primary targets of identity: unique self, positive self, coherent self and future self. Each group cycle will include a session where psycho-education is provided to foster different ideas for how Parents may increase their support systems.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>4a</b></p>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>At this time, there are no immediate changes that are being made to the program. As mentioned in the previous PSSF report, for Reunity House staff as well as Family Connections staff to continue utilizing the trauma based framework with families, the Attachment, Self-Regulation and Competency (ARC) model, an agency-wide training occurred from January 13, 2016 through January 14, 2016 given by Trainer, Dr. Joseph Spinazzola from the Trauma Center Justice Resource Institute in Massachusetts. For Family Connections to sustain this model in the programs and for supervisors to incorporate this model into regular supervision with the clinicians, Laurie Brown, began implementing consultations to supervisors regarding how to incorporate ARC concepts into regular and continuous supervision with clinicians. These consultations continue to occur monthly.</p> <p>Additionally, three Reunity House staff were able to attend the SVN (Supervised Visitation Network) 24-Hour Visit Supervisor Certificate Program. This content included: reviewing code of ethics; boundaries; child welfare laws; child abuse reporting; family violence; cultural sensitivity; child development; parenting skills; effects of separation, grief and loss; child abuse, neglect and sexual abuse; mental health and substance abuse, documentation and parent-child introduction or re-introduction.</p>
<p><b>4b</b></p>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>When appropriate, Clinicians will meet with clients and workers at DCP&amp;P office prior to intake. Reunity House staff also presents the program at Local Division offices on a regular basis to ensure that the caseworkers are aware of the service and can present the information to clients.</p>
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p>

	<p>For the reporting period of October 1, 2016 to September 30, 2017 Reunity House is expected to serve eighty (80) families/units of service. Families with more than five children will be counted as two units of service.</p>
<p><b>4d</b></p>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>  <b># of unduplicated individuals:</b> 200  <b># of unduplicated families:</b> 80</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>5a</b></p>	<p><b>How will you measure progress?</b>  Reunity House clients are given the Adult-Adolescent Parenting Inventory (AAPI-2) pre- and post test to measure their progress in the following constructs: Inappropriate Expectations of Children; Parental Lack of Empathy Towards Children’s Needs; Strong Parental Belief in the Use of Corporal Punishment; Reversing Parent-Child Family Roles and Oppressing Children’s Power and Independence. This information is utilized to identify treatment goals and formulate assessments regarding family reunification. Reunity House is also addressing trauma with clients utilizing the ARC Model.</p> <p>Reunity House staff will continue to work collaboratively with substance abuse and mental health service providers as well as DCP&amp;P staff to promote client progress in the program, support follow through with court requirements, and potentially reduce the amount of time children spend in foster care. In addition, stakeholder feedback from community partners will be utilized to improve program services.</p>
<p><b>5b</b></p>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b>  The Family Connections’ Quality Improvement Program is responsible for continually ensuring that the latest and generally recognized “best practice” standards for service delivery are met and exceeded, and that desirable service outcomes are achieved for all Family Connections’ consumers.</p> <p>Both the Consumer Satisfaction Survey (CSS) and Stakeholder Survey are self-administered, anonymous, and facilitated through a handout/mail-back format, as well as during focus groups. Participants in the supervised visitation program are given the survey after they attend group or a supervised visit. Those consumers who do not come into the agency for services (i.e. those involved in the aftercare program component) are provided an addressed, postage-paid envelope and encouraged to mail the survey to our agency. These surveys are recognized “outcome” tools that can be helpful in evaluating interventions, staff, the agency as a whole, or individual programs. This process is overseen by the Family Connections Quality Improvement Committee (QIC). Data is reviewed and correlated, which are then presented to the Executive Director, Program Directors, Program staff, and consumers. The data is presented and reviewed in the QI Committee meeting. Agency and programmatic changes are proposed and implemented based on data outcomes.</p>

	Following each supervised visitation session at the Reunity House, the Clinician continues to document in NJ SPIRIT so the caseworker has immediate access to information. That process is now implemented in all NJ Visitation Programs and notes are entered within a week of the contact occurring.
<b>5c</b>	<p><b>How do you collaborate with community partners?</b></p> <p>Collaboration efforts with community partners (i.e. substance abuse treatment, mental health treatment providers, DCP, court, schools, and other community agencies) are made through attendance at staff and/or clinical meetings to address client and program needs. Collateral contacts are made with community partners regarding program development or client progress and attendance in the program when indicated. Program managers, clinicians, and case managers outreach to community resources and are present at community health fairs in efforts to educate and inform our community partners and the families in the community about the Reunity House services. The program conducts stakeholder survey once every three years to assess areas needing improvement as suggested by community partners.</p>

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> The North Ward Center, Inc.</p> <p><b>1b Program Name:</b> Permanency Links Program NWC – Life Links Program</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <input checked="" type="checkbox"/> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 286 Mt. Prospect Avenue Newark, New Jersey 07104-2008
<b>1e</b>	<p><b>Objective:</b></p> <p>The purpose of the program is to provide permanent connections with caring adults that can assist and support youth. The North Ward Center staff will act as advocates for the youth in the engagement of these adults and in the process of securing a commitment for a permanent caring relationship. The youth will be assisted in identifying and implementing a plan of self-sufficiency and identifying lifelong connections.</p>
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b></p> <p>The goal of the program is to identify connections that will lead to permanency pacts and/or</p>

	<p>permanent connections that support the adolescent. The process includes the identification of caring adults who will provide a safe and supportive relationship for the youth as he/she transitions from out of home placement. Potential supportive adults will be identified through discussion and activities with youth, the DCP&amp;P caseworker and a review of the case file by North Ward Center staff. The DCP&amp;P caseworker will help screen identified adults as necessary. Adults to be considered may include a resource parent, teacher, CASA advocate, mentor, or members of the biological or adoptive family as indicated. North Ward staff will prepare the youth for a conversation with the identified adult resource(s) and will reach out to prepare the adult as well. If appropriate and amenable, a permanency pact that specifies the support to be received will be developed between the youth and the caring adult. It is envisioned that some of the individuals to be considered will emanate from the DCP&amp;P worker's family team meeting. For those youth referred for the permanency pact program, it will be advantageous for the North Ward staff member assigned to participate in the family team meeting.</p> <p>The North Ward Center will service all youth deemed appropriate and referred by DCF/DCP&amp;P. Upon receipt of a referral, the North Ward Center will contact the referring caseworker within two business days and arrange for an intake appointment. The caseworker is required to accompany the youth to the initial session.</p> <p>Following an Intake session, the permanency pact worker will coordinate with the youth and engage in meaningful activities to assist the youth in exploring positive past relationships. They will visit the DCP&amp;P Office in order to mine the case records, contact potential supports, maintain communication with DCP&amp;P to facilitate contact, and upon clearance will develop a permanent connection and/or formalize permanency pact(s) with the youth and the individual(s).</p> <p>Youth served in the permanency pact program will have access to all supportive services offered by the North Ward Center. Efforts will be made to identify youth from the Life Skills Program who need life long connections to successfully transition to adulthood.</p>
<p><b>2b</b></p>	<p><b>Population Served:</b>                  The North Ward Center will serve youth under the supervision of Essex County DCP&amp;P that reside in Essex County that are in DCP&amp;P authorized out of home placement. Ages served are youth 14 to 21 years old that require permanency services and who are aging out of placement. They may be legally free for adoption and/or lack a permanent plan. Their case goal must be Individual Stabilization, Independent Living or Other Long Term Specialized Care.</p> <p>Youth in adolescent housing programs as well as youth placed through PerformCare are eligible for permanency services. Services provided help ensure that permanent relationships are established and sustained with caring individuals.</p>
<p><b>2c</b></p>	<p><b>Geographical Area of Services:</b>                  The North Ward Center will serve all children/youth that reside in Essex County that are in DCP&amp;P authorized out of home placement that are expected to "age out" of that placement who meet the referral criteria.</p>

	Exceptions may be made at the mutual discretion of DCP&P and The North Ward Center.
<b>2d</b>	<p><b>Referral Sources:</b> DCP&amp;P Essex County Local Offices and DCF Office of Adolescent Services.</p> <p>All referrals must be approved by the DCF Office of Adolescent Services (OAS) prior to engagement.</p>
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b> <b>Include data where available:</b> Fourteen youth ages 14 to 21 years old participated in the NWC Life Links Program. Youth are more involved in the planning process. Youth were able to identify adults that they believed to be reliable and willing to work with them beyond the child welfare system.</p>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> 100% of the permanency pacts remained intact for 6 months+. 90% of the youth agreed to other alternative arrangements and/or delayed the connection. 90% of youth know at least one adult they can depend on when they exit care. 90% of the youth felt no need to “formalize” a permanent connection. 90% of youth understood the purpose of a permanent connection 90% of youth know at least one adult they can depend on when they exit care 60% of youth participated in the intake process 33% of the youth have at least one formalized permanent connection to a caring adult. 15% of the youth who participated in the program were able to establish a permanency pact.</p>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> All meetings are held in a neutral, homelike setting apart from the DCP&amp;P Local Offices. All youth feel that their ideas and opinion are valued; they are listened to and have a major part and vital input into their permanency planning process.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b> Lack of referrals being received. Networking, attendance at statewide OAS meetings, staff meetings with OAS and DCP&amp;P Area Offices to discuss the Program and value of initiating this planning for the aging-out population. Continued discussion with DCF/DCP&amp;P staff regarding the benefits of the permanency program. Additionally, The North Ward Center has continued to train staff and MSW interns to facilitate, assist in the linkages, and fill any void as needed.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> A unit of service entails a youth referred to the program in an effort to develop a permanent connection with at least one caring supportive adult.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 20 youth per year.</p>

<p><b>3g</b></p>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 20 youth per year.</p>
<p><b>3h</b></p>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals: 14</b> <b># of unduplicated families: n/a</b></p>
<p><b>3i</b></p>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> Fourteen Participant Surveys were sent to all who participated in the NWC Life Links Program.</p> <p>A total of 2 responses were received during this reporting period.</p> <p>Every response was positive.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>4a</b></p>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> Greater emphasis will continue to be placed on increasing referrals for aging-out youth as many seem to be unprepared to function independently outside of the child welfare system. Consideration will be given to expanding referral criteria. Additionally, for the next contract period, discussion of combining the current Life Skills program with this Life Links program is underway, in an effort to provide permanency services to more eligible youth.</p>
<p><b>4b</b></p>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b> Continued efforts will be made to identify youth from the Life Skills Program who need life long connections to successfully transition to adulthood.</p>
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> It is anticipated that the contracted level of service will be achieved, i.e., 20 youth will be serviced annually.</p>
<p><b>4d</b></p>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> <b># of unduplicated individuals: 20</b> <b># of unduplicated families: n/a</b></p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	

<p><b>5a</b></p>	<p><b>How will you measure progress?</b>                  It is anticipated that the contracted level of service will be achieved, i.e., 20 youth will be serviced annually.                  In order to comply with federal reporting requirements, the Life Links program reporting is completed electronically as required by the office of Adolescent Services. The mechanism for this report is utilization of the provided excel spreadsheet submitted via email.                   Monthly summary reports are due to the Office of Adolescent Services on the 10<sup>th</sup> calendar day of each month. Each report will capture data from the previous month’s activities.                   The Coordinator and Project Director monitor these reports. Corrective action measures are developed and implemented to address any apparent deviation from achieving program objectives.</p>
<p><b>5b</b></p>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b>                  All pending and completed permanent pacts are reviewed by the Coordinator and Project Director to ensure that they address all concerns that have been indicated through the process. All pending/considered connections are cleared through the DCP&amp;P staff.                   Stakeholder and consumer satisfaction feedback surveys are reviewed by program staff, evaluated and used as a tool to identify weaknesses and implement program improvement.                   Ongoing discussions occur with DCF/DCP&amp;P staff at meetings, conferences and trainings. There is a high commitment placed on attending these events in an effort to ensure ongoing positive working relationships.</p>
<p><b>5c</b></p>	<p><b>How do you collaborate with community partners?</b>                  The North Ward Center partners with Independence, A Family of Services to create pathways to success for at-risk youth.                   The program also has established connections with the various Family Success Centers in the County to ensure that youth that receive support from these agencies and may also access additional planning services through the program.</p>

**2017 PSSF Update Report**

<p><b>Section 1 – Identifying Information</b></p>	
<p><b>1a</b></p>	<p><b>Provider:</b> The Children’s Home Society of New Jersey (CHSofNJ)      <b>1b Program Name:</b> Intensive Services Program (ISP)</p>
<p><b>1c</b></p>	<p><b>Relevant PSSF Program:</b> <input checked="" type="checkbox"/> X_FPS, <input type="checkbox"/> FSS, <input type="checkbox"/> TLFRS, <input type="checkbox"/> APSS</p>

<b>1d</b>	<b>Program Address:</b> 635 South Clinton Avenue, Trenton NJ, 08611
<b>1e</b>	<b>Objective:</b> The objective of ISP is to work with families who have had their children removed by The Division of Child Protection and Permanency because of abuse and/or neglect, and to provide them education, support, counseling, that therapeutic visitation to help them increase their capacity to parent and prepare them for possible family reunification.
<b>1f</b>	<b>Outcome(s) Addressed:</b> ___ Safety __X__ Permanency ___ Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b>  The ISP program provides a number of services to help parents increase their capacity to parent and to help them prepare for possible family reunification. These services include individual and family parent education, individual and family counseling, parent support and education groups, and therapeutic visitation.
<b>2b</b>	<b>Population Served:</b> Families who have had their children removed by The Division of Child Protection and Permanency because of abuse or neglect.
<b>2c</b>	<b>Geographical Area of Services:</b>  Mercer County New Jersey
<b>2d</b>	<b>Referral Sources:</b> The Division of Child Protection and Permanency, Mercer North and Mercer South Local Offices.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<b>Provide a summary of program accomplishments on goals. Include data where available:</b>  <u>ISP has the goal of improving parental capacity in 90% of families who take part in the services.</u> An analysis of the treatment plan goals, and the results of the North Carolina Family Assessment Scales (NCFAS) and the Adult-Adolescent Parenting Inventory (AAPI) indicated the following related to the improvement of parental capacity  A review of treatment plans shows that 63.9% of reviewed treatment plan goals had at least 52% improvement towards goal achievement. 30% had fully achievement treatment goals.  Based on the standardized assessments used (AAPI-2 and NCFAS-R) the following results were determined.  Of the reviewed treatment plans, there were 47 established treatment goals related to the

NCFAS-R domain of parental capabilities. 63.8% of those goals had at least 52% improvement from the time they were established.

Of the reviewed treatment plans there were 7 established treatment goals related to the NCFAS-R domain of readiness for reunification. 57% of those goals had at least 75% improvement from the time they were established.

Below is a review of the clients in respect to their scores on the NCFAS-R at the time of closure. On the domain of Overall Caregiver/Child Ambivalence 54% scored at baseline or above while 46% showed improvement in this domain. On the domain of Overall Child Well-Being 77% scored at baseline or above while 35% showed improvement in this domain. On the domain of Overall Environment 58% scored at baseline or above while 35% showed improvement in this domain. On the domain of Overall Family Interactions 46% scored at baseline or above while 42% showed improvement in this domain. On the domain of Overall Family Safety 58% scored at baseline or above while 50% showed improvement in this domain. On the domain of Overall Parental Capabilities 50% scored at baseline or above while 50% showed improvement in this domain. On the domain of Overall Readiness for Reunification 46% scored at baseline or above while 46% showed improvement in this domain.

A review of the Adult Adolescent Parenting Inventory (AAPI-2) yielded the following results. At discharge 24% of clients scored average to low risk on the domain of: Children's Power and Independence and 21% of clients improved. At discharge 28% of clients scored average to low risk on the domain of: Expectations of Children and 15% of clients improved. At discharge 39% of clients scored average to low risk on the domain of: Parent-Child Role Reversal and 15% of clients improved. At discharge 27% of clients scored average to low risk on the domain of: Parental Empathy and 15% of clients improved. At discharge 36% of clients scored average to low risk on the domain of: Use of Corporal Punishment and 12% of clients improved.

Analysis using this inventory was challenging as 62% of clients did not complete the closing form therefore progress could not be compared to intake ratings.

ISP has the goal that 85% of families will be able to develop a permanency plan within 12 months of starting the program. ISP served 45 families and 80 children. 3 other families were referred and had their referrals withdrawn prior to their intake. During this period we closed 28 families. 77% of those families had permanency plans supported by ISP (38% Reunification, 23% KLG, and 19% Adoption). 38% of these families achieved the permanency goal set forth by DCP.

Time frames for permanency are as follows.

87.5% of families who achieved the DCP permanency goal did so within 12 months of their referral to ISP with the average occurring at 6.8 months. 100% of families who achieved the DCP permanency goal did so within 12 months of their ISP intake. Cases were typically opened approximately 30 days from the time they were referred to the program.

<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b>          The results of ISP’s goals indicate that the ISP program helps to identify parental strengths and weaknesses that are necessary to address to achieve healthy permanency outcomes. These results would indicate that parents either improve their ability to parent and therefore it would suggest reunification would be successful or indicate that it would not be safe to return children thus supporting the Division move forward with alternative permanency outcomes for children.</p>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b>          The comprehensiveness of the services to include both education and counseling, and the incorporation of the parent support and education group appear to have a significant positive effect on the outcomes.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b>          Some of the specific barriers faced in achieving the goals are family’s lack of resources and consistent engagement in services. Due to a variety of reasons specifically trauma related birth parents struggle to obtain the necessary personal stability to improve their parenting.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b>          Level of service is 20 families per month for a total of 240 duplicated families per year.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b>          Level of service is 20 families per month for a total of 240 duplicated families per year.</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b>          The intensive services program saw 215 families during this reporting period representing 89.6% of contracted level of service.</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:</b> 80 Individuals – including children during visitation  <b># of unduplicated families:</b> 45 Families</p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>          The Consumer Satisfaction Survey Version 8 (CSQ8) is sent to all families upon their discharge. During this period there were no respondents. We will also be implementing a client NCFAS exit instrument which will be compared with the clinician’s exit instrument to evaluate services.</p>

<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>There are no planned changes at this time.</p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>There are no planned changes at this time.</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p> <p>ISP is projected to serve 20 families per month for a duplicated count of 240 families</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p><b># of unduplicated individuals:</b> This may vary as the LOS is determined by duplicated numbers.</p> <p><b># of unduplicated families:</b> This may vary as the LOS is determined by duplicated numbers.</p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b></p> <p>ISP measures progress in several ways, including treatment plan goal review, pre and post measurements of the North Carolina Family Assessment Scales (NCFAS) and the Adult-Adolescent Parenting Inventory (AAPI), and a review of discharge summaries.</p>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <p>The Consumer Satisfaction Survey Version 8 (CSQ8) is sent to all families upon their discharge and when results are received we incorporate the feedback into our quality assessment. Also, the Quality Assurance Department competes quarterly chart reviews to monitor both the quantitative and qualitative aspects of the staff’s work. In addition, the Quality Assurance Department reviews all Critical Incident Reports and Child Abuse and Neglect reports by program and identifies any program trends and/or staff training needs indicated by these reports. This information is then incorporated into a quality improvement plan.</p>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b></p> <p>CHSofNJ and the ISP program collaborate with the Division of Child Protection and</p>

	Permanency Mercer North and Mercer South local offices. When necessary, we also collaborate with other service providers that the ISP clients may have once proper releases have been secured.
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**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Robins’ Nest
	<b>1b Program Name:</b> Creative Visitation
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, ___ FSS, <u>X</u> TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 42 S. Delsea Drive Glassboro, NJ 08028
<b>1e</b>	<b>Objective:</b> The goal of this program to help foster the parent-child relationship for children in out of home placement and improve parenting capacity by facilitating visits between the parent and children; assisting in their ability to meet their child’s physical, emotional and developmental needs during visits.
<b>1f</b>	<b>Outcome(s) Addressed:</b> ___Safety <u>X</u> Permanency <u>X</u> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> This program assists with permanency planning in a manner consistent with the Adoption and Safe Families Act (ASFA). The program provides services that address the goals of: improving parental capacity and parent-child interactions, supporting and maintaining family bonds; providing parents with opportunities to identify and practice skills that meet their child’s needs; decreasing the length of time children remain in out of home placement. Staff also provide documentation of visits strengths and needs to support permanency planning. Services provided include: transporting children to and from visits; supervising visits; coaching parents on their parenting skills, debriefing after each visit to reinforce what went well and to plan ways to meet their child’s needs during future visits, and providing comprehensive relevant documentation regarding our observations and interactions. During visits, staff assess and document the parent's parenting skills and interaction with their children. Staff utilize Visit Coaching which supports the parents in meeting their children’s needs and building upon their strengths. Staff intervene as needed to ensure the child's physical and emotional safety and to teach, model, and coach parenting skills. Staff utilize feelings exploration while transporting the children to and from visits to help the children process their feelings.

<b>2b</b>	<b>Population Served:</b> DCP&P involved parent whose children (birth to 18) are in an out of home placement in our service area and in the legal custody of DCP&P.
<b>2c</b>	<b>Geographical Area of Services:</b> Parents and children who reside in Burlington, Camden, Gloucester, Salem, Cumberland, Atlantic, and Cape May counties in New Jersey.
<b>2d</b>	<b>Referral Sources:</b> The Department of Children and Families, Division of Child Protection and Permanency local offices from within our geographic coverage area refer to our program.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b></p> <p><b>Include data where available:</b> Creative Visitation exceeded the contracted 1400 visits and provided 1,663 or 116% parent-child and sibling visits during this time frame.</p> <p>Where reunification is the child’s primary DCP&amp;P goal: <b>50% will improve parental interactions at 90 days post intake.</b></p> <p><b>Outcome:</b> 96% of the cases where the child’s primary goal was reunification had improved parental capacity.</p> <p><b>75% will improve parental interactions at 6 months.</b></p> <p><b>Outcome:</b> 100% of the cases where the child’s primary goal was reunification had improved parental capacity.</p>
<b>3b</b>	<b>How did this improve outcomes for children and families?</b> Through our facilitation of weekly visits, the familial bond is able to be maintained. By helping coach and guide parents during visits, they are helped to improve their parental readiness and parental capacity. More parents are able to meet the physical, emotional and safety needs of their children so they can have more meaningful visits, assisting with the children’s emotional well-being.
<b>3c</b>	<b>Identify specific factors that contributed to this improvement:</b> The nature of our visitation is tremendously beneficial. The design of Visit Coaching, which includes debriefing with the family each week, allows us to specifically target the parenting issues they need to work on to achieve their ultimate goal. It allows for opportunities to practice learned parenting skills and provides documentation of the parents’ abilities and parent-child interactions as we work with the DCP&P. Our use of Visit Coaching provides families with a strength-based approach to identifying their children’s needs and how to

	<p>meet those needs during each visit. Staff provided support, empowerment, modeling and feedback throughout each visit. The documentation that we provided gives DCP&amp;P and the court an objective picture of the parent’s parenting skills and interaction with their children during visits. Staff complete a detailed training on writing a thorough and relevant DAP note. Each DAP note reflects directly to the goals on the Family Interaction Plan, allowing progress and areas of improvement to be assessed and reported on weekly.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b>          Many parents have severe and chronic mental health issues and this contributes to their ability to have consistent visitation with their children. If a parent is not stable with their mental health, this may delay or prevent visits from happening. We are addressing this issue by helping parents to advocate for the appropriate diagnosis and treatment. We look at their mental health through a trauma informed lens, this helps us to set realistic goals with clients and better define effective intervention techniques. While we would like to get to every family as soon as they are referred, that is not always possible. Consistently, our program has a waitlist of 4 - 6 months before receiving Creative Visitation services.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b>          Units of service are defined as client related hours.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b>          Our contracted level of service portion that is Title IV-B funded for the period of 10/1/15-9/30/16 is 13.24% or 794.4 hours.</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b>          The actual level of service that is Title IV- B funded for the period of 10/1/15-9/30/16 is 103% or 818.23 hours.</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals: 33</b>  <b># of unduplicated families: 14</b></p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>          100% of families surveyed were very satisfied with their relationship with the Creative Visitation visit coach.          100% of families surveyed were very satisfied with the program services.          100% of referral sources surveyed were either very satisfied or satisfied with the Creative Visitation visit coach.          100% of referral sources surveyed were either very satisfied or satisfied with the program services.</p>

<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>Robins' Nest will be offering monthly ongoing training modules covering various topics essential to developing staff skill sets and enhancing job performance. These ongoing training can be attended on an as needed basis. CV will continue to utilize Visit Coaching during visits to empower parents to successfully meet their children's individual needs, implementing intervention strategies from the Attachment, Self-Regulation, Competency (ARC) Model.</p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>To further solidify our collaboration and partnership with all resource parents and minimize potential confusion about their role with our services, we've expanded our orientation process with them. Staff supply informational materials to resource parents including The Roles and Responsibilities Matrix which delineates roles and responsibilities for visitation staff, resource parent, child and birth parent. Resource parents are also provided with a Resource Parent Pamphlet which provides program and visitation details. This information increases awareness and involvement of the resource parents, creating a supportive network around visits and increasing the likelihood of a positive rapport and collaborative process toward the goal of permanency being achieved.</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p> <p>We expect to deliver 13.24% or 794.4 hours of service.</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p><b># of unduplicated individuals: 30</b>  <b># of unduplicated families: 6</b></p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b></p> <p>We will continue to utilize the North Carolina Family Assessment Scale for Reunification (NCFAS-R) to measure the parental capacity readiness and improvement. This tool assists in determining improvement in significant life domains, including family interactions and readiness/parental capacity. This data can be aggregated by permanency disposition to help determine areas of effectiveness with reunified vs non-reunified families. Creative Visitation uses an electronic record process (Qualifacts CareLogic) in which data can be compiled and immediately accessed to determine progress toward performance benchmarks. Program performance outcomes will be reviewed monthly during staff meeting, allowing for a timely review; recognition of what went well and readjustments as necessary.</p>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <p>All agency programs track performance outcomes on a monthly basis, which get reviewed</p>

	<p>at management team meetings. On a monthly basis, programs complete Program Performance Scorecards, highlighting areas where outcomes have been exceeded, met or fall short of the benchmark. The agency’s Child Protection and Permanency Department Director meets quarterly with the program director and program staff to review results and discuss how to maintain successes and improve areas in need of enhancement. During opening paperwork, parents are given the opportunity to participate in a confidential phone survey during the visit component of the program. Parents are randomly selected and contacted for their feedback. Receiving feedback while we are still providing services to the parent allows us to adapt our services and improve customer satisfaction. Internal record reviews are conducted quarterly to monitor and enhance quality of services and documentation. At the end of the program, the parent is given a confidential self-administered mail survey with a pre-stamped envelope to provide their feedback. A percentage of randomly selected DCP&amp;P caseworkers receive an e-mail asking them to participate in a confidential survey. These surveys ask the parent and caseworker to indicate their level of satisfaction with the visit coach/therapist and program services</p>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b>          In addition to a strong DCP&amp;P-Creative Visitation partnership, staff has established relationships with community providers involved in the family’s treatment. Staff recognize that family’s outcomes are better when there is timely open communication and collaboration amongst those involved with the family. Staff willingly participate in Family Team Meetings when requested and encourage families to enhance their formal and informal support system. Our relationship with these community providers helps us link families to the community services and resources they need.</p>

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>			
<b>1a</b>	<table border="1"> <tr> <td data-bbox="235 1209 860 1318"><b>Provider:</b> Mercy Center</td> <td data-bbox="860 1209 1429 1318"><b>1b Program Name:</b> Family Resource Center</td> </tr> </table>	<b>Provider:</b> Mercy Center	<b>1b Program Name:</b> Family Resource Center
<b>Provider:</b> Mercy Center	<b>1b Program Name:</b> Family Resource Center		
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <u>  x  </u> FSS, ___TLFRS, ___APSS		
<b>1d</b>	<b>Program Address:</b> 1108 Main Street Asbury Park, NJ 07712		
<b>1e</b>	<b>Objective:</b> To establish a Family Resource Center/Community Based Drop-in Center in Asbury Park where consumers from Asbury Park and Neptune have access to a continuum of services that address the needs of underserved children and families.		
<b>1f</b>	<b>Outcome(s) Addressed:</b> <u>  x  </u> Safety ___ Permanency <u>  x  </u> Well-Being		
<b>Section 2 – Service Description Basics FFY ’15 (10/1/15 – 9/30/16)</b>			
<b>2a</b>	<b>Overview of Service:</b> The FRC’s overall purpose is to provide an array of supportive and treatment services to		

	<p>prevent or reduce the incidence of child abuse and neglect. All services are implemented in a context that assures the physical, psychological, and spiritual wellbeing of the children and families of Asbury Park and Neptune. Services are tailored to the families' needs and situations.</p> <p>The FRC serves as a community based social service agency, where service delivery methods are designed to address the family needs and strengthen the family system. Families have the ability to access and obtain information regarding community resources. Presentations, educational workshops, community resource guides are provided to social service providers, individuals, organizations, churches and schools. Crisis intervention services are available to walk-ins in crisis. Families have the option of receiving direct support services on-site, or referred to the appropriate agency to address their needs/situations. FRC's services are provided within an unrestricted, family friendly environment where customers feel free to drop in during a crisis. In the situation of a family crisis, services are immediately put in place to deflate the situation and create some level of stability. If the FRC is unable to provide direct services on site, every effort is made to connect the family with the appropriate agency.</p>
<p><b>2b</b></p>	<p><b>Population Served:</b></p> <p>The FRC serves the vulnerable/fragile families in Asbury Park, Neptune and the immediate surrounding areas, who are experiencing some level of crisis that has put their children at risk for out of home placement. FRC also serves individuals and families whose behaviors/issues created a level of instability and dysfunction that affects their ability to maintain a healthy family unit.</p> <p>Population Profile:</p> <ul style="list-style-type: none"> <li>• 20 % are single mothers with at least 2 children</li> <li>• 50 % are under or unemployed</li> <li>• 40 % have not completed high school</li> <li>• 10 % have no child care</li> <li>• 35 % indicate they have some concrete needs</li> <li>• 42 % Females</li> <li>• 58 % Males</li> <li>• 65 % have history of substance abuse</li> <li>• 57 % African American</li> <li>• 24 % Latino</li> <li>• 8 % Other</li> <li>• 11% Caucasian</li> </ul> <p>During this reporting year, FRC received over 2,000 phone calls requesting information about a range of resources; concrete services, social service, emergency assistance and referrals. The FRC continues to serve a significant number of males who appear motivated to complete mandatory treatment services and become self-sufficient. Unfortunately, many are often faced with the obstacle of their criminal history that hinders their ability to obtain gainful employment. On a positive note, more fathers are beginning to undertake their role and responsibilities of custodial parents; others are taking a more active role in their</p>

	<p>children’s lives. Regrettably, lack of funding to support the Fatherhood Program has a significant impact on the FRC’s ability to adequately address the needs of many young fathers.</p> <p>Approximately 625 children/youth between the ages of 0-18 years participated in individual counseling, group sessions and summer camp activities. These referrals came mainly from the local school districts and or parents. The catchment continues to change, as a result there are different ethnic groups seeking supportive and clinical services. There is a consistent increase in the Latino population seeking support services and becoming more involved in the child welfare system.</p>
<b>2c</b>	<p><b>Geographical Area of Services:</b> Asbury Park and Neptune areas in Monmouth County</p>
<b>2d</b>	<p><b>Referral Sources:</b> The following number reflects clients who participated in treatment services</p> <ul style="list-style-type: none"> <li>• 25% DCP&amp;P</li> <li>• 25% Self-referrals</li> <li>• 19% Community providers</li> <li>• 31% Legal System</li> </ul> <p>FRC is well established as a Community Based Drop-In Center, the number of self-referrals is an indicator of how well residents utilize the center. This also indicates that families/individuals appear to be more motivated and proactive in seeking services when they recognize the need.</p> <p>There is also a regular flow of referrals from DCP&amp;P requesting family services, Judicial System request treatment and support services for both juveniles and adults on probation or parole, County &amp; Local Social Services, Faith Community Providers, local school districts &amp; the Health Care System and Walk-Ins.</p>
<p><b>Section 3 – The Year in Review FFY ’15 (10/1/15 – 9/30/16)</b></p>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b> <b>Include data where available.</b></p> <p>During this reporting year, the FRC has seen a significant increase in walk-ins/self-referrals seeking and utilizing program services which suggest that the community residents are more aware of the program. Approximately 2000 families and children benefited from an array of services not limited to; family preservation, family support, family reunification, camperships, Christmas gifts, thanksgiving baskets, conference/workshop presentations, concrete services, advocacy, community events, information resources and referrals.</p> <ul style="list-style-type: none"> <li>• 24 families received Family Preservation services/ 18 families remained intact with children maintained safely in their homes at the completion of services</li> <li>• 30 families received Family Reunification services /14 children were returned home from foster care placements</li> <li>• 171 families received Family Support services/100 families were stabilized</li> <li>• 22 individuals enrolled in parenting classes/ 10 completed;</li> <li>• 49 enrolled in adult substance abuse intervention /19 completed</li> </ul>

	<ul style="list-style-type: none"> <li>• 48 enrolled in adult anger management/ 26 completed</li> <li>• 96 participated in individualized/comprehensive services that include but not limited to mental health counseling through individual, family and or group modality.</li> </ul> <p>Mercy Center has expanded family services under the umbrella of the FRC by exploring other funding opportunities. The successful implementation of the Community Intervention Coaches program, to address the issues of youth involved with probation. This program has resulted in a reduction of the probation violation rate among minority youth. Engaged families also participate in support services through the FRC. A small grant from NJNG enables FRC to provide trauma focus therapy (Resiliency Group) for adolescent and teens. The agency continues to seek funding to adequately address the needs of the Spanish speaking population. The program also utilizes masters' level graduate interns from local colleges and universities.</p>
<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b></p> <p>Children and families experienced better outcomes as a result of a combination of factors such as; the increased community awareness regarding child abuse and neglect prevention services, and the available family support services. Families also obtain information at community presentations and through the distribution of educational and informational materials including updated resource guides (with links to website: <a href="http://www.mercycenternj.org">www.mercycenternj.org</a> for calendar of program activities). By maintaining visibility within the community, connecting more families to needed resources such as; summer camp, after-school and recreation programs. Connected families to the appropriate services to address crisis situations and basic needs, in an effort to stabilize and strengthen the family unit. Program staff participated in DCP&amp;P team meetings; Monmouth Cares - Family team meetings; immediate connection to crisis screening/suicide prevention; linkage to Perform Care for mental health assessment and referrals. In addition to access to job training /employment, housing and emergency assistance information and resources.</p> <p>Families demonstrated improvement in their functioning and stability by active participation in individualized services such as; parenting education, substance abuse counseling, individual and family counseling, anger management and wraparound services. Interventions such as parenting classes helped to strengthen/enhance parental relationship by using more appropriate and effective parenting practices. Wraparound approach provides the families with the support, skills, techniques and resources to reduce their stress level.</p> <p>The most significant indications of improved outcomes are reflected by the number of families that had their child welfare cases closed by DCP&amp;P; the number of individuals who successfully completed their probation requirements; the children and youth who maintained stable school placements and the number of individuals who obtained and retained jobs.</p>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement.</b></p> <p>The following factors have contributed to families and children having improved</p>

	<p>outcomes:</p> <ul style="list-style-type: none"> <li>• Access to a continuum of on-site services.</li> <li>• Application of evidence based therapeutic approaches.</li> <li>• Online access to a community resource guide.</li> <li>• Connection and follow up with the appropriate services.</li> <li>• Working with a diverse, competent, dedicated and compassionate staff.</li> <li>• Ongoing professional development training for staff.</li> <li>• Effective working relationship with staff.</li> <li>• Delivery of culturally sensitive services and a bilingual staff.</li> <li>• An environment that is friendly, non-threatening, and accessible.</li> <li>• Additional support services from other funding sources e.g. Victim/Witness Advocates &amp; Community Intervention Coaches.</li> <li>• Access to computers with internet availability, use of telephone and fax machine.</li> <li>• Maintaining collaborative relationships with other agencies and stakeholders.</li> <li>• Maintaining an active role on local and county advocacy committees and advisory councils.</li> <li>• Families having access to the agency’s emergency assistance services (food pantry and clothing closet).</li> </ul>
<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment.</b></p> <p>The inability to obtain stable and affordable housing continues to be a major barrier for the underserved residents on the west side of the city of Asbury Park; as well issues related to unemployment; the gang violence within the community continues to created a stressful and dangerous environment for the families and children in both Asbury Park and in areas of Neptune Township. Street violence sometimes prevents families from accessing services, and parents mired by the feeling of helplessness and hopelessness struggle to provide and maintain a healthy, safe and nurturing environment. Other barriers: the lack of transportation, transient living situations due to unaffordable housing, and the inability to maintain communication due to unreliable phone system. There are also the arduous and time consuming efforts to engage the more guarded, undocumented families.</p> <p>Undocumented immigrants’ families with children demonstrate major difficulties in creating an environment of safety and stability for their children. The fear of deportation and lack of trust in the system prohibits many families from accessing needed help for their children. To address these barriers, FRC continues to advocate and engage other interested community stakeholders to review polices and interventions that hinder families and children’s safety and stability.</p>
<p><b>3e</b></p>	<p><b>Definition of Level of Service as per contract:</b></p> <p>A unit of service consists of one hour of direct service provided to clients such as; case management, individual/family counseling, team meetings, meeting with collaterals, concrete services-transportation, clothing, program meals, emergency assistance, urine testing; and education and information workshops.</p>

<p><b>3f</b></p>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16</b> LOS per year 4,800</p>
<p><b>3g</b></p>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16</b></p> <p>FRC delivered 4,822 actual LOS which does not account for other supplemental services such as; use of fax and phone, access to computers for job searches and resume writing to walk-in clients.</p>
<p><b>3h</b></p>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals: <u>NA</u></b> <b># of unduplicated families: 225 families</b></p>
<p><b>3i</b></p>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <p>Fifteen (15) questionnaires were sent out to stakeholders to gather feedback about the services provided at the FRC, ten (<b>10</b>) were completed and returned. The questionnaire consisted of a series of items referencing the accessibility of services, services delivery, staff professionalism and cultural competency and sensitivity. Responses were based on a Liker scale, responses ranged from strongly agree to strongly disagree or not sure/not applicable.</p> <p>Respondents were asked to state the degree to which they considered the services were delivered according to appropriate standards of practice. Overall the responses were very positive. Responses indicated a high level of satisfaction in the following areas: services delivered in a timely manner; the organization’s convenient location and accessibility; services provided were culturally sensitive; organization works with other community organizations to advocate on behalf of the persons it serves; organization reputation with the community is favorable and the organization’s personnel are qualified and competent in the performance of their jobs.</p> <p>A few respondents suggested expansion to provide services tailored to the needs of fathers, especially those with a history of incarceration, and enrichment skills for boys and young adults.</p> <p>Fifty-three (53) consumer satisfaction surveys were distributed on-site or via mail. Overall the evaluations were very positive. Seventy –four percent (<b>74%</b>) rated the services as excellent, <b>22%</b> good and <b>4%</b> fair. Majority of consumers indicated that the services were provided in a timely manner and the workers were friendly and helpful. Some indicated having more evening hours and Saturday hours.</p>
<p><b>Section 4 – The Year Ahead FFY ’16 (10/1/16 – 9/30/17)</b></p>	

<p><b>4a</b></p>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program</b></p> <p>For the second year, Mercy Center has expanded its behavioral treatment services to children between the ages of 5-12, as a result of a small grant for the New Jersey Natural Gas (NJNG). This program is designed to address the needs of children who have experienced trauma in their homes and communities. The agency is also vigorously exploring funding opportunities to implement a sustainable fatherhood program. This program needs additional funding to provide the need services to adequately and effectively address the needs that strengthen families and reduce the incidences of child abuse and neglect. Mercy Center also received a VOCA grant to provide advocacy services to victims/witnesses from Asbury Park and Neptune.</p>
<p><b>4b</b></p>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>FRC is in the process of constructing a Facebook page in an effort to increase knowledge of available community resources and information. Mercy Center maintains and an updated website with a monthly calendar of program activities and events, distribute information through the local social service providers and the United Way of Monmouth County Listserv, present information regarding community resources at various events and, continue to explore funding opportunities to sustain the Fatherhood Empowerment Project. The agency also plans to engage and inform residents through social media.</p>
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/15 – 9/30/16?</b></p> <p>An anticipated 4,800 units of services will be delivered. Units of Service will include direct services, case management, information and referrals, and other concrete services.</p>
<p><b>4d</b></p>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>  <b># of unduplicated individuals: <u>NA</u></b>  <b># of unduplicated families: 150</b>  <i>Since FRC's goal is to strengthen and support families, services are centered on the family as a unit.</i></p>
<p><b>Section 5 – Evaluating Progress FFY '16 (10/1/16 – 9/30/17)</b></p>	
<p><b>5a</b></p>	<p><b>How will you measure progress?</b></p> <p>FRC has a more updated case management system “Little Green Light” (LGL) to track client information, programs outcome data and level of service delivery. The outcome progress will be evaluated by establishing a baseline of the family’s level of functioning at the start of the services and benchmarks to measure goal achievements. Client and counselor will mutually develop an individualized treatment plan, and or service plan with measurable and attainable goals.</p>

<p><b>5b</b></p>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <p>The following components will be used to assess and improve services: Client service plan evaluation; treatment plan goals and objectives; staff observation regarding changes in client behavior and attitude; consumer satisfaction surveys and stakeholders questionnaires; and staff participation in family team meetings. In addition, staff will administer a pre and post-test depending on the treatment modality.</p>
<p><b>5c</b></p>	<p><b>How do you collaborate with community partners?</b></p> <p>FRC continues to build and maintain successful collaborative relationships by sharing resources, partnering on different community initiatives and utilizing program services through partnerships, referrals and networking. As a result of these collaborative relationships, clients now have easier access to services and programs such as child abuse and prevention programs, domestic violence counseling, substance abuse education, prevention and treatment, camp scholarships, Christmas and Thanksgiving assistance, medical assistance, housing assistance, recreation, job training /employment opportunities and community events. In an effort to increase awareness of child abuse and neglect in Asbury Park, in April- Prevent Child Abuse month, the Family Resource Center and the City of Asbury Park collaborate with other social service agencies, the school district, DCP&amp;P, and the faith community to organize community events. The agency maintains ongoing communication with providers to closely monitor the gaps in services, thereby reducing the chances of the duplication of services and maximize community resources.</p>

### 2017 PSSF Update Report

Section 1 – Identifying Information	
<b>1a</b>	<p><b>Provider:</b> Care Plus NJ, org</p> <p><b>1b Program Name:</b> Healthy Families – TIP Hudson County</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <input checked="" type="checkbox"/> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 600 Meadowlands Parkway Suite 142 Secaucus, NJ 07094
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
<b>2b</b>	<b>Population Served:</b> All TANF families with children under the age of 12 months old, and new parents living in Hudson County.
<b>2c</b>	<b>Geographical Area of Services:</b> Hudson County
<b>2d</b>	<b>Referral Sources:</b> Hudson County Central Intake,
Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b></p> <p><b>Include data where available:</b></p> <ol style="list-style-type: none"> <li>1. 97% of children were enrolled in health insurance</li> <li>2. 84% of participating infants/children were up-to-date on immunizations.</li> <li>3. 100% of participants increased their interpregnancy interval (birth to conception) to 18 months</li> </ol>

	<p>4. 95% of participating infants/children had a medical home</p> <p>5. 94% of participating infants/children received developmental screening and appropriate referrals.</p>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b></p> <p>Some of the barriers HF-TIP faced during this period were retention of the TANF families. TANF families dropped out of the program once their TANF case closes or if they enrolled in a 35-hour weekly core activity. HF-TIP is outreaching more prenatal families referred by Central Intake. HF-TIP continues to offer evenings and weekend home visits to accommodate these families.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b></p> <p>149</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b></p> <p>107</p>

<p><b>3h</b></p>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:</b> 100  <b># of unduplicated families:</b> 50</p>
<p><b>3i</b></p>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <p>On 2016, satisfaction surveys were hand delivered by FSW to 55 families. Families were asked to complete surveys in the FSW’s absence and return them in a sealed envelope to their FSW. Out of surveys, 34 surveys were returned. There were a high number of participants that stated they are pleased with the program and they feel comfortable talking and discussing issues with their workers. In addition, families addressed that they are receiving a lot information and support from FSW.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>4a</b></p>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>Healthy Families – TIP Hudson County is collaborating with Central Intake, Board of Social Services and Friends/ Families (Families that are already in the program and they are referring her friends and relatives) to obtain referrals for the program.</p>
<p><b>4b</b></p>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>No changes to report</p>
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p> <p>Healthy Families – TIP is expected to serve a case weight of 143.</p>
<p><b>4d</b></p>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p><b># of unduplicated individuals:</b> 149  <b># of unduplicated families:</b> 75</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>5a</b></p>	<p><b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.</p>

<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
<b>5c</b>	<b>How do you collaborate with community partners?</b> The Healthy Families Program will continue working with Central Intake Hudson County; CCYC (Hudson County Council for Young Children), Board of Social Services, Partnership for Maternal & Child Health of Northern New Jersey, Parent As Teacher and other community services to meet our target objectives. In addition the program manager will continue attending meeting with B.O.S.S to assists families with educational and employment goals, and HF-TIP participates in a joined advisory board committed with NFP, Central Intake and Parent as Teacher.

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Care Plus, NJ Inc. <span style="float: right;"><b>1b Program Name:</b> Healthy Families-TIP</span>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <input checked="" type="checkbox"/> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 611 Route 46 West, Suite 100 Hasbrouck Heights, NJ 07604
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant

	parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
<b>2b</b>	<b>Population Served:</b> The Healthy Families-TIP target population is first time families who are screened through Central Intake who reside in Bergen County and TANF recipients with a child 12 months and under.
<b>2c</b>	<b>Geographical Area of Services:</b> Bergen County
<b>2d</b>	<b>Referral Sources:</b> Central Intake
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals. Include data where available:</b></p> <ol style="list-style-type: none"> <li>6. <u>97</u> % of children were enrolled in health insurance</li> <li>7. <u>99</u> % of participating infants/children were up-to-date on immunizations.</li> <li>8. <u>100</u> % of participants increased their interpregnancy interval (birth to conception) to 18 months</li> <li>9. <u>96</u> % of participating infants/children had a medical home</li> <li>10. <u>97</u> % of participating infants/children received developmental screening and appropriate referrals.</li> </ol>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>

<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment:</b>                  Some of the barriers HF-TIP faced during this time period were enrolling first time prenatal mothers. HF-TIP is outreaching more prenatal families referred by Central Intake and reengaging level X families.                  HF-TIP continues to offer evenings and weekend home visits to accommodate these families.</p>
<p><b>3e</b></p>	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.</p>
<p><b>3f</b></p>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b>                  Level of services from July 1<sup>st</sup>, 2016 – 87 case weight.</p>
<p><b>3g</b></p>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b>                  128</p>
<p><b>3h</b></p>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals: 192</b>  <b># of unduplicated families: 96</b></p>
<p><b>3i</b></p>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>                  Our host agency Care Plus NJ conducts confidential, voluntary “Customer Satisfaction” surveys on an annual basis. Satisfaction surveys were hand delivered by Family Support Workers to 85 families receiving home visitation services. Families were asked to complete surveys in the FSW’s absence and return them in a sealed envelope to their Family Support Worker. Of the 85 surveys, 60 (71%) surveys were returned. The majority agreed that FSWs provide information on parenting, health and development for the child. Also, that they find the staff to be non-judgmental.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>4a</b></p>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b>                  Healthy Families-TIP Bergen County is collaborating with Central Intake, local hospitals in Bergen County and Friends-Family (Families that are already in the program and they are</p>

	referring her friends) to increase the number of prenatal enrollments.
<b>4b</b>	<b>Identify changes you will make that stem from stakeholder feedback.</b> No changes to report.
<b>4c</b>	<b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> Healthy Families – TIP is expecting to serve a case weight of 117
<b>4d</b>	<b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: 190 # of unduplicated families: 95
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
<b>5c</b>	<b>How do you collaborate with community partners?</b> Healthy Families – TIP Bergen County works collaboratively with CCYC (Bergen County Council for Young Children), Central Intake, Board of Social Services and local hospitals in Bergen County to identify appropriate services to meet our targeted objectives. In addition, Healthy Families TIP participates in a joined advisory board committee with NFP, Central Intake, CCYC and Parent as Teachers.

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Burlington County Community Action Program
	<b>1b Program Name:</b> BCCAP Healthy Families-TIP
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <u><b>X</b></u> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 718 Route 130 S., Burlington, NJ 08016
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and

	well-being of participating infants, children and families.																																												
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being																																												
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<b>2b</b>	<p><b>Population Served:</b> Families in Burlington County, NJ</p> <table border="0"> <tr> <td colspan="2"><u>Race/Ethnicity</u></td> <td colspan="2"><u>Caregiver Age</u></td> </tr> <tr> <td>White, non-Hispanic</td> <td>25</td> <td>Under 16</td> <td>0</td> </tr> <tr> <td>Black, non-Hispanic</td> <td>57</td> <td>16-19</td> <td>13</td> </tr> <tr> <td>Hispanic</td> <td>13</td> <td>20-19</td> <td>50</td> </tr> <tr> <td>Multiracial</td> <td>9</td> <td>Over 30</td> <td>33</td> </tr> <tr> <td colspan="2"><u>Marital Status</u></td> <td colspan="2"><u>Education</u></td> </tr> <tr> <td>Single, never married</td> <td>70</td> <td>Less than 12</td> <td>24</td> </tr> <tr> <td>Living together, not married</td> <td>16</td> <td>HS/GED</td> <td>37</td> </tr> <tr> <td>Married</td> <td>8</td> <td>Vocational/Some College</td> <td>29</td> </tr> <tr> <td></td> <td></td> <td>Associates</td> <td>4</td> </tr> <tr> <td></td> <td></td> <td>Bachelors</td> <td>2</td> </tr> </table>	<u>Race/Ethnicity</u>		<u>Caregiver Age</u>		White, non-Hispanic	25	Under 16	0	Black, non-Hispanic	57	16-19	13	Hispanic	13	20-19	50	Multiracial	9	Over 30	33	<u>Marital Status</u>		<u>Education</u>		Single, never married	70	Less than 12	24	Living together, not married	16	HS/GED	37	Married	8	Vocational/Some College	29			Associates	4			Bachelors	2
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<b>2c</b>	<b>Geographical Area of Services:</b> Burlington County, NJ																																												
<b>2d</b>	<b>Referral Sources:</b> Central Intake, Southern Jersey Family Medical Center, Virtua Women’s Center, Dept. of Child Protection and Permanency, WorkFirst NJ, Project Teach, staff referrals and self referrals																																												
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>																																													
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b></p> <p><b>Include data where available:</b></p> <ol style="list-style-type: none"> <li>11. 100% of children were enrolled in health insurance</li> <li>12. 87 % of participating infants/children were up-to-date on immunizations.</li> <li>13. 88% of participants increased their interpregnancy interval (birth to conception) to 18 months</li> <li>14. 100 % of participating infants/children had a medical home</li> </ol>																																												

	15. 89% of participating infants/children received developmental screening and appropriate referrals.
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b> We had a lower number of referrals last year but Central Intake has already increased our number and of referrals this year. We will work to increase our Level of Service and Family Retention.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16: Case weight of 125</b></p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16: 92</b></p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals: 160</b></p>

	<b># of unduplicated families: 80</b>
<b>3i</b>	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results. 58 Satisfaction Surveys were distributed to parents 48 were returned – 83%.</b>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> We are planning to start a diaper bank that will have diapers for our families and others in the community that are in need. We will also be a Distributor for Baby Boxes.
<b>4b</b>	<b>Identify changes you will make that stem from stakeholder feedback.</b> No planned changes.
<b>4c</b>	<b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17? 114</b>
<b>4d</b>	<b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> <b># of unduplicated individuals: 160</b> <b># of unduplicated families: 80</b>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
<b>5c</b>	<b>How do you collaborate with community partners?</b> Quarterly Advisory Board Meetings are held in collaboration with the Burlington County Council for Young Children. Staff members also participate in a variety of stakeholder meetings such as Healthy Mother/Healthy Babies, and the March of Dimes. Community partners include representatives from transitional housing, domestic violence, mental health, substance abuse and child protective services.

### 2017 PSSF Update Report

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Center for Family Services</p> <p><b>1b Program Name:</b> Healthy Families-TIP Camden</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <u><b>X</b></u> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 180 South White Horse Pike Clementon, NJ 08021
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <u><b>X</b></u> Safety <u><b>X</b></u> Permanency <u><b>X</b></u> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
<b>2b</b>	<b>Population Served:</b> First time mothers and mothers who are receiving TANF benefits and have a child under 12 months.
<b>2c</b>	<b>Geographical Area of Services:</b> Camden County
<b>2d</b>	<b>Referral Sources:</b> Central Intake, Board of social Service, Local Hospitals, Prenatal Clinics, Federally Qualified Health Centers, OB/GYN Physicians, WIC, Local Schools, School Based Youth Services, self referrals.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b></p> <p><b>Include data where available:</b></p> <p>16. 94__% of children were enrolled in health insurance</p>

	<p>17. 84__% of participating infants/children were up-to-date on immunizations.</p> <p>18. 100__% of participants increased their interpregnancy interval (birth to conception) to 18 months</p> <p>19. 88__% of participating infants/children had a medical home</p> <p>20. 95__% of participating infants/children received developmental screening and appropriate referrals.</p>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b></p> <p>The program continues to experience problems retaining mothers who return to work/school/training. The enrollment of pregnant women has increased but is still an issue. The staff salaries are low and they have not received a raise in 8 years. Staff has left for better paying jobs. Two of our FSW were on sick leave for during this reporting period.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b></p> <p>The contracted level of service is 188</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b></p> <p>The average case weight was 157.75 (84%)</p>

<p><b>3h</b></p>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:</b> 546  <b># of unduplicated families:</b> 273</p>												
<p><b>3i</b></p>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <p>The staff of Healthy Families-TIP Camden distributed the Annual Client Satisfactory Survey to 35 families in May 2016. The families were in the program for a minimum of 3 months.</p> <p>20 surveys were returned to Healthy Families –TIP Camden program. The questionnaire contained thirteen (13) statements and clients were asked to rate their level of agreement with the statements as follow:</p> <table data-bbox="349 892 755 1102"> <tr> <td>No Applicable</td> <td>1</td> </tr> <tr> <td>Strongly Disagree</td> <td>2</td> </tr> <tr> <td>Disagree</td> <td>3</td> </tr> <tr> <td>Agree</td> <td>4</td> </tr> <tr> <td>Strongly Agree</td> <td>5</td> </tr> <tr> <td>Neutral</td> <td>N</td> </tr> </table> <p>A score of 5.0 would be the highest possible rating; a score of 1.0 would be the lowest possible rating.</p> <p>Two statements received the highest overall rating of 4.95 and 4.9:</p> <p><b>Statement #9</b> My Family Support Worker is respectful and understands my .culture or way of living, even though it may be different from hers/his. <b>(4.9)</b></p> <p><b>Statement # 22</b> The Program has helped me. <b>(4.95)</b></p> <p>One statements received the lowest scores of 4.30</p> <p><b>Statement # 20</b> The program uses pictures, videos and handouts that remind me of my own family. <b>(4.30)</b></p> <p>. All thirteen statements were rated at least 4.30 or higher. Nine statements were rated 4.65 or higher.</p> <p>There were two open ended questions: One question asked if the program was meeting their expectations and all 18 clients responded that the program is meeting their expectations. 2 did not answer the question.</p>	No Applicable	1	Strongly Disagree	2	Disagree	3	Agree	4	Strongly Agree	5	Neutral	N
No Applicable	1												
Strongly Disagree	2												
Disagree	3												
Agree	4												
Strongly Agree	5												
Neutral	N												

	<p>The second question asked what can the program do differently to improve services, and the answers were:</p> <p>Provide more efficient transportation          Helps provide other necessary things families need who have new baby          I guess just providing more information on different services          I like it the way it is          Everything is great          Everything is wonderful, no need for improvements.          The program is working fine          Nothing! It's the bomb.dot com          It is great for now          You guys are great! Keep up the good work!          It's a great program          3 Nothing</p> <p>Enmi opinion todo esta bien (In my opinion everything is fine)          Asta ahorita todoesta bien mi trabajadora social me ayuda mucho ( up to now everything is fine my social worker helps a lot)          Nada (Nothing)</p>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>The program Statewide has adopted the one step enrollment as of 1/1/17 in an effort to enroll more families and address the issue of retention.</p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>Supervisor has been able to connect with resources for the families, including food banks, diapers/children clothes. There is an effort to provide parents with materials/books with pictures reflecting their race/ethnicity.</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p> <p>Case weight 213</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p><b># of unduplicated individuals: 600</b>  <b># of unduplicated families: 300</b></p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b> The program will track progress through the FamSys</p>

	database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
<b>5c</b>	<b>How do you collaborate with community partners?</b> Supervisor and Program Manager participate in the Central Intake committee of Camden County. The Healthy Families Advisory Board is composed of representatives from the Nurse Family Partnership, Federal Qualified Health Center (Camcare), Camden City School system; Southern New Jersey Perinatal Cooperative/Addictions Prevention; Healthy Mothers-Healthy Babies/Healthy Start/Parents as Teachers.

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Central Jersey Family Health Consortium <b>1b Program Name:</b> Middlesex/Somerset Healthy Families-TIP
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <u><b>X</b></u> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 2 King Arthur Court Suite B North Brunswick, New Jersey 08902
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <u><b>X</b></u> Safety <u><b>X</b></u> Permanency <u><b>X</b></u> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment

	through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
<b>2b</b>	<b>Population Served:</b> The target population for the Middlesex/Somerset County Healthy Families-TIP program is any parent residing in these counties, that is pregnant or has a child under the age of three months old. Also TIP component connects with prenatal and newly parenting TANF families receiving assistance from the Board of Social Services in both counties.
<b>2c</b>	<b>Geographical Area of Services:</b> The geographical areas this site serves is Middlesex and Somerset counties.
<b>2d</b>	<b>Referral Sources:</b> Potential clients are referred to the program through a Central Intake and SPECT System. The State of N.J. centralized intake system for home visiting. Referrals received by the program come from Board of Social Services, hospitals, clinics and other programs such as Community Health Workers.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<b>Provide a summary of program accomplishments on goals. Include data where available:</b> 21. _95_% of children were enrolled in health insurance 22. _48_% of participating infants/children were up-to-date on immunizations. 23. _86_% of participants increased their interpregnancy interval (birth to conception) to 18 months 24. 90__% of participating infants/children had a medical home 25. _83_% of participating infants/children received developmental screening and appropriate referrals.
<b>3b</b>	<b>How did this improve outcomes for children and families?</b> Program accomplishments increased: <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<b>3c</b>	<b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and

	intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.
<b>3d</b>	<b>Identify significant barriers to goal accomplishment:</b> A challenge that the program faced was staff turnover during this period.
<b>3e</b>	<b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> The program’s LOS for this period was 165.
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> The actual LOS for this period was 93.
<b>3h</b>	<b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  # of unduplicated individuals: 206 # of unduplicated families: 103
<b>3i</b>	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> The program distributed 67 surveys of which 22 were returned. Participants shared that the program has helped them with providing age appropriate information on child development. This has assisted parents to develop a better relationship with their children. Parents also commented that they have learned to be patient with their children and also information on positive discipline has taught them alternatives to use when disciplining their children.
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> We anticipate changes to the LOS with the implementation of the one-step enrollment process. The LOS for 2017 will be 156.

<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>No changes will be implemented. Only changes that come directly from the State or PCA.</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p> <p>The case eight for 2016-2017 will be 156. This is due to the change to the on-step enrollment program.</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p><b># of unduplicated individuals:</b> 200  <b># of unduplicated families:</b> 100</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<b>5a</b>	<p><b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.</p>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.</p>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b>  I have quarterly meetings with Somerset and Middlesex Board of Social Services. I provide updated reports on all referrals received by them. Also I meet quarterly and whenever necessary with Central Intake committee and there regional meetings. Healthy Families also participates in the Middlesex/Somerset County Advisory Board. This group is composed of other Home Visiting programs, community programs and program participants.</p>

**2017 PSSF Update Report**

<p><b>Section 1 – Identifying Information</b></p>			
<b>1a</b>	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;"><b>Provider:</b> Partnership for Maternal and Child Health of Northern New Jersey</td> <td style="width: 50%;"><b>1b Program Name:</b> Healthy Families/TANF Initiative for Parents-Essex</td> </tr> </table>	<b>Provider:</b> Partnership for Maternal and Child Health of Northern New Jersey	<b>1b Program Name:</b> Healthy Families/TANF Initiative for Parents-Essex
<b>Provider:</b> Partnership for Maternal and Child Health of Northern New Jersey	<b>1b Program Name:</b> Healthy Families/TANF Initiative for Parents-Essex		
<b>1c</b>	<p><b>Relevant PSSF Program:</b> ___FPS, <u><b>X</b></u> FSS, ___TLFRS, ___APSS</p>		

<b>1d</b>	<b>Program Address:</b> 50 Park Pl, Suite 700, Newark, NJ 07102
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
<b>2b</b>	<b>Population Served:</b> The Healthy Families/TIP-Essex Program (HF/TIP-E) serves new and expectant parents in Urban Essex County which includes Newark, Irvington, East Orange, and Orange. We also provide home visitation services to expectant women in their third trimester and/ or with children under the age of 12 months who are TANF (Temporary Assistance to Needy Families) eligible throughout Essex County. TANF includes General Assistance, Emergency Assistance, and Food Stamps.
<b>2c</b>	<b>Geographical Area of Services:</b> The Healthy Families/TIP-Essex Program (HF/TIP-E) serves new and expectant parents throughout Essex County.
<b>2d</b>	<b>Referral Sources:</b> The HF/TIP-E Program receives referrals from the Essex Pregnancy & Parenting Connection (Central Intake) and on and off-site free pregnancy testing services which identifies women in early pregnancy.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<b>Provide a summary of program accomplishments on goals. Include data where available:</b> 26. <u>92</u> % of children were enrolled in health insurance 27. <u>63</u> % of participating infants/children were up-to-date on immunizations.

	<p>28. <u>89 %</u> of participants increased their interpregnancy interval (birth to conception) to 18 months</p> <p>29. <u>94 %</u> of participating infants/children had a medical home</p> <p>30. <u>85%</u> of participating infants/children received developmental screening and appropriate referrals.</p>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community and health resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b> The HF/TIP-E program experienced a hardship due to one part-time employee going on medical leave from March 2016-June 2016. We placed most of her families on level TR to accommodate this change in staffing. As a result, our LOS/CW suffered.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 195</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> <u>143.88</u></p>

3h	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p># of unduplicated individuals: <u>202</u> # of unduplicated families: <u>101</u></p>
3i	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <p>During the period 10/1/15-9/30/16, a total of 94 surveys were completed. Please see attached survey results.</p>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
4a	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> There are no planned changes to the Healthy Families/TIP-E target population or service area.</p>
4b	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>Beginning in January 2017, the network of home visitation programs in New Jersey, under the monitoring of PCANJ, will undergo the new One-Step enrollment process, in hopes of reaching and maintaining our newly contracted case weight of 221. As a result of this change, HF/TIP-E has two new policies to reflect the One-Step Enrollment Process; Creative Outreach- Critical Element 3 (3-2.A &amp; 3-3.A) and Screening Procedures-Critical Elements 1 and 2 (1-2.A, C &amp; 2-1.A).</p> <p>In regards to the results of the surveys and ensuring participants see more activities/workshops and events, the HF/TIP Essex Program plans to add more events and workshops geared towards health, money, and parent-child interaction for the PY 2017. Each April we host two events geared towards literacy and parent child-interaction through hands on activities, which is our Pajama Party and Family Fun Night.</p>
4c	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> From 10/1/16 through 12/31/16, the program is expected to maintain a case weight of 195. In January 2017, our newly contracted LOS will be <u>221</u> to reflect the new One-Step Enrollment Process; all 8.5 FTE staff will be 100% FSW each with a target case weight of 26. Number of families served depends on the levels of each family enrolled.</p>
4d	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p># of unduplicated individuals: <u>202</u> # of unduplicated families: <u>101</u></p>

<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.</p>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed. The County-wide Advisory Board will also be approached for input and feedback.</p>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b></p> <p>The collaborations established through partnerships ensure that potential HF/TIP-E participants have access to quality care. The following agencies, hospitals, clinics, and schools are located within our target service area and provided many of our clients with referral services.</p> <ul style="list-style-type: none"> <li>• The University Hospital</li> <li>• Columbus Hospital</li> <li>• Saint Barnabas Medical Center</li> <li>• Newark Beth Israel Medical Center</li> <li>• The City of Orange Department of Health</li> <li>• The City of East Orange Department of Health</li> <li>• Newark Community Health Centers, Inc.</li> <li>• City of East Orange Department of Health, East Orange and Orange Women, Infant, Children (WIC) Program</li> <li>• Newark Department of Health &amp; Human Services</li> <li>• Turning Point, Inc.</li> <li>• Renaissance House</li> <li>• St. Rocco’s Family Shelter</li> <li>• Furniture Assist</li> <li>• Tri-City Peoples Corporation</li> <li>• North Porch</li> <li>• Various Church based Food Pantries             <ul style="list-style-type: none"> <li>• Central Intake-Essex Pregnancy and Parenting Connection</li> </ul> </li> <li>• DCP&amp;P</li> </ul> <p>The HF/TIP-E program also has a very committed Advisory Board which meets quarterly to discuss program strengths and challenges. The Advisory Board members are committed individuals from community agencies that are invested in our program goals and outcomes. Lastly, the HF/TIP-E program has a contractual partnership with the Essex Pregnancy and Parenting Connection for the distribution of referrals to the program.</p>

### 2017 PSSF Update Report

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Partnership for Maternal and Child Health of Northern New Jersey</p> <p><b>1b Program Name:</b> Healthy Families – TIP of Morris County</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <u><b>X</b></u> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 73 Bassett Highway , Dover , NJ 07801
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <u><b>X</b></u> Safety <u><b>X</b></u> Permanency <u><b>X</b></u> Well-Being
<b>Section 2 – Service Description Basics FFY '14 (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.</p>
<b>2b</b>	<p><b>Population Served:</b> Our service population is predominately White (93%); Black (4%); Asian (1%); Multi-racial (1%); and other (1%) make up the next four smallest racial groups in our service population. Of those families, (88%) reported to be of Hispanic Ethnicity and the other (12%) reported no Hispanic descent.</p> <p>These statics do not directly reflect our target population.</p> <p>Our target population is predominately White (96%); Black (2%), Asian (2%), and Multi-racial (&lt;.01%). Of the above participants 91% reported to be of Hispanic Ethnicity and the other (5%) reported no Hispanic descent.</p>
<b>2c</b>	<b>Geographical Area of Services:</b> Program covers all of Morris County
<b>2d</b>	<b>Referral Sources:</b> The majority of the referrals come from the prenatal clinics of the agency's member

	<p>hospitals (Morristown Memorial Hospital and Saint Clare’s Hospital). Our program also receives many referrals from Morris County Office of Temporary Assistance office. In addition, the program receives a number of referrals from the local DCP&amp;P offices, First Choice and self-referrals. Morris County Central Intake became the major source of referrals as of 07/01/15.</p>
<p><b>Section 3 – The Year in Review FFY ’15 (10/1/15 – 9/30/16)</b></p>	
<p><b>3a</b></p>	<p><b>Provide a summary of program accomplishments on goals. Include data where available.</b></p> <ol style="list-style-type: none"> <li>31. 92% of children were enrolled in health insurance</li> <li>32. 70% of participating infants/children were up-to-date on immunizations.</li> <li>33. 100% of participants increased their interpregnancy interval (birth to conception) to 18 months</li> <li>34. 81% of participating infants/children had a medical home</li> <li>35. 85% of participating infants/children received developmental screening and appropriate referrals.</li> </ol>
<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement.</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>
<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment.</b> One barrier our program has encountered over the past year is meeting our contracted LOS and HV Rate. The reasons for this are two-fold. Over the past year the program has encountered staff changes. During this time the program supervisor wasn’t unable to maintain the program’s LOS and HV Rate. Over the past year, our program has also experienced staff pregnancy which has affected our ability to meet our LOS; however, a temporary Family Support Worker was hired and was able to enroll new families into the program.</p>

	Another barrier our program has encountered is the wage ceiling our staff has seem to hit for the past three years. Staff has commented that there is not much opportunity for upward mobility built into the Healthy Families program; therefore wage increases are necessary in order to stay with the agency and/or company.
<b>3e</b>	<b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16</b> 87
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16</b> 45 (77%)
<b>3h</b>	<b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  # of unduplicated individuals: 110____ # of unduplicated families: _55_____
<b>3i</b>	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> There were 28 surveys sent and 24 were received. The responders strongly agreed (20) and agreed (4) with the program’s objectives and their relationship with their Family Support Worker. The responders would not want to see anything changed. All 24 responders stated that the program was meeting their expectations.
<b>Section 4 – The Year Ahead FFY ’15 (10/1/15 – 9/30/16)</b>	
<b>4a</b>	<b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program</b> One-Step Enrollment process will be implemented as of 1/1/2017.
<b>4b</b>	<b>Identify changes you will make that stem from stakeholder feedback.</b>
<b>4c</b>	<b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> 91
<b>4d</b>	<b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>

	<p><b># of unduplicated individuals: <u>  112  </u></b>  <b># of unduplicated families: <u>  56  </u></b></p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>5a</b></p>	<p><b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.</p>
<p><b>5b</b></p>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.</p>
<p><b>5c</b></p>	<p><b>How do you collaborate with community partners?</b>  Collaboration continues on many different fronts within our program. Our program meets with our Advisory Board members on a quarterly basis and the relationship assist with referrals, problem solving, quality assurance, policy making and resources for our families. Members on our board include social workers and employees from local health clinics, domestic violence shelter, our county’s OTA office, Head Start and substance abuse facilities.</p> <p>Morris County has a highly functioning Family Success Center and the HF-TIP program is housed in the same facility which is a win-win situation for families in Morris county. The program manager sits on the Healthy Families Operations committee. This collaboration assists with the programs quality assurance and optimum functioning.</p>

### 2017 PSSF Update Report

Section 1 – Identifying Information	
<b>1a</b>	<p><b>Provider:</b> Partnership for Maternal and Child Health of Northern New Jersey</p> <p><b>1b Program Name:</b> Passaic County HF-TIP</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <input checked="" type="checkbox"/> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 1 Ottilio Terrace, Paterson, NJ 07502
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
<b>2b</b>	<b>Population Served:</b> Passaic County Healthy Families-TIP (TANF Initiative for Parents) program serves any first time pregnant mother or any first time mother with a baby younger than 3 months of age or mothers under the age of 25 with multiple children. that residing in the cities of Paterson, Passaic and Clifton; all TANF, GA and/or EA families with children under 12 months residing in Passaic County.
<b>2c</b>	<b>Geographical Area of Services:</b> Passaic County
<b>2d</b>	<b>Referral Sources:</b> All referrals are provided through Central intake. Referrals sources include: Local Hospitals, Prenatal Clinics, Federally Qualified Health Centers, OB/GYN Physicians, WIC, Local Schools, School Based Youth Services, Passaic County Board of Social Services and local organizations.
Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)	

<p><b>3a</b></p>	<p><b>Provide a summary of program accomplishments on goals. Include data where available:</b></p> <p>36. 98% of children were enrolled in health insurance</p> <p>37. 66% of participating infants/children were up-to-date on immunizations.</p> <p>38. 96% of participants increased their inter-pregnancy interval (birth to conception) to 18 months</p> <p>39. 98% of participating infants/children had a medical home</p> <p>40. 88% of participating infants/children received developmental screening and appropriate referrals.</p>
<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>
<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment:</b></p> <p>Over the year the loss of two staff people has a negative impact on our case weight. However, we had one staff person who had left two years ago return to the program. We continue to train, support and nurture the staff to improve staff retention.</p>
<p><b>3e</b></p>	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.</p>
<p><b>3f</b></p>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b></p> <p>Expected case weight: 255.</p>

3g	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> Average Case Weight: 189.06</p>
3h	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b> # of unduplicated individuals: 372 # of unduplicated families: 186</p>
3i	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <p>The program received 33 completed surveys. The clients have positive comments about the program. The answers indicate that the families agree or strongly agree that the Family Support Workers are providing the intended services in a way that they can understand and that feels respectful to the families. Over all, the clients are satisfied with services. When asked what would improve the program 16 said that the program did not need improvement while others asked for the program to provide more visits or for longer than three years (3). Others asked for weekend visits (1), more baby items (1) and tablets for home visitors (1). In response program has started to provide more weekend visits and we are starting an incentive program that includes diapers for the families.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
4a	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> The program is transitioning to the new one step enrollment process. The new expected case weight will be 273.</p>
4b	<p><b>Identify changes you will make that stem from stakeholder feedback.</b> We have begun to work closely with DCP&amp;P during the case conferencing meeting. We are attending the monthly meetings as a referrals source and information source. We expect this partnership to increase the number of referrals.</p>
4c	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17</b> Expected case weight: 273</p>
4d	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: 274 # of unduplicated families: 137</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
5a	<p><b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families,</p>

	number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
<b>5c</b>	<b>How do you collaborate with community partners?</b> We invite community partners to our advisor board meeting. We provide referrals to our community partners and the community partners send referrals to us. When we do events for our client we include community partner so that they can offer their services to our clients. We also encourage clients to attend events that our community partners provide. Central Intake also visits with some of our community partners to encourage referrals and collaboration.

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Holy Redeemer <b>1b Program Name:</b> Healthy Families Cape May Co.
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <u><b>X</b></u> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 1801 Route 9 North Swainton, NJ 08210
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <u><b>X</b></u> Safety <u><b>X</b></u> Permanency <u><b>X</b></u> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained

	home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
<b>2b</b>	<b>Population Served:</b> The Healthy Families-TIP program in Cape May County is available to families from pregnancy to age three. Additionally, the program is available to parents with an infant up to twelve months old if they are currently receiving or eligible to receive TANF, EA, or GA. All services are free and voluntary.
<b>2c</b>	<b>Geographical Area of Services:</b> All of Cape May County
<b>2d</b>	<b>Referral Sources:</b> Our referrals come through Central Intake. Complete Care Clinic, Cape Regional Medical Center, Family Success Center, WIC, DCP&P, Cape May Board of Social Service, Reliance Clinic, and Shore Memorial Hospital are the agencies that have formal agreements in place through the Central Intake.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b></p> <p><b>Include data were available:</b></p> <ul style="list-style-type: none"> <li>41. _99_% of children were enrolled in health insurance</li> <li>42. _84_% of participating infants/children were up-to-date on immunizations.</li> <li>43. _100_% of participants increased their interpregnancy interval (birth to conception) to 18 months</li> <li>44. _100_% of participating infants/children had a medical home</li> <li>45. _90_% of participating infants/children received developmental screening and appropriate referrals.</li> </ul>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b> We are taking different measures to enhance the timeliness of the ASQ’s and Level X clients who may be due for the developmental screen.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is</p>

	measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 174
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 116.12 or 67%
<b>3h</b>	<b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  # of unduplicated individuals: 318 # of unduplicated families: 159
<b>3i</b>	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> Of the 101 surveys sent out, 76 were returned which is 75%.
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> Due to the one-step enrollment process our program’s case weight will be 169 as of 1/1/17. Our LOS has increased considerably since implementing the one-step process.
<b>4b</b>	<b>Identify changes you will make that stem from stakeholder feedback.</b> For our families who requested evening events we refer them to the Family Success Center. If possible the FSW of that family will meet them there. More families have requested FSWs to accompany them to Doctor appointments, Family Court, and DCP&P Team Meetings.
<b>4c</b>	<b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> 169, See 4a.
<b>4d</b>	<b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: 338 # of unduplicated families: 169
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency

	that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
<b>5c</b>	<p><b>How do you collaborate with community partners?</b></p> <p><u>Annually</u>, we collaborate with Caring for Kids, Nurse Family Partnership, and thirteen other community agencies in hosting the Annual Community Baby Shower. Again, this year it will be held at the Lower Township Fire Department Hall. In April, Healthy Families is involved with the Health Department’s Healthcare Resource Day at the Wildwood Convention Center and boardwalk.</p> <p><u>Monthly</u>, the Program Supervisor attends the CMC Council for Young Children Committee Meeting. All staff attends the Healthy Mothers/Healthy Babies Coalition meetings.</p> <p><u>Bi-weekly</u>, our staff facilitates the Infant Playgroup at the Family Success Center.</p> <p><u>Quarterly</u>, our Planning Board meets. Our Board is comprised of representatives from various community agencies. These agencies are:</p> <ul style="list-style-type: none"> <li>• DCF Contract Administrator</li> <li>• Holy Redeemer Food Pantry</li> <li>• CMC Catholic Charities</li> <li>• Project Teach/ DCF Tech School</li> <li>• Cape May Health Department</li> <li>• CM Special Child Health Services</li> <li>• CM Early Intervention Program</li> <li>• Community Liaison (S. Keen)</li> <li>• Christ Child Society representatives</li> </ul>

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Mercer Street Friends</p> <p><b>1b Program Name:</b> Healthy Families-TIP Mercer County</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <u><b>X</b></u> FSS, ___TLFRS, ___APSS

<b>1d</b>	<b>Program Address:</b> 222 N Hermitage Ave Trenton NJ 08618
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
<b>2b</b>	<b>Population Served:</b> The program serves pregnant/parenting women residing in the East and West Wards of the City of Trenton, identified either prenatally or within 14 days of giving birth, and any pregnant/parenting woman residing in Mercer County receiving TANF, GA or EA with a child under 12 months of age.
<b>2c</b>	<b>Geographical Area of Services:</b>  All of Mercer County (226 square miles)
<b>2d</b>	<b>Referral Sources:</b> Central Intake (Local Hospitals, Prenatal Clinics, Federally Qualified Health Centers, OB/GYN Physicians), WIC, Local Schools, School Based Youth Services, Self-referrals and County Board of Social Services.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<b>Provide a summary of program accomplishments on goals. Include data where available:</b> 46. <u>100%</u> of children were enrolled in health insurance 47. <u>86%</u> of participating infants/children were up-to-date on immunizations. 48. <u>100%</u> of participants increased their interpregnancy interval (birth to conception) to 18 months 49. <u>97%</u> of participating infants/children had a medical home 50. <u>93%</u> of participating infants/children received developmental screening and appropriate referrals.

<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>
<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment:</b>          Barriers to goal achievement are primarily related to engagement and retention of families. Factors that impact these challenges include: the impact of living in poverty, unresolved issues related to childhood trauma, and homelessness resulting in increased transiency. An additional challenge to lack of understanding of the importance of health care and the health care system.          The Program Supervisor continues to focus on the importance of working diligently to identify various ways to motivate and nurture staff as they are challenged with responding to the various barriers to service delivery. During monthly staff meetings and Team building exercises, staff is given the opportunity to share frustrations and to brainstorm solutions; this may include role playing a home visit, an assessment conversation, or a discussion about strategies related to presenting the Program in an honest and appealing manner. Accomplishments are recognized during Team meetings as well as in Statewide Site Networking meetings as they occur. Sources for additional training that will support staff in effective service delivery are also being explored.</p>
<p><b>3e</b></p>	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.</p>
<p><b>3f</b></p>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16: 165</b></p>

<p><b>3g</b></p>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16: 114</b></p>
<p><b>3h</b></p>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:250</b>  <b># of unduplicated families: 125</b></p>
<p><b>3i</b></p>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <p>74 surveys distributed (21 S – 64 E (14 level X)  46 surveys returned ( 11 S – 35 E)</p> <p>62% of all surveys distributed were returned  52% of all Spanish language surveys distributed were returned  55% of all English language surveys distributed were returned</p> <p>Of the 46 returned:  24% were from H parents  54% were AA parents  10% multi-racial parents  4% were from African parents  8% were from Caucasian parents</p> <p><b><u>Summary of parent feedback:</u></b></p> <ul style="list-style-type: none"> <li>▪ All families surveyed felt that their culture (race, language, family style, age, parental expectations), were accepted and respected.</li> <li>▪ All families said that they could communicate feelings freely with their FSW without the concern of being judged.</li> <li>▪ Most participants felt that the materials that they were given were age appropriate, (parent and child), respectful, culturally relevant and easily understood.</li> <li>▪ All families expressed that they benefited from the Program and felt that the information provided assisted them in developing a better understanding of their child’s growth and development.</li> <li>▪ Most mothers indicated that their quality of life was improved in many ways through their Program participation; such as having more patience with their children, increased problem solving skills, being satisfied with themselves, controlling their temper, and taking better care of their own personal health.</li> </ul> <p><b><u>What participants liked best about the program’s services</u></b></p> <p>Upon reviewing the individual participant’s responses to this question, it seems evident that parents appear to enjoy the opportunity to access teaching, support, role modeling, and information offered to them about being a healthy individual and parent; provided to them through a relationship with a caring, respectful and culturally sensitive home visitor.</p>

	<p><b><u>How participants have benefited from the program:</u></b>  Upon reviewing the individual participant's responses to this question it seems that most participants feel that have gained additional skills/strategies in a variety of areas related to their role as parents and in their journey to be healthy individuals</p>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program. The program has gone to a one step enrollment process as of January 1, 2017. Case Weight has been changed from 165 to 154.</b></p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback. Based on the stakeholders' response there does not appear to be a need for any changes</b></p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b>  154</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>  # of unduplicated individuals: 308  # of unduplicated families: 154</p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.</p>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.</p>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b>  Mercer Street Friends is part of a formalized, broad based collaborative of service providers. This is a network of medical and social service agencies sharing resources; training, support, information, planning, data and trend analysis; as well as philosophy of the importance of a series of integrated strength based intervention strategies to support young</p>

	families in the City of Trenton. In addition, MSF works with a wide variety of community agencies and organizations in mutual support of young families. Members of The Community Advisory Network committee include HF-TIP, Parents As Teachers, Nurse Family Partnership, Children’s Futures Central Intake, Health Resource and Service Administration and Community Health Workers. Members of the Committee come from a number of community agencies including: WIC, Early Head Start, Project Teach, RWJ Hamilton, Trenton Health Team, Teen Pregnancy Prevention, Home Front, Trenton Health Team, Capital Health Prenatal Clinic and consumers
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**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Preferred Behavioral Health Group
	<b>1b Program Name:</b> Healthy Families/TIP Ocean County
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <u><b>X</b></u> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> Mailing Address: Preferred Behavioral Health Group, Healthy Families/TIP Ocean County, P.O. Box 2036, Lakewood, NJ 08701  (Office Location: 591 Lakehurst Rd., Toms River, NJ 08755)
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <u><b>X</b></u> Safety <u><b>X</b></u> Permanency <u><b>X</b></u> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
<b>2b</b>	<b>Population Served:</b> The service population consists of 2 tiers. At the beginning of this reporting period the HF program was serving all first time expectant mothers; and teenage

	<p>mothers, under the age of 21 years, who many have one or more births. In April 2016, the target population was changed by the stakeholders, Prevent Child Abuse-NJ and the Dept. of Children and Families, to serve all pregnant mothers, including those who may have experienced one or more births. The second tier of the Healthy Families/TIP Ocean County Program serves mothers and families who are receiving Temporary Assistance for Needy Families (TANF). The TIP component may enroll families up until the baby is twelve months old.</p>
<b>2c</b>	<p><b>Geographical Area of Services:</b> At the beginning of this reporting period, the target service area for the HF component was Lakewood, Brick and Point Pleasant. The targeted service area for the TIP component was northern and central Ocean County. As of April 2016, the targeted service area was changed by the stakeholders, Prevent Child Abuse-NJ and the Dept. of Children and Families, for both tiers to Ocean County, from the northern part of Ocean County to the Central portion of Ocean County north of Lacey Twp.</p>
<b>2d</b>	<p><b>Referral Sources:</b> All Referrals come through the Central Intake Hub. The referrals sources include local hospitals, prenatal clinics and Federally Qualified Health Centers in both Monmouth and Ocean Counties; Ocean County Board of Social Services, community based services, Lakewood High School and the Division of Children Protection and Permanency.</p>
<p><b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b></p>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals. Include data where available:</b></p> <ul style="list-style-type: none"> <li>51. <u>99%</u> of children were enrolled in health insurance</li> <li>52. <u>69%</u> of participating infants/children were up-to-date on immunizations.</li> <li>53. <u>95%</u> of participants increased their interpregnancy interval (birth to conception) to 18 months</li> <li>54. <u>100%</u> of participating infants/children had a medical home</li> <li>55. <u>99%</u> of participating infants/children received developmental screening and appropriate referrals.</li> </ul>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted</p>

	on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.
<b>3d</b>	<b>Identify significant barriers to goal accomplishment:</b> The first identifiable barrier entails maintaining up-to-date immunizations. The majority of the population served is undocumented who have transient living conditions. Understanding how to access and maintain health care coverage is extremely difficult. The FSW’s are proactive. The FSW’s guide and assist through the entire process to secure linkage to initial medical coverage and renewals. The second impediment to goal accomplishment is that transportation is virtually non-existent in Ocean County, NJ. There is only one bus route that runs north to south along the Route 9 corridor. Whenever warranted, the FSW’s transport families to secure medical insurance, health care, SNAP, WIC, etc. Thirdly, another pervasive obstacle is that fathers/partners are unable to secure viable employment. They are day laborers or seasonal, temporary workers. This compels the mothers to become the primary bread winners and seek full-time employment. The families become less accessible and are eventually unable to maintain consistent home visitation. This adversely affects all the program goal attainments. Extraordinary efforts are made to re-engage the families; involve the fathers and other care givers; and to continue creative outreach attempts. There was one vacated FSW position during this reporting period. This position was filled in November 2015. This new FSW will receive her core trainings, wrap around trainings and PBHG trainings over the course of this reporting period.
<b>3e</b>	<b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> The expected case weight was 107 for this reporting period.
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> The average case weight for this reporting period was 66.37.
<b>3h</b>	<b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  # of unduplicated individuals: 210 # of unduplicated families: 105
<b>3i</b>	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> Client

	<p>Satisfaction surveys were distributed during the annual “Holiday Fiesta” in December 2015. Thirteen surveys were distributed and completed. 100% of the clients said the HF/TIP Ocean County program was meeting their expectations. 93% strongly agreed and 7% agreed that their FSW was respectful and understanding of their culture or way of living. All of the clients were satisfied with the services and resources they were receiving from their FSW. Several clients would like to see more group events for the mothers so they get a chance to meet and interact with each other. In addition, several clients would like to see more group activities/events for the children so they get to know each other and to play with each other.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>4a</b></p>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> There are no changes to our target population or our service population anticipated for the upcoming year. The program will be transitioning to the One Step Process in January 2017. Our case weight will decrease as a result of this transition.</p>
<p><b>4b</b></p>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b> Based on feedback from the Client Satisfaction Surveys and feedback from the FSWS, the Ocean County HF/TIP program will be organizing more group events. There will be at least one group event per quarter starting in January 2017. These events will focus on either women only, families or men only. A variety of topics will be presented from women’s health to lead poisoning information sessions. This program, based on feedback from DCF will also work more closely with community partners, such as the CCYC, to hold joint advisory board/stakeholder meetings in order to minimize the number of meetings attended and to collaborate more with community partners.</p>
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> During the period 10/1/16 to 12/31/16 our expected case weight will be 107. Starting on January 1, 2017, with the One Step enrollment, our expected case weight will decrease to 104.</p>
<p><b>4d</b></p>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>  <b># of unduplicated individuals:</b> 208  <b># of unduplicated families:</b> 104</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>5a</b></p>	<p><b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.</p>

<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
<b>5c</b>	<b>How do you collaborate with community partners?</b> Annually, the Healthy Families/TIP Program reviews, updates, and re-distributes their existing “Memorandums of Understanding” with the referral sources and collaborating entities. The program participates in community, county and state-wide functions; as well as In-Service Trainings. Alliances are well-established with the Family Planning Center of Ocean County, Ocean Health Initiatives, Lakewood School Based Youth Services, Ocean Medical Center, the three Brick Township School Based Youth Services Programs, Preferred Behavioral Health Group, Early Head Start/Head Start, Monmouth Medical Center, Jersey Shore Medical Center, Children’s Home Society, Early Intervention of Ocean County Health Department, WIC, Ocean County Board of Social Services, Central Jersey Family Health Consortium, and D.C.P.& P. Many of the above mentioned are active members on the Healthy Families Advisory Board. Healthy Families/TIP Supervisor/Manager is a member of the Early Head Start/Head Start Policy Council; and on the Executive Board of the Family Planning Center. The Program Supervisor/Manager leads the quarterly TIP Operational Meetings; participates in the Ocean County Maternal and Child Health Network Meeting; and the Ocean County ONE-STOP Collaborative Meetings. The Senior FSW attends the monthly Improved Pregnancy Outcome Meetings and another FSW attends the monthly general meetings of the CCYC.

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Prevent Child Abuse-New Jersey <b>1b Program Name:</b> Healthy Families NJ
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <u><b>X</b></u> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 14 host agencies, with 17 PSSF Healthy Families programs, within a 21 site network (see Healthy Families New Jersey Data attached as Table A).  <b>Provider Address:</b> 103 Church Street, Suite 210, New Brunswick, NJ, 08901
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <u><b>X</b></u> Safety <u><b>X</b></u> Permanency <u><b>X</b></u> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	

<p><b>2a</b></p>	<p><b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.</p>
<p><b>2b</b></p>	<p><b>Population Served:</b> The program serves new and expectant parents who meet at risk screening and assessment criteria for the Healthy Families Program.</p>
<p><b>2c</b></p>	<p><b>Geographical Area of Services:</b> Statewide</p>
<p><b>2d</b></p>	<p><b>Referral Sources:</b>Local hospitals, prenatal clinics, Federally Qualified Health Centers (FQHCs), OB/GYN physicians, pediatricians, WIC, local schools, School Based Youth Services, Family Success Centers, regional Maternal-Child Health Consortia, community-based organizations and County Boards of Social Services (Welfare Boards).</p>
<p><b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b></p>	
<p><b>3a</b></p>	<p><b>Provide a summary of program accomplishments on goals. Include data where available:</b></p> <ul style="list-style-type: none"> <li>➤ Within the 21 Healthy Families Sites: <ul style="list-style-type: none"> <li>• 96% of infants/children had a medical home</li> <li>• 91% of eligible children are enrolled in WIC.</li> <li>• 93% of participating infants/children are up to date on well-child visits</li> <li>• 93% of participating infants/children received developmental screening and appropriate referrals</li> </ul> </li> </ul> <p>96% of participants increased their inter-pregnancy interval (birth to conception) to 18 months</p>
<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b> PCA-NJ’s role in quality assurance, training and technical assistance ensures that all HF New Jersey programs adhere to Healthy Families America model fidelity.</p> <p>Program accomplishments:</p> <ul style="list-style-type: none"> <li>• Increased the number of children and parents linked to a primary health care provider</li> <li>• Increased the number of children linked to WIC.</li> <li>• Increased the number of families who make use of available community resources</li> <li>• Increase in the appropriate identification and referral of infants and children at risk for developmental delays</li> </ul>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers</p>

	<p>(FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b> Flat funding to Healthy Families New Jersey programs for the past ten plus years also makes it difficult to attract and retain experienced home visitors.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> See Healthy Families New Jersey Data attached as Table A.</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> See Healthy Families New Jersey Data attached as Table A.</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals: N/A</b>  <b># of unduplicated families: N/A</b></p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <ul style="list-style-type: none"> <li>➤ In 2016, each Healthy Families New Jersey site distributed surveys to the families they served to assess client satisfaction. The results of those surveys are contained within each site’s individual PSSF Update Report, submitted under separate cover.</li> <li>➤ In 2016, Prevent Child Abuse NJ distributed site satisfaction surveys to all active programs that we serve. 22 surveys were distributed and 20 surveys were returned from the sites with the following themes:</li> </ul>

	<ul style="list-style-type: none"> <li>○ When asked if they are pleased with the support provided by PCANJ, 95% strongly agreed/agreed, 5% (1 individual) was neutral.</li> <li>○ When asked if the database gives them tools to measure progress, 85% strongly agreed/agreed and 15% disagreed.</li> <li>○ When asked if PCA has made advanced trainings available for staff including explanation and information about ELearning opportunities, 90% strongly agreed/agreed.</li> </ul> <p>Comments included requests for:</p> <ul style="list-style-type: none"> <li>● More on-site trainings for home visiting staff</li> <li>● Faster, more user friendly database system</li> </ul>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <ul style="list-style-type: none"> <li>➤ To prevent all incidents of child abuse and neglect for participating families by providing education on child development and promoting positive parent child interaction;</li> <li>➤ To have 100% of participating children receive developmental screening and assistance with appropriate referrals;</li> <li>➤ To have 100% of participating children referred to and followed by an appropriate medical provider for scheduled well care visits;</li> <li>➤ To increase family functioning and financial security; and</li> <li>➤ NJ HF programs will be transitioning to a one-step enrollment process, where they will no longer conduct the Kempe assessment/parent survey prior to enrollment but instead will use it as a tool with all enrolled families. This will enable sites to engage families sooner and hopefully improve retention rates as well.</li> </ul>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b>          We are hoping to make improvements to our web-based data collection systems on an ongoing basis.          See also, each site’s individual PSSF Update Report, submitted under separate cover.</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b>          See Healthy Families New Jersey Data attached as Table A.</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>  <b># of unduplicated individuals:</b> N/A  <b># of unduplicated families:</b> N/A</p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program.</p>

	Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
<b>5c</b>	<b>How do you collaborate with community partners?</b> PCA-NJ collaborates with all agencies that provide Healthy Families services in New Jersey. The Healthy Families New Jersey staff also collaborates with the various maternal child health consortiums, birthing hospitals, community organizations, CCYC’s, state agencies, local boards of social services, among others, to ensure programs have the latest data on births and eligible families in each county.

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Robins’ Nest, Inc. <b>1b Program Name:</b> Healthy Families/TIP Salem County
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <u><b>X</b></u> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 531 Ellis Mill Rd., Glassboro, NJ 08028
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <u><b>X</b></u> Safety <u><b>X</b></u> Permanency <u><b>X</b></u> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at

	birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
<b>2b</b>	<b>Population Served:</b> All parents in Salem County who are pregnant or have an infant 3 months old or younger, or have an infant 12 months or younger if receiving TANF or GA.
<b>2c</b>	<b>Geographical Area of Services:</b> Salem County, NJ
<b>2d</b>	<b>Referral Sources:</b> Local Hospitals, Prenatal Clinics, Federally Qualified Health Centers, OB/GYN Physicians, WIC, DCP&P, Local Schools, School Based Youth Services, Family Success Centers, and County Social Services. All referrals directed through the Central Intake, CSG Connect.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b>  <b>Include data where available:</b></p> <ul style="list-style-type: none"> <li>56. 100% of children were enrolled in health insurance</li> <li>57. 92% of participating infants/children were up-to-date on immunizations.</li> <li>58. 93% of participants increased their interpregnancy interval (birth to conception) to 18 months</li> <li>59. 100% of participating infants/children had a medical home</li> <li>60. 98% of participating infants/children received developmental screening and appropriate referrals.</li> </ul>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b> During the report period, the site experienced two staff vacancies. The site was able to retain many of these clients through</p>

	contact from the supervisor and visits covered by other staff to minimize the impact on disruption of program services. One vacancy has been filled and new staff is in process of building up a full case load.
<b>3e</b>	<b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 120
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 97
<b>3h</b>	<b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b> # of unduplicated individuals: 212 # of unduplicated families: 106
<b>3i</b>	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> 15 satisfaction surveys were distributed and 14 were returned for the year 2016. All 14 responded “Yes” when asked if the program was meeting their expectations. When asked “What do you like best about the program’s services?” many of the clients expressed that the program helped them to better understand their child’s stages of growth and development and what to expect. They liked the information about how to encourage child’s development. Clients also stated that the program helped them and their families set and achieve goals and learn ways to relieve stress.
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> There are no planned changes to the program.
<b>4b</b>	<b>Identify changes you will make that stem from stakeholder feedback.</b> There are no planned changes to the program.
<b>4c</b>	<b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> 120

<p><b>4d</b></p>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>  <b># of unduplicated individuals:</b> 212  <b># of unduplicated families:</b> 106</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>5a</b></p>	<p><b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.</p>
<p><b>5b</b></p>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.</p>
<p><b>5c</b></p>	<p><b>How do you collaborate with community partners?</b>  The program maintains a collaborative relationship with many other agencies which can provide assistance to our families such as the Salem County Board of Social Services, Tri-County WIC Center, PRAC, One-Stop Career Center, Family Success Centers, the local hospital and pre-natal clinic, etc. These agencies not only facilitate our ability to obtain needed services for our families but are a rich source of referrals. The program also participates in quarterly CGS Central Intake Partners meetings.  In delivering services, staff also works closely with the local clinic and OB/GYN, which welcome Healthy Families at their sites to outreach to mothers. WIC clinic staff and the Southern Jersey Family Medical Center have also welcomed regular Healthy Families presence on site.  In addition, school nurses, DCP&amp;P caseworkers, and social workers identify potential candidates and make referrals.  The program is now collaborating with the Salem County Council on Young Children and has begun to utilize their quarterly meetings as our Advisory Board. We have also participated in several SCCYC events.  Finally, staff collaborates with a broad array of services (such as medical providers, employment services, vocational training, day care, etc.), linking new families to the resources they need to provide their baby a loving, financially viable home.</p>

### 2017 PSSF Update Report

Section 1 – Identifying Information	
<b>1a</b>	<p><b>Provider:</b> Robin’s Nest Inc</p> <p><b>1b Program Name:</b> Healthy Families-TIP Cumberland County</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <input checked="" type="checkbox"/> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 531 Ellis Mill Road Glassboro NJ 08082
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
<b>2b</b>	<b>Population Served:</b> The target population for Healthy Families-TIP Cumberland program is any parent residing in Cumberland County who is pre-natal to three months post-natal. In addition, any parent who is GA/TANF (General Assistance/ Temporary Aid to Needy Families) eligible may enroll up to infant turning one year of age as part of the TIP program (TANF Initiative for Parents).
<b>2c</b>	<b>Geographical Area of Services:</b> Cumberland County
<b>2d</b>	<b>Referral Sources:</b> Inspira Health Network, Complete Care Prenatal Centers, OB/GYN Physicians, WIC, Local Schools, School Based Youth Services, Family Success Centers, and County Social Services.
Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b></p> <p><b>Include data where available:</b></p> <p>61. 90% of children were enrolled in health insurance</p>

	<p>62. 91% of participating infants/children were up-to-date on immunizations.</p> <p>63. 97% of participants increased their interpregnancy interval (birth to conception) to 18 months</p> <p>64. 100% of participating infants/children had a medical home</p> <p>65. 98% of participating infants/children received developmental screening and appropriate referrals.</p>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b> There were not a significant barriers that the program encounter in the past year.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 150 Case weight</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 136.50 (91%) Case weight</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:</b> 226</p> <p><b># of unduplicated families:</b> 113</p>

<p><b>3i</b></p>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>          Thirty-three satisfaction surveys were distributed and Thirty-one were returned. The results from the most recent survey revealed the following findings: 29 of families strongly agreed that their Family Support Worker is respectful and understands the families’ culture or way of living. 29 families strongly agreed that their Family Support Worker talks with them about their child, health and safety every visit. 30 families responded that they have participated in forming goals with their Family Support Worker. When asked if the program had meeting their expectations: 30 families responded yes and 27 of them respond that the program has helped them. 29 of them strongly agreed that the program gives the opportunity to share feelings about the program and services. Some of the comments of how the program has helped included: “I understand how important my actions can affect my child”, “This program helps me in the way I can be a better mother. Thanks to the program I’m not scare to take care of my son and they help me to be a better person as well”, “During my pregnancy I am been learning to know the stages of the labor, my worker provides me with emotional support and activities that stimulate my baby in the womb”.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>4a</b></p>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b>          There are no planned changes to the program</p>
<p><b>4b</b></p>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b>          We will maintain our efforts in improving quality services to enhance parents’ knowledge, self-efficient and family functioning.</p>
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b>          150 Case Weight</p>
<p><b>4d</b></p>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>          # of unduplicated individuals: 226          # of unduplicated families: 113</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>5a</b></p>	<p><b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.</p>
<p><b>5b</b></p>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the</p>

	program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
<b>5c</b>	<p><b>How do you collaborate with community partners?</b></p> <p>Healthy Families collaborates with the county’s local hospital and Complete Care Prenatal Health Centers. Hospital and Prenatal Health Center’s staff identifies families to refer to Healthy Families-TIP program for a comprehensive assessment. In addition, school nurses and social workers identify potential candidates. Also Healthy Families-TIP partnered with the County Board of Social Services to serve GA/TANF eligible parents as well as participated in the monthly Cumberland County Work First New Jersey Local Partnership meetings. Finally the Healthy Families-TIP program participates in the Cumberland County Council for Youth Children (CCCYC) quarterly meetings were different community providers that serve in Cumberland county, collaborate in planning, implementing, and assessing program services.</p>

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Robins Nest Inc.</p> <p><b>1b Program Name:</b> Healthy Families Gloucester County</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <u><b>X</b></u> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 42 S. Delsea Drive Glassboro, NJ 08028
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <u><b>X</b></u> Safety <u><b>X</b></u> Permanency <u><b>X</b></u> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.

<b>2b</b>	<p><b>Population Served:</b>          Any parent who is pregnant or has an infant 3 months or younger is eligible for Healthy Families-TIP Gloucester. Additionally, the program is available to parents with an infant up to twelve months old if they are currently receiving or eligible to receive Temporary Assistance to Needy Families (TANF), Emergency Assistance (EA) or General Assistance (GA). Potential clients are screened for a variety of risk factors, including but not limited to teen pregnancy, first-time or subsequent pregnancy, low income, inadequate or no prenatal care, unstable housing, social isolation, depression, substance use, domestic violence and other indicators that place a child at risk of abuse and neglect.</p>
<b>2c</b>	<p><b>Geographical Area of Services:</b> Gloucester County</p>
<b>2d</b>	<p><b>Referral Sources:</b> Local Hospitals, Prenatal Clinics, Federally Qualified Health Centers, OB/GYN Physicians, WIC, Local Schools, School Based Youth Services, County Social Services.</p>
<p><b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b></p>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals. Include data where available:</b></p> <ul style="list-style-type: none"> <li>66. 100% of children were enrolled in health insurance</li> <li>67. 87% of participating infants/children were up-to-date on immunizations.</li> <li>68. 96% of participants increased their interpregnancy interval (birth to conception) to 18 months</li> <li>69. 98% of participating infants/children had a medical home</li> <li>70. 91% of participating infants/children received developmental screening and appropriate referrals.</li> </ul>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>

<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment:</b> There were no significant barriers to goal accomplishment.</p>
<p><b>3e</b></p>	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.</p>
<p><b>3f</b></p>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> The contracted level of service was 120.</p>
<p><b>3g</b></p>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 95.13</p>
<p><b>3h</b></p>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:</b> 184 <b># of unduplicated families:</b> 92</p>
<p><b>3i</b></p>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <p>Fifty satisfaction surveys were distributed to participating families. Twenty-two surveys were returned. Four respondents were African American, 14 were Caucasian, 2 Hispanic, and 2 multi-ethnic. All twenty-two respondents felt that the program met their expectations. When asked what they like best about the program some of the comments included: <i>It’s helped me to learn new ways of teaching my children and also watching and learning from them. Tiffany has helped me with new parenting skills. We have worked on goals, safety, development, and self-care especially with mine and my spouses PPD. I receive resources and handouts to give me any help I need. She gives me someone to talk to and voice any concerns I have. Susan gives me great resources for my family. She makes sure my son reaches proper milestones as well. We always enjoy her company too! Helped me to be focused on my career, children and entire family. Very helpful with my health and keep me up on my feet. Love the program and my family worker. The program helped me with my electric bill and x-mas help. Also handouts, and information is good. It helped me with clothes for the kids from the little hands little feet. I feel the activity and resources have strongly helped with Zoey’s development. Tiffany has helped me so much. She makes me very happy.</i></p>

<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> There were no planned changes planned to the program.
<b>4b</b>	<b>Identify changes you will make that stem from stakeholder feedback.</b> There were no changes due to stakeholder feedback.
<b>4c</b>	<b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> The expected case weight is 120.
<b>4d</b>	<b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: 184 # of unduplicated families: 92
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
<b>5c</b>	<b>How do you collaborate with community partners?</b>  The program maintains a collaborative relationship with many other agencies which can provide assistance to our families such as the Gloucester County Board of Social Services, local WIC Center, One-Stop Career Center, the local hospitals pre-natal clinic, etc. These agencies not only facilitate our ability to obtain needed services for our families but are a rich source of referrals.  Using a simple pre-screen instrument, local hospital staff identify families to refer to Healthy Families for a comprehensive assessment. In addition, prenatal clinic staff, school nurses, social workers and community agencies identify potential candidates and contact our central intake system to make a referral. Program staff work closely with WIC which welcomes Healthy Families at their site to outreach to parents. Staff collaborate with a

<p>broad array of services (such as medical providers, employment services, vocational training, day care, etc.), linking new families to the resources they need to provide their child(ren) with a loving and financially viable home. Representatives on our Advisory Board (CCYC) are from: Woodbury Family Success Center, Glassboro Family Success Center, and Underwood Hospital Prenatal Clinic.</p> <p>Relationships with the Board of Social Services (BSS), Workforce Investment Board and Gloucester County One-Stop have strengthened due to the addition of TIP (TANF Initiative for Parents). Healthy Families provides in home parenting education for families who receive cash assistance, food stamps, temporary rental assistance, education/employment counseling. The BSS is notified of TIP families participation in our program.</p>
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**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Southern NJ Perinatal Cooperative</p> <p><b>1b Program Name:</b> Atlantic County Healthy Families</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <input checked="" type="checkbox"/> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 2922 Atlantic Avenue 2 <sup>nd</sup> Floor Atlantic City, NJ 08401
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.</p>
<b>2b</b>	<b>Population Served:</b> The Atlantic County Healthy Families program enrolls women who

	<p>are either pregnant or with a newborn younger than 3 months, regardless of number of previous live births. We continue to offer home visitation services to families until the child's 3<sup>rd</sup> birthday or until the child becomes enrolled in Preschool.</p>
<p><b>2c</b></p>	<p><b>Geographical Area of Services:</b> The Atlantic County Healthy Families-TIP Program serves families residing in Atlantic City, Ventnor, Brigantine, Pleasantville, Egg Harbor Township, Absecon, Galloway Township, Egg Harbor City, Mays Landing, and Somers Point.</p>
<p><b>2d</b></p>	<p><b>Referral Sources:</b></p> <ul style="list-style-type: none"> <li>• Southern Jersey Family Medical Center: Atlantic City location</li> <li>• Southern Jersey Family Medical Center: Pleasantville location</li> <li>• Southern Jersey Family Medical Center: Hammonton location</li> <li>• Southern Jersey Family Medical Center: Burlington location</li> <li>• Southern Jersey Family Medical Center: IPO Community Health Workers</li> <li>• AtlantiCare Regional Medical Center - AC Division: Case Management</li> <li>• DCP&amp;P of Atlantic County</li> <li>• Children's Home Society of Ocean County</li> <li>• Lourdes Medical Associates at Osborn Family Health Center</li> <li>• Lourdes Medical Associates Women's Health Care of Collingswood</li> <li>•</li> <li>• Jaffe Family Women's Care Center in Camden</li> <li>• Cooper Obstetrics &amp; Gynecology (Sewell, NJ)</li> <li>• Atlantic County Project Teach (DCF Regional) High School</li> <li>• Help Me Grow 2-1-1</li> <li>• Inspira Hospital</li> <li>• AtlantiCare Regional Medical Center – Center for Childbirth</li> <li>• Self-Referral (Info into PRA/SPECT &amp; assigned to HF-TIP)</li> <li>• Southern NJ Perinatal Cooperative</li> <li>• AtlantiCare Physician's Group - Pavilion OB/GYN (Egg Harbor Township, NJ)</li> <li>• Shore Regional Medical Center – Community Referrals</li> <li>• Somers Manor OB/GYN (Somers Point, NJ)</li> <li>• Reliance Medical Center of Atlantic City</li> <li>• Reliance Medical Group of Somers Point</li> <li>• Robin's Nest</li> </ul>
<p><b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b></p>	
<p><b>3a</b></p>	<p><b>Provide a summary of program accomplishments on goals.</b>  <b>Include data where available:</b></p> <ol style="list-style-type: none"> <li>71. 100% of children were enrolled in health insurance</li> <li>72. 84% of participating infants/children were up-to-date on immunizations.</li> <li>73. 96% of participants increased their interpregnancy interval (birth to conception) to 18 months</li> <li>74. 100% of participating infants/children had a medical home</li> <li>75. 95% of participating infants/children received developmental screening and appropriate referrals.</li> </ol>

3b	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
3c	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>
3d	<p><b>Identify significant barriers to goal accomplishment:</b> A barrier to accomplishing our target goal of achieving 85% of our participating infants/children being up-to-date on immunizations is definitely a documentation/data entry issue on behalf of the pediatrician offices. Our program staff utilizes the online New Jersey Immunization Information System (NJIIS) in order to obtain all immunization dates for each participating target child. When medical providers do not update the immunization information successfully, this information is then unavailable to our home visiting staff. It is important to note that majority of the families we serve do not maintain up-to-date child health records or document immunization dates to provide to their designated Family Support Worker. In an attempt to overcome this barrier, home visiting staff is encouraged to ask participating mothers to inform their FSW when their baby sees the Pediatrician and receives immunizations.</p>
3e	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.</p>
3f	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 143</p>
3g	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 113.60</p>

<p><b>3h</b></p>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:</b> 210  <b># of unduplicated families:</b> 105</p>
<p><b>3i</b></p>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>  Please see the attached 2015 Client Satisfaction Survey data. Out of approximately 75 surveys distributed, 34 surveys were completed and returned to us.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>4a</b></p>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b>  There are currently no planned changes for the program.</p>
<p><b>4b</b></p>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b>  The AC HF program shared our 2015 Annual Service Review with our Advisory Board members during our meeting on April 5<sup>th</sup>, 2016. A highlight of our discussion regarding areas for growth is as follows:</p> <ul style="list-style-type: none"> <li>- After presenting some data points on specific outcome objectives, a representative (nurse) from our local health department suggested that our program could benefit from some additional low-literacy Lead education tools. She even agreed to look into finding some for us. Our program will continue placing emphasis on educating participants on the dangers of Lead exposure.</li> <li>- The AC HF Program Manager asked the Advisory Board members for any tips they could share regarding engaging new families. Two members (Community Health Workers) shared that they find it’s easiest for them to engage families when they focus on making their questions very conversational, easy-going, and present a relaxed body language. Our home visiting staff will continue engaging families in this manner.</li> </ul>
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> 143</p>
<p><b>4d</b></p>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>  <b># of unduplicated individuals:</b> 286  <b># of unduplicated families:</b> 143</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>5a</b></p>	<p><b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program.</p>

	<p>Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.</p>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.</p>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b>                  In spring, 2013, a Central Intake referral hub was established in Atlantic County. The Central Intake hub in Atlantic County is funded by the New Jersey Department of Health as a component of the Improvement of Pregnancy Outcome project and oversees the home visiting referrals. The 5 home visitation programs in Atlantic County get together for planning meetings and have established business rules that are based on program eligibility criteria and outline how the referrals are assigned to each program. All local prenatal care providers and other referring agencies have been instructed on the Central Intake process and utilize the Perinatal Risk Assessment, the Community Health Screening, or the general home visitation referral form.                  SNJPC (SNJPC) is the designated Central Intake agency for Atlantic County. Family Health Initiatives (FHI) is the sponsor of the web-based Perinatal Risk Assessment/Single Point of Entry Client Tracking System (PRA/SPECT) used by all NJ Central Intake hubs. FHI is a subsidiary company of SNJPC. SNJPC/FHI has business and data sharing agreements with the prenatal care sites using the PRA/SPECT system and with all the home visiting programs who receive referrals from Central Intake in Atlantic County.                  Additionally, our program supervisor attends the bimonthly Atlantic County Healthy Mothers Healthy Babies Coalition meetings and the Atlantic County United Way Success by Six meetings. These meetings are comprised of a variety of maternal, infant, and early childhood health professionals, and networking amongst everyone is ongoing. All meeting members provide ongoing updates regarding their specific programs and/or agencies.</p>

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Visiting Nurse Association Health Group</p> <p><b>1b Program Name:</b> Monmouth Health Families/TIP</p>
<b>1c</b>	<p><b>Relevant PSSF Program:</b> ___FPS, <u><b>X</b></u> FSS, ___TLFRS, ___APSS</p>
<b>1d</b>	<p><b>Program Address:</b>                  1301 Main Street Asbury Park, NJ 07712 and 200 Broadway Long Branch NJ 07740</p>

	<p><b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.</p>
<p><b>1f</b></p>	<p><b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being</p>
<p><b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b></p>	
<p><b>2a</b></p>	<p><b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.</p>
<p><b>2b</b></p>	<p><b>Population Served:</b></p> <p>The target population at the time of the first implementation of Healthy Families by VNA in 1997 was decided based on the high poverty levels in Asbury Park, high unemployment, poor graduation rate, high numbers of undocumented Hispanics, high teen birth rates and poor prenatal care numbers. In order to meet the most vulnerable pregnant and parenting women, it was decided to identify first-time pregnant or parenting women who lived in Asbury Park as the target population to be served by HF. With expansion into Long Branch in 2008, the site continued serving first-time mothers because the TIP part of the program was added in 2006 which allowed the HF site to serve mothers who were not first time parents as well as serving some TANF receiving families with a child less than 12 months.</p> <p><u>Target Population Updated:</u></p> <p>As of July 1, 2015, the updated target population is defined as: available to serve all eligible pregnant and parenting women, who live in Monmouth County, with a child less than three months of age. The program also serves prenatal clients or parents who reside in Monmouth County, are receiving TANF/GA benefits, and have a child younger than 12 months in age. The service area focus is on the high-risk municipalities of Asbury Park, Long Branch, Neptune, Red Bank, Keansburg, and Freehold; many of which were listed in the Perinatal Risk Index (PRI).</p> <p>MHF/TIP identified a need for change of the target population based on feedback from Advisory Board members and program staff. The site expanded the eligibility criteria as of July 1, 2015 to include any prenatal or parenting mom (not just first time) with a child under 3 months of age. The site found that our previous criteria, which accepted only first time moms, yielded fewer referrals and a case weight below target.</p>
<p><b>2c</b></p>	<p><b>Geographical Area of Services:</b></p> <p>Monmouth Healthy Families/TIP program serves parenting families living in Monmouth County with a focus on parents living in the following communities: Asbury Park, Neptune, Keansburg, Freehold, Red Bank, and Long Branch; the program also serves parents who reside in Monmouth County and are receiving TANF/GA benefits and have a child younger than 12 months in age. The program’s goal is to engage and enroll women prenatally or within three months of the birth of the baby.</p> <p>As of July 1, 2015, the updated target population is defined as: available to serve all eligible pregnant</p>

	<p>and parenting women, who live in Monmouth County, with a child less than three months of age. The program also serves prenatal clients or parents who reside in Monmouth County and are receiving TANF/GA benefits and have a child younger than 12 months in age. The service area focus is on the high-risk municipalities of Asbury Park, Long Branch, Neptune, Red Bank, Keansburg, and Freehold; many of which were listed in the Perinatal Risk Index (PRI).</p>
<p><b>2d</b></p>	<p><b>Referral Sources:</b>                  Monmouth Healthy Families/TIP receives referrals from the Monmouth/Ocean Family Connections Central Intake Program, local hospitals, Prenatal Clinics, Federally Qualified Health Centers, OB/GYN Physicians, WIC, local schools, Project Teach, and Monmouth County Social Services.</p> <p>In June 2014, the Central Jersey Family Health Consortium (CJFHC) was awarded the grant for a Central Intake for Monmouth County. Currently, community agencies and providers make referrals to Central Intake by filling out the one-page Community Referral Form, which is faxed to Monmouth Central Intake. Prenatal providers use a Perinatal Risk Assessment (PRA), and automatically send the PRA to Central Intake through the SPECT data system. Participants can also make self-referrals by calling Central Intake.</p>
<p><b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b></p>	
<p><b>3a</b></p>	<p><b>Provide a summary of program accomplishments on goals. Include data where available:</b></p> <ul style="list-style-type: none"> <li>76. 100% of children were enrolled in health insurance</li> <li>77. 86% of participating infants/children were up-to-date on immunizations.</li> <li>78. 97% of participants increased their inter-pregnancy interval (birth to conception) to 18 months</li> <li>79. 100% of participating infants/children had a medical home</li> <li>80. 93% of participating infants/children received developmental screening and appropriate referrals.</li> </ul>
<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>
<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment:</b>                  Among the challenges experienced by the site in 2016, were:</p> <ul style="list-style-type: none"> <li>• The Monmouth HF/TIP had challenges maintaining consistency with meeting LOS throughout the four quarters. The program acknowledged that this was a result of personnel changes.</li> </ul>

	<p>Through these quarters, the program had staff out on medical leave, bereavement, family leave, disability, and two resigned from their positions as FSWs in 2016. The program met the challenge by balancing caseloads, hiring new personnel, and covering cases that were put on temporary reassignment (TR) while staff members were on leave.</p> <ul style="list-style-type: none"> <li>The site was also challenged with maintaining retention of clients enrolled versus the client that discharged through the 4 quarters. The program has been working on improving retention this year, by providing incentives to participants during the completion of screenings- ASQs every 6 months. The program has also invested time to evaluate the staff needs, and is actively providing encouragement, team building workshops, recognition, and support to staff to counter any needs and reduce the staff turn-over-rate. The site is also working with central intake, to become more consistent with communicating changes and challenges. . The program’s implementation of the one-step- enrollment process is also being looked as a new change to positively influence our retention rates. The one-step-enrollment offers the possibility for client’s to connect with their FSW from the beginning of their involvement in the program, which affords a faster acclimation to consistent home visitation, and the rapport building process with FSWs.</li> </ul>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b>          Monmouth Healthy Families/TIP programs case weight is 240</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b>          188 of units of service</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals: 245</b>  <b># of unduplicated families: 122</b></p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>  <b>See Below Attached #1</b></p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b>          There are no planned changes to the Monmouth HF/TIP program at this time.</p>

<p><b>4b</b></p>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b> N/A</p>
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> Monmouth Healthy Families/TIP program case weight from 10/01/16 to 12/31/16 was 240. The site implemented the one-step-enrollment process as of 01/01/17. Therefore, the new case weight is 218.</p>
<p><b>4d</b></p>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: 218 # of unduplicated families: 109</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>5a</b></p>	<p><b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, which provides the technical assistance and quality assurance training for our MHF/TIP program staff. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the Advisory Board. The program is also collaborating with DCF’s Division on Women by hosting a grant for a Safety and Accountability Domestic Violence Pilot program. The pilot has been in effect since Mar 2016, and it is evaluating best practices and community responses to our program participants, their children and participants of the Asbury Park area who have suffered or are currently suffering from abuse.</p>
<p><b>5b</b></p>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey, as well as through their DV pilot initiative. The observations and subjections will be used to make adjustments and improvements to benefit participants, as need.</p>
<p><b>5c</b></p>	<p><b>How do you collaborate with community partners?</b> The Monmouth HF/TIP collaborates with community agencies/resources that provide services tour target population. The site participates in Community Heath Fairs, Latino Festival. The Monmouth HF/TIP also facilitates the Monmouth County MCH Network and Home Visitation quarterly advisory board meeting which is attended by various community partners throughout Monmouth County. The program invites community partners to do presentations and share information on programs and resources that they provide. The Monmouth Healthy Families/TIP program has established a relationship with the Improving Pregnancy Outcomes grant, which utilizes Community Health Workers to outreach and engage women of childbearing age into medical care and the CCYC, Monmouth County Council for Young Children where parents and community are able to meet to share ideas and affect change to make a healthier community.</p>

### 2017 PSSF Update Report

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Visiting Nurse Association</p> <p><b>1b Program Name:</b> Healthy Families Perth Amboy</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <input checked="" type="checkbox"/> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 313 State St Floor 2 Perth Amboy, NJ 08861
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
<b>2b</b>	<b>Population Served:</b> Healthy Families serves low income, pregnant and parenting women with a child less than 3 months of age who live in the City of Perth Amboy.
<b>2c</b>	<b>Geographical Area of Services:</b> The service area of focus is on the high risk City of Perth Amboy as indicated on the Perinatal Risk Index (PRI).
<b>2d</b>	<b>Referral Sources:</b> The Perth Amboy HF site receives referrals via the PRA/SPECT system from the Central Jersey Family Health Consortium Central Intake sites in North Brunswick. A list of referral sources include: Family Success Center with the Jewish Renaissance Foundation in Perth Amboy, Puerto Rican Association of Human Development, self referrals, and other community partners. The Perth Amboy HF program has a formal MOU/Business Agreement established with Central Intake in order to receive referrals. Central Intake is funded and responsible to establish formal and/or informal agreements with the referral

	sources in the community.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals. Include data where available:</b></p> <ul style="list-style-type: none"> <li>81. 98% of children were enrolled in health insurance</li> <li>82. 87% of participating infants/children were up-to-date on immunizations.</li> <li>83. 97% of participants increased their interpregnancy interval (birth to conception) to 18 months</li> <li>84. 99% of participating infants/children had a medical home</li> <li>85. 86% of participating infants/children received developmental screening and appropriate referrals.</li> </ul>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Program accomplishments increased:</p> <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> </ul>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b> There were many challenges for the HF Perth Amboy site for the FY16 due to staff turnover, maternity leave, training of new staff, etc. A number of families were placed on Temporary Reassignment, of those families, HFPA had 6 discharges that did not want a change of FSW. This resulted in a lower percentage than the site typically achieves. The site was not able to meet the LOS target due to all of the mentioned circumstances.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.</p>

3f	Enter your <b>contracted</b> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16: 62
3g	Enter your <b>actual</b> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16: 44 or 68%
3h	How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.  # of unduplicated individuals: 92 # of unduplicated families: 46
3i	Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results. 25 surveys were sent out and 18 surveys were received back by the program; all had positive feedback on program services and stated the program was meeting their expectations.
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
4a	Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program. In light of the changes of the one step enrollment process, the site’s LOS is increasing from 62 to 68.
4b	Identify changes you will make that stem from stakeholder feedback. There will not be any changes, the HFPA will continue referring participants to community partners for more support and events to attend.
4c	How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17? Due to the one step enrollment process, the LOS is increasing from 62 to 68.
4d	Indicate how many unduplicated individuals and unduplicated families you expect to serve. # of unduplicated individuals: 136 # of unduplicated families: 68
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
5a	How will you measure progress? The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client

	feedback, the annual service review and feedback from the advisory board.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
<b>5c</b>	<b>How do you collaborate with community partners?</b> The HFPA Supervisor is part of the Middlesex/Somerset Community Advisory Board which meets quarterly. The community partners that attend the Community Advisory Board include the Central Jersey Health Consortium, HF Middlesex, Parents as Teachers Middlesex, Improving Pregnancy Outcome Workers, Community Health Workers, CCYC, Pediatricians, FSC, PRAB, etc. The Supervisor also attends the Central Intake Regional Meetings held on a quarterly basis. The program works closely with the Puerto Rican Association of Human Development in connecting families to services such as First Time Home Buyer, Mi Escuelita Preschool, HIV Awareness Health Fairs, Sista’s Group Women Empowerment Support Groups, etc.

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider: VNAHG</b>  <b>1b Program Name: Healthy Families/TIP Essex County</b>
<b>1c</b>	<b>Relevant PSSF Program: ___FPS, <u>X</u> FSS, ___TLFRS, ___APSS</b>
<b>1d</b>	<b>Program Address: 80 Main St. Suite 300, West Orange, NJ 07052</b>
<b>1e</b>	<b>Objective:</b> Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.
<b>1f</b>	<b>Outcome(s) Addressed: <u>X</u> Safety <u>X</u> Permanency <u>X</u> Well-Being</b>
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term

	home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
<b>2b</b>	<b>Population Served:</b> Essex VNA Healthy Families/TIP Program will serve all eligible pregnant and parenting women with a child less than 3 months who live in Essex county; the site will focus concentration on families living in the high risk towns of Newark, Irvington and the Oranges. In addition, the site will serve pregnant and parenting women who are eligible to receive TANF benefits, live in Essex County and are parenting a child less than 12 months.
<b>2c</b>	<b>Geographical Area of Services:</b> Essex County New Jersey with a focus on Newark, Irvington, the Oranges.
<b>2d</b>	<b>Referral Sources:</b> Central Intake
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<b>Provide a summary of program accomplishments on goals. Include data where available:</b> <b>86. _97_% of children were enrolled in health insurance</b> <b>87. _81_% of participating infants/children were up-to-date on immunizations.</b> <b>88. _95_% of participants increased their interpregnancy interval (birth to conception) to 18 months</b> <b>89. _99_% of participating infants/children had a medical home</b> <b>90. _90_% of participating infants/children received developmental screening and appropriate referrals.</b>
<b>3b</b>	<b>How did this improve outcomes for children and families?</b> Program accomplishments increased: <ul style="list-style-type: none"> <li>• the number of children and parents linked to a primary health care provider</li> <li>• number of children receiving up to date immunizations</li> <li>• number of families use of community resources</li> <li>• appropriate identification and referral of infants and children for developmental delays</li> <li>• number of moms who initiated breastfeeding</li> </ul>
<b>3c</b>	<b>Identify specific factors that contributed to this improvement:</b> Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child’s emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation

	tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child’s immunizations and well-child visits.
<b>3d</b>	<b>Identify significant barriers to goal accomplishment:</b> One of the biggest barriers the site faced was working to rebuild the site’s LOS with 5 new FSWs out of a team of 6 FSWs. The site has focused on building a strong team that is informed and equipped with the information to serve the target population.
<b>3e</b>	<b>Definition of Level of Service as per contract:</b> In Healthy Families, the level of service is measured by “case weight.” Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> <b>Level of Service 174</b>
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> <b>103.19</b>
<b>3h</b>	<b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  <b># of unduplicated individuals: 330</b> <b># of unduplicated families: 165</b>
<b>3i</b>	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> In FY16 the site distributed a total of 61 participant satisfaction surveys and received 24 back. Participants provided our program with feedback and suggestions to help improve our services. Many participants felt that the program has met their expectations and has provided them with the support that they need. Many comments include statements related to learning about their baby’s development, learning to be a patient and caring parent, receiving resources about social services and employment, assuring that they are up to date with any appointments, learning about breastfeeding, and the benefits of being encouraged to overcome obstacles. In regards to program improvements 9 out of 24 participants suggested having access to text messaging with our workers, having summer outings with our families & using media as a

	<p>form of teaching new things about their baby. 6 of 24 of our participants had no suggestions to improve our services and 9 of 24 of our participants stated that they are satisfied with services the way it is.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
4a	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b>                  Due to the one-step enrollment process the site’s new level of service is 182. This change is being made because each worker’s case weight has changed from 30 to 26 to accommodate the time needed for the assessment; in addition, those workers in dual roles have now been incorporated into one role, allowing for an additional 4-5 families.</p>
4b	<p><b>Identify changes you will make that stem from stakeholder feedback.</b>                  In an effort to connect families to more services the site will host monthly in-services with representatives from local organizations or specialists in challenging areas that mom’s are facing. The site is also planning to host monthly outings in the summer at different locations in the county to allow parents in each target area opportunities to connect.</p>
4c	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b>                  Expected level of service is 182.</p>
4d	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>                  # of unduplicated individuals: 364                  # of unduplicated families: 182</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
5a	<p><b>How will you measure progress?</b> The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.</p>
5b	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.</p>
5c	<p><b>How do you collaborate with community partners?</b>                  The site works with other agencies serving similar populations in the Essex LAUNCH Young Child Wellness meetings which also serves as the board meetings for the site. There</p>

	<p>are representatives from Programs for Parents, the County Council for Young Children, Public School systems, Departments of Health from East Orange and Newark, Healthy Start, Prevent Child Abuse NJ, NFP, PAT, Healthy Families at the Partnership for Maternal and Child Health, Department of Children and Families, Montclair State University, Newark Beth Israel Medical Center, YouthBuild Newark, Family Intervention Services, SPAN, Youth Development Clinic, Newark Fairmount Promise Neighborhood, Parents, Doulas, Montclair Child Development Center, Irvington Department of Health, Advocates for Children of NJ, Cerebral Palsy NJ, University Hospital, Horizon, Autism NJ, East Orange Child Development Center, East Orange School District, START, Orange Public Schools, Ironbound Community Corporation, The Leaguers, Youth Consultation Services, First Choice Women’s Resource Center, FamilyLink, NCHC, Healthcare Foundation of NJ, The Partnership for Maternal and Child Health, Tri City People’s Corporation, Youth Consultation Services.</p> <p>The site also has MOUs with HYACNTH, Rutgers University SNAP Ed Program, and SPAN. The site supervisor/team leader also attends board meetings for the March of Dime’s Healthy Babies are Worth the Wait Initiative. The site supervisor served as the stakeholder co-chair for the Essex County Council for Young Children and has been one of the leading members of the Essex Birth and Breastfeeding Coalition.</p>
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**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Family &amp; Children’s Services</p> <p><b>1b Program Name:</b> Pre Adoption, Post Finalization and Kinship Legal Guardianship Programs (PACS)</p>
<b>1c</b>	<p><b>Relevant PSSF Program:</b> ___FPS, ___ FSS, ___TLFRS, <u> X </u>APSS</p>
<b>1d</b>	<p><b>Program Address:</b> 40 North Avenue Elizabeth, NJ 07208</p>
<b>1e</b>	<p><b>Objective:</b> to provide counseling and support services to pre-adoptive, KLG, and adoptive families; to strengthen attachment among family members and preserve the family unit.</p>
<b>1f</b>	<p><b>Outcome(s) Addressed:</b> ___Safety <u> X </u>Permanency ___ Well-Being</p>
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b> Counseling and support services were provided to families on a weekly basis. The focus of counseling services was to facilitate adjustment to the foster home (for pre-adoption children) or to the adoptive or kinship home (for post-adopted and KLG children). Counseling</p>

	<p>focused on strengthening parent/child attachment. Psychoeducation was provided to families to develop their knowledge and understanding of the psychological impact of the transition to permanency on the child’s emotional, social and cognitive development. Support services include advocacy, linkage to adoption/kincare resources, linkage to community resources, and respite.</p>
<b>2b</b>	<p><b>Population Served:</b> Services were provided to families of diverse ethnic backgrounds, religions, socioeconomic levels, and cultures. Our client population included same-sex parents, single and two-parent families, multi-racial families, and clients with chronic disabilities and medical challenges.</p>
<b>2c</b>	<p><b>Geographical Area of Services:</b> Families in the PACS programs reside in Middlesex, Essex and Union counties.</p>
<b>2d</b>	<p><b>Referral Sources:</b> Clients entered the program via referral from DCP, self-referral, intra-agency referral or via linkage from other social service/community agencies.</p>
<p><b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b></p>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b> <b>Include data where available:</b> <b>Goal #1:</b> Stabilize the family unit to ensure permanency (adoption dissolution does not occur) <b>Projected Outcome:</b> 90% of adoptive families will remain intact. <b>Outcome:</b> 100% of adoptive families remained intact.</p> <p><b>Goal #2:</b> Ensure the safety and well- being of the child in the home. <b>Projected Outcome:</b> There will be no allegations of safety concerns in 90% of families. <b>Outcome:</b> There were safety concerns in (3) of the (77) families we served. (No safety concerns in 96% of families) The children remained in the home as allegations were deemed unfounded by DCP. Psychoeducation was provided to families to develop their efficacy parenting children w/complex trauma and developmental disabilities.</p> <p><b>Goal #3:</b> Family counseling will facilitate the child’s adjustment to the home over time, as measured by a decrease in problematic behaviors, per parent’s report or as indicated by referral to a higher level of care. <b>Projected Outcome:</b> 90% of children will not require a higher level of care (e.g. inpatient, RTC). <b>Outcome:</b> Two children were referred to a higher level of care.(97% of children in this program remained stabilized with PACS services)</p> <p><b>Goal #4:</b> Parents’ understanding of the impact of pre-adoption/adoption/permanency on the child will improve, as measured by an increase in their expressed recognition of its effect on the child. <b>Projected Outcome:</b> 90% of parents will demonstrate new knowledge of the impact on their child. <b>Outcome:</b> Based on therapists’ report, 100% of parents stated that they gained greater</p>

	awareness of the impact of pre-adoption/adoption/permanency issues on their child's emotional status and level of functioning.
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b>            These outcomes suggest that family participation in counseling, and psychoeducation for parents, are key factors in strengthening attachment and ensuring permanency. Parental commitment to supporting the child emotionally was strengthened by their understanding of the impact of permanency issues on the child's emotional stability. When parents actively engaged in the counseling process, there was an increase in their willingness to adapt their parenting style to the unique needs of their particular child.</p>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b>            Factors such as respite resources, flexible service availability and continuity of care continued to contribute to positive outcomes in the PACS programs. Continuity of care includes children who received services from the pre-permanency stage to the post permanency stage were most often able to continue working with the same therapist. This enabled all family members to establish rapport and a level of comfort with the therapist.</p> <p>Flexible service delivery includes appointments offered to families based on their schedules, in order to accommodate parents' work schedules and allows the children the opportunity to participate in after-school activities, yet still receive services.</p> <p>Families who used respite services identified and worked with their PACS therapist to enroll their children in enrichment activities, camps and cultural events. These activities strengthened the child's self-image and social skills. Family respite activities (parent-child activities, restaurants and movies) provided families with the opportunity to interact with each other in a positive context, and to process their outing with the PACS therapist.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b></p> <p>There were no significant barriers to goal accomplishment during this contract period.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b>            Contracted units of service are defined as the number of children in adoptive or relative care homes who receive program services. A separate case is opened for each child in placement.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/16 – 9/30/17:</b>            The contracted LOS is aggregated to include adoptive, pre-adoptive and kinship families pre-placement and post-finalization. The annual LOS is <u>86</u> slots.</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/16 – 9/30/17:</b>            The actual LOS was <u>77</u>.</p>

<p><b>3h</b></p>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p># of unduplicated individuals: <u>225</u>          # of unduplicated families: <u>77</u></p>
<p><b>3i</b></p>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>          At intake, all clients/caregivers are informed of the Agency’s grievance procedure should they wish to report dissatisfaction or concern about any aspect of service provision. The program supervisor responds to all concerns directly and confers with the Clinical Supervisor in accordance with agency policy. No grievances were filed during this time frame.</p> <p>Referral sources provided direct feedback about services to the program director and the Clinical Director. Clients can provide comments or suggestions anonymously by placing comments in the Suggestion Box in the FACS waiting room. In addition, satisfaction surveys continue to be sent to all agency clients. The surveys inquired about overall satisfaction as well as: perceived comfort when visiting the office, convenience of appointment scheduling, whether they felt they were treated with respect, etc. While only 4 families answered the written survey (and expressed satisfaction with services), 17 families communicated with the program supervisor directly, either via note or in person during the most recent Family Night event.</p> <p>The families who attended the Family Night event, expressed highly positive feedback about the activities that were provided (meditation, stress tool kit, light dinner and take home tools to alleviate stress). Telephone follow-up continues to be conducted at 3 and 6 month intervals after service termination. Clients are asked to provide feedback as well as given an opportunity to request follow-up services. Overall, clients expressed satisfaction with program service delivery and outcome. It was noted that families sometimes expressed dissatisfaction with the litigation process (for finalization). While this is not the therapists’ domain, support was provided to these clients to increase their understanding of the legal process in order to alleviate their understandable feelings of frustration and anxiety.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>4a</b></p>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b>          Currently there are no planned changes to the program.</p>
<p><b>4b</b></p>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b>          FACS continually works to maintain up-to-date information about resources available to clients on our website and in our newsletters.</p>
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of</b></p>

	<p><b>10/1/16 – 9/30/17?</b> We expect to provide services to <u>86</u> clients.</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: 185 # of unduplicated families: 86</p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b> <b>Progress will be measured as:</b></p> <ol style="list-style-type: none"> <li>1) Permanence of placement for 90% of children served in the program.</li> <li>2) Improvement in the child’s level of functioning as measured by the CBCL (Child Behavior Checklist), pre-and post measures as well as self-report from family members.</li> </ol>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> FACS utilizes an internal Quality Assurance/Utilization Review system for review of all client records. FACS therapists are licensed or certified as applicable by their respective professions. Likewise, therapists in this program receive training in the Adoption Certificate Program as sponsored by DCPD and Rutgers University. Consumer satisfaction will be measured via telephone follow-up at 3 and 6 months after termination of services, and via program review during service implementation. Clients are given ongoing opportunities to provide suggestions about service delivery.</p>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b> We value collaboration with our community partners, as this enhances our ability to provide comprehensive, quality care to our clients. Our Training &amp; Outreach Coordinator participates in resource fairs, community meetings and adoption activities in order to advertise our availability to provide services to the community. We continue to work closely with DCPD and other agencies to identify the needs of families and provide an array of services (therapy, support services, respite). We also provide linkages to resources in the community, as many of our families have a myriad of needs in addition to those that we provide. We schedule case conferences with DCPD on a regular basis to coordinate client care. Interagency referrals are provided for those clients who are referred to us but who are not in our catchment area. Our screening/intake form has recently been revised; it now includes more detailed questions to capture adoption status, if applicable.</p>

### 2017 PSSF Update Report

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Oaks Integrated Care</p> <p><b>1b Program Name:</b> Pre-Post Adopt/KLG Counseling (PACS)</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, ___ FSS, ___TLFRS, <u>X</u> APSS
<b>1d</b>	<b>Program Address:</b> 175 Route 70 West, Unit 12 Medford, NJ 08055
<b>1e</b>	<b>Objective:</b> Use of a strength-based and solution-focused multi-systemic model of services to improve permanency outcomes.
<b>1f</b>	<b>Outcome(s) Addressed:</b> ___Safety <u>X</u> Permanency ___Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> PACS (Pre-Post Adopt/KLG Counseling) is a home-based program which includes pre-adoption, pre-KLG, post-adoption and post KLG services. Each of the therapists working in the PACS program completes the Adoption Certificate program offered through Rutgers University in New Brunswick. The goals are to stabilize the family; to finalize adoption and KLG; to prevent the dissolution of an adoption; to maintain stability post-discharge; and for consumers to be deemed “goals achieved” at discharge. Adoption specific services focus on grief and loss, and the significant trauma many foster and adoptive children experience. The underlying belief is that adoptive placements will stabilize as the children and families resolve complex issues and move towards bonding and attachment. The duration of services varies by case, but are generally open for approximately 6 months with some exceptions made.
<b>2b</b>	<b>Population Served:</b> The target population is children under 21 years of age whose permanency plan is adoption or KLG and are either placed in a home with the goal of adoption/KLG or for whom DCP&P is seeking a permanent adoptive placement. Also served are children and families who had previously adopted and are in need of therapeutic services.
<b>2c</b>	<b>Geographical Area of Services:</b> Atlantic, Burlington, Camden, Cumberland, Gloucester, and Salem counties in New Jersey.
<b>2d</b>	<b>Referral Sources:</b> For Pre-Adopt and Pre-KLG referrals are sent by the assigned DCP&P caseworker. Referrals can come from any DCP&P offices in the State of New Jersey, as long as the child is placed within the geographical area served (2c). For Post-Adopt and Post-KLG cases the majority of referrals are from families who self-refer directly to the Program Supervisor. The families get information about the program from therapists who specialize in adoption, NJ Arch, DCP&P caseworkers, subsidy workers, and RDS, and from families who previously received our services. The local DCP&P RDS often links the family to our program. Some families have self-referred more than once, if a crisis evolves, re-occurs, or developmentally a child has additional questions or issues regarding adoption.

<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals. Include data where available:</b></p> <ul style="list-style-type: none"> <li>• Performance Outcome: 80% of youth served will remain in their homes at the time of discharge. 92%. For this reporting period, 40 consumers were discharged from the program. 37 of them remained in their adoptive home, with no plans for dissolution.</li> <li>• Performance Outcome: At six-month post-termination of services, at least 80% of the consumers served will have a finalized adoption or be in a permanent placement (i.e. pre or post adoptive home or KLG home). 97%. For this reporting period, families provided 6-month follow-up data for 30 youth. 29 of these youth remained in a stable placement.</li> <li>• Performance Outcome: At least 75% of total clients who complete services in the program during the contract period will be deemed “goals achieved.” 95%. During this twelve-month period, 40 consumers were discharged. 38 of them were deemed “goals achieved.”</li> </ul>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Data measured on all Performance Outcomes indicate that program services were successful in stabilizing many families. As the above data indicates, there were significant degrees of impact resulting from our services, with an average of 92% of families intact and not considering out-of-home placement at discharge. 97% of children remained intact at 6 months post discharge.</p>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> The emphasis is to ensure that services for the consumer are not presented in an isolative fashion. Therapists recognize that therapy must be inclusive and family-centered to be successful. Therapists provide a high intensity of services, many times 2 hours in length. They also focus on providing services in a collaborative fashion with representatives of other agencies, school personnel, mental health practitioners, etc. who are also involved in the lives of the consumer(s) and family. Since we are home-based, we are able to reach more families, regardless of transportation issues of the family. Therapists are available by cell phone 24 hours per day, 7 days per week and parties can speak to the Program Supervisor, if needed, at any time. Since our therapists are professionally trained specifically in adoption issues, their interventions are very directed and focused on the most essential issues that could pose a risk to permanency. Because of their collaborative experience, therapists are able to share available resources within the community, to extend success beyond the services we offer. Our staff members also plan events that bring multiple families and children together, to demonstrate the value of and encourage families to do fun activities with their children. During this timeframe we had a family bowling night, multiple children’s activity/craft groups, and scrapbooking/lifebook groups. Our program also hosted a Family Group where we provided a chance for the caretakers to interact with one another and the children to do activities separately. All who participated, in addition to having fun, expressed it being helpful to get to know others dealing with the same challenges. We also now provide booster sessions to families who may need a couple sessions due to a crisis in the home, assessment, or just to review coping skills with the child and family.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b> The greatest barriers to accomplishing the goals of the programs are:</p> <ol style="list-style-type: none"> <li>1. Lengthy wait lists-While waiting for services, some families make a decision to ask</li> </ol>

	<p>for their foster or adoptive child’s removal from their home. The waitlist is lessening due to increased funding and the ability to hire additional therapists. Some consumers experience extreme distress and require other interventions (i.e. crisis screening, CMO) and other services are put in place. Fortunately, some cases have been stabilized when Oaks Integrated Care is able to offer support through our outpatient program or the Post-Adopt Respite program while the consumer/family waits for adoption-specific services.</p> <ol style="list-style-type: none"> <li>2. Referrals while consumers are still in Permanency. This is a major contributor to lengthy wait lists. Therapists begin to work with consumers prior to the termination of parental rights. With lengthy court appeals, case can remain “in limbo” for long periods of time. During that time, the therapists establish a trusting and productive therapeutic relationship with the consumers. However, they are restricted from working directly on adoption issues, while the consumer continues to visit with biological family members.</li> <li>3. Changes in status of case. Often, when therapists plan to discharge a case, to create an opening, there are major changes in terms of TPR and/or the consumer moves to a different home. During these difficult times of transition it is preferable to keep cases open. To meet LOS expectations sometimes cases need to be closed before a child/family feels “ready.” In post-adopt cases 6 months often does not feel like enough time to make significant changes in the family. Often, these families wait until they are already at a crisis level before they call for services and 6 months is not enough time to completely stabilize and work through their adoption related issues.</li> </ol>
<b>3e</b>	<b>Definition of Level of Service as per contract:</b> Contracted units of service are defined as the number of children in adoptive, foster, or relative care placements who are served by the program. A separate case is opened for each child in placement. Siblings that are placed together are counted as separate cases.
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 115 consumers per year
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 130
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:</b> 130</p> <p><b># of unduplicated families:</b> 91</p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> To ensure accurate outcome data, we give all families satisfaction surveys at various points throughout treatment. These surveys measure satisfaction with program services and with the assigned therapist. The Program Supervisor supports satisfaction through periodically accompanying therapist to conduct topic-specific family meetings and meetings including</p>

	<p>other providers. He or she also speaks via telephone with the families served, to elicit feedback on services and suggestions for program improvement. The Program Supervisor calls the families at 3 and 6 months post-discharge to assess if services were satisfactory, in terms of whether stability was maintained. During the period of 10/1/15 to 9/30/16, 26 children and 20 families returned Satisfaction Surveys. All Satisfaction Surveys indicated overall satisfaction with the PACS Program. The following families provided feedback at 3 and 6 months post discharge:</p> <p><b>3 Months</b> post discharge 23 families provided feedback. 22 of the 23 families reported that their child was still living in the home and they had no plans for dissolution or placement in an out-of-home setting. 1 child was placed in a residential facility with the goal of returning back to the adoptive home.</p> <p><b>6 Months</b> post discharge 24 families provided feedback. All 24 families reported that their child was still living in the home and they had no plans for dissolution or placement in an out-of-home setting.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>4a</b></p>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> We hope to provide more support to children and families by doing support groups on a regular basis. The program has begun using an assessment tool to aid in treatment and to measure progress made as a result of receiving our services.</p>
<p><b>4b</b></p>	
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> 155</p>
<p><b>4d</b></p>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>  <b># of unduplicated individuals:</b> 155  <b># of unduplicated families:</b> It varies based on specific referrals received.</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>5a</b></p>	<p><b>How will you measure progress?</b> Since we believe that the methodology we currently employ to measure outcomes historically has provided valid data, we will continue this model of evaluation. Also, we will continue to use the assessment which is done at intake and again at discharge. The current assessment is the Columbia Impairment Scale (C.I.S). This assessment will help us determine treatment goals as well as measure progress from intake to discharge. The program will be evaluating other assessments to determine if there are any others that would better serve our specific population.</p>
<p><b>5b</b></p>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> We measure three markers of outcomes:</p> <ol style="list-style-type: none"> <li>1. Families at the time of discharge that have their adopted/foster living with them and have no imminent plans for residential or other out-of-home placement (goal 80%).</li> <li>2. Consumers at 6 month post-discharge are adopted or in a permanent placement with no plans for dissolution or out-of-home placement (goal 80%).</li> </ol>

	<p>3. Consumers who complete our services and are discharged “goals achieved” (goal 75%).</p> <p>Additionally we will continue to use the Columbia Impairment Scale which measures multiple child behaviors or another assessment deemed more thorough or specific to our specific population. The assessment will be done at intake to help determine treatment goals, and at discharge to measure progress. We have recently begun to hold a Kinship group for grandparents and relatives who are raising their relative children. While the caretakers talk and support one another, the children participate separately in another group. We have gotten very positive feedback from the caretakers and the children about these groups.</p>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b> It is the responsibility of the Program Supervisor or assigned alternate, to attend regularly scheduled statewide PACS meetings. The Program Supervisor visits local DCP&amp;P offices and educates personnel on the services offered. If DCP&amp;P is involved in a case, therapists and the Program Supervisor participate in face-to-face meetings with their representatives. Throughout the course of treatment, our therapists attend community meetings regarding their clients (i.e. Child Study Team/IEP meetings). They also may meet with or provide written summaries to other service providers such as: Performcare, CMO, psychiatrists, courts, and other therapists.</p>

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Catholic Charities of the Archdiocese of Newark</p> <p><b>1b Program Name:</b> Pre/Post-Adoption/Kinship Counseling</p>
<b>1c</b>	<p><b>Relevant PSSF Program:</b> ___FPS, ___ FSS, ___TLFRS, ___APSS</p>
<b>1d</b>	<p><b>Program Address:</b> 249 Virginia Ave, Jersey City, NJ 07304</p>
<b>1e</b>	<p><b>Objective:</b></p> <p>The program strengthens families, promotes the well-being and permanency of children through home-based individual and family counseling, parenting support and skill building, and play therapy. This is supplemented by socialization groups and activities, concrete services, educational training, and summer programming in order to address issues of loss, family conflict, and parent-child issues. The program’s focus is:</p> <ul style="list-style-type: none"> <li>• To prevent the dissolution of adoptions;</li> <li>• To prevent residential placement of adopted children;</li> <li>• To build and/or strengthen skills, family relationships and coping strategies to all members of the adoptive family where dissolution or disruption is a threat;</li> <li>• To strengthen skills, family relationships and coping strategies to all members of the adoptive family to address adoption related challenges and to improve the health and well-being of the family.</li> </ul>

<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b>          (describe): Since 1992, the Catholic Charities Pre/Post Adoption/Kinship Counseling Services has had a contract with the Division of Youth and Family Services, now the Division of Child Protection and Permanency, to provide post adoption counseling services to Hudson County families. The program was developed in response to a dire need for supportive services for adoptive families with “special needs” children (children with emotional and behavioral problems, minority children, older children, and children with long foster care histories) in a variety of placement situations (foster homes, kinship care, and select adoptive families).</p> <p>The Post-Adoption Counseling Program offers services to special needs children and their families in their homes for periods of up to one year or longer (in select cases). Through supportive counseling and education, parents learn to understand and cope with the host of emotional and behavioral issues the child often brings into their adoptive family. Individual, family, and therapeutic group counseling assist the children in dealing with issues of separation, loss, and abandonment; histories of abuse and neglect; and resulting maladaptive behaviors. Parents gain support, information, skills and insights in ways to best meet the needs of their adopted child and to manage the various related issues that the whole family may be experiencing as an adoptive family. Post KLG services provide counseling and support to families where kinship legal guardianship has occurred and there is a need to services and supports to stabilize and/or strengthen the family to insure that wellbeing for the children and family, and permanency, are maintained.</p>
<b>2b</b>	<p><b>Population Served:</b>          The program serves Hudson County adoptive families and parents/families who are kinship legal guardians. “Families” served can include the adoptive parents, grandparents, siblings, foster siblings, or other family members living in the household and kinship legal guardians.</p>
<b>2c</b>	<p><b>Geographical Area of Services:</b>          Hudson County</p>
<b>2d</b>	<p><b>Referral Sources:</b> Division of Child Protection and Permanency self-referred Hudson County families, school, churches and any other social service agency.</p>
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b>  <b>Include data where available:</b>          From October 1st, 2015 through September 30th, 2016, we provided in-home pre/post family counseling as described below:</p> <ul style="list-style-type: none"> <li>• Pre-post counseling services were provided to a total of 44 families and 58 children.</li> <li>• Of the 44 families served, 9 were families receiving Post Adoption counseling</li> </ul>

services and 2 families were receiving KLG counseling services.

During this reporting period, 9 families and 12 children completed the program. The outcomes for this group included:

1. From the nine (9) families discharged, seven (7) were successful adoptions a total of nine children
2. Of this seven(7) adoptions, six (6) were discharged due to successfully completing their goals: Some of these goals included and were not limited to:
  - 4 children with low self-esteem increased
  - 6 children relationship with parents improved
  - 1 child with academic challenges improved from “D” to B’s and A’s
  - 9 of 12 Improved ability to express feelings and process difficult emotions
  - 3 children Improved ability to connect and socialize with their peers
  - 9 of 12 Improved ability to manage emotions resulting in a reduction of explosive outbursts and aggressive behavior

These nine families learned how to navigate the system of care when needing help for their children’s behavior; they increased their knowledge about the grieving process children will go through and the skills needed to handle this.

Other goals applied to all families they improved or develop one or all of these skills:

- Family members were prepared to handle questions and challenges encountered from their child with special needs close to adoption day. A five year old asked his mother: “does this mean I will never have to move out of your house”? Mom answered: “this means you’ll be here forever”.
- Families learned how to develop a plan to keep children feeling safe and connected and how to help them transition to permanency.
- Families learned how to help children connect with extended family members and to develop a plan to increase biological family connections.
- Families were able to identify their own support system and to develop respite services for them or the children
- Adoptive families learned to identify triggers and how to redirect and minimize disruptive behaviors while increasing and encouraging positive behaviors
- Evidence of families understanding of trauma was demonstrated by their willingness to work with children’s limitations and in helping the children accomplish their own goals.
- The more those parents were able to understand attachment and how this plays a major role in children’s emotional development, the more connected and loving they were of the children.

<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b>          As mentioned last year, since our Post Adoption/Kinship Counseling Services is part of our larger program offering ancillary services of benefit to the children. We are able to utilize individual outpatient services and expedite the referral to provide children the opportunity to receive a number of services in one place and create comprehensive and a rich service array that can benefit the entire family. The West Side Children’s Counseling Center in our same facility provides clinical services to help those children presenting mental health challenges and/or requiring medication and therapy sessions. Individual and family counseling is provided to the family. We see that the opportunity to work through different modalities allows us to develop strong and trusting relationships with both parents and children, and provides additional insights and advantages in supporting change during the counseling process. Another service that we have the opportunity to utilize is the Teen Enrichment Program (TEP) which supports teens 13-17 to improve in areas of need, including but not limited to: increasing social awareness, self-esteem, an improved sense of responsibility for instance. By linking our teens this service, teens are able to put in practice many of the skills they learned through counseling. Since we are able to offer multiple resource under one roof, parents feel connected and trusting of our services which greatly supports consistent service involvement and, in turn, improves outcomes for children and parents alike.</p>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement:</b>          Monthly communication with DCPP workers and bi-monthly meetings with the Division to discuss improvements contributes to better outcomes. Another factor that contributes to our success with our families is that we make every effort to connect families with community services, without overwhelming them with too many services at once. The goal of the counselor is to put services in place when needed. Counselors specialize in creating a short term and long term plan for the family, to help them navigate the services and prioritize what is more important for the success of the child. We create this through weekly supervision and constant communication with our system partners and Division workers.</p>
<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment:</b> Barriers include family inconsistency with our services, lack of understanding that their participation in our services is key to achieving good outcomes. We have made improvements on behalf of families by advocating and working with DCPP or other providers (children’s system of care) to triage needs so as to avoid the “stacking” of services (many services involved all at the same time) in order to promote the “sequencing” of services (putting an order and sequence to services to best help the family) , which is less likely to overwhelm families and more likely to be productive and more therapeutic. Another barrier is staffing due to salaries that make it hard to both hire, and keep qualified staff. This bring two separate but related challenges: we work to recruit and hire new counselors, train them, provide good supervision and hope to retain them as long as possible, often staff leave in a year or two for better paying jobs. They often hate to leave but cannot support themselves on the salaries afforded by the grant funding. The second challenge is that when staff leave, families do not want to work with a new counselor or, if they do, they may not always make a successful transition to a new counseling, despite our best efforts to help them with the transition.</p>

3e	<p><b>Definition of Level of Service as per contract:</b> Each unit of service is defined as one “family.”</p>
3f	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b></p> <p>37 families</p>
3g	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b></p> <p>We served 44 families and a total of 58 children for pre-post counseling services</p> <ul style="list-style-type: none"> <li>• 9 families received post adoption counseling</li> <li>• 2 family received KLG-counseling services</li> </ul>
3h	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:</b> 55 <b># of unduplicated families:</b> 42</p>
3i	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <p>Between October 1, 2015 and September 30th 2016, we sent 20 surveys. Of those, 9 were returned with an aggregate score, overall, of 4.72 out of a possible 5. Surveys responses are scored on a scale of 1 to 5 where 1 is “strongly disagree” and 5 is “strongly agree”. A 5 indicates that, in the aggregate, families were very satisfied with program services. Some of the comments included on the surveys were as follows:</p> <p>“The children are very comfortable with Karen and look forward to her visit. She also works with the kids changing schedule.”</p> <p>“Vivian has been great. I just think it's a tough job and difficult to make a significant impact, especially given schedule constraints, etc... I do really appreciate Vivian as a professional and person. “</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
4a	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>We are not planning to make any changes to the program</p> <p>We are planning to continue providing services such as the Life book work will continue. The use of Pre and Post-test measures to track improvements in peer relationships and self-esteem, both relevant issues among children who have been adopted, will continue. Teen Enrichment services and expanding education and support to parents as implemented this year.</p>

<p><b>4b</b></p>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b> None needed at this time.</p>
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> 37 Families</p>
<p><b>4d</b></p>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: 60 # of unduplicated families: 37</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>5a</b></p>	<p><b>How will you measure progress?</b> We have been using a combination of methods to measure client’s progress. One of them is assessed and measured by the tracking of goal attainment on each family’s Plan of Care. The treatment team discusses the progress on identified client goals quarterly, or more regularly, as appropriate to the family’s need and Care Plan.  We are also using standardized measures to measure client and program progress. The tools include, but are not limited to: the Family Resource Scale, the Family Support Scale, the Parent-Child Relationship Inventory, the Inventory of Self-Esteem, and the Peer Relations Scale Index.</p>
<p><b>5b</b></p>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> Catholic Charities has been using a very effective method to collect consumer and stakeholder feedback—as mentioned in previous reports, the agency has a formal continuous quality improvement committee comprised of the agency’s Division Directors and the Executive Director. This PQI steering committee meets monthly and reviews program related data to monitor quality. This includes the review of client satisfaction survey data, focus group data, aggregated pre-and post-test measures of program performance, community stakeholder feedback including community partners, DCP&amp;P workers and supervisors, and contract monitoring, performance improvement initiative activities and outcomes, and risk management issues. Feedback and recommendations are made by the committee back to the program through each Division Director for follow through in each program. The PQI steering committee receives follow-up reports on program improvements and follow-through on a schedule determined by the committee. The program sends out satisfaction surveys to all families served, every 6 months, to get feedback. We provide a stamped addressed envelope which comes back to the administrative office, not the program, and is aggregated and then reviewed at the program level. Families can respond anonymously to the standard questions and have space to write in their comments. Feedback from consumers, whether received through focus groups, formal satisfaction surveys, or informal feedback, is discussed and reviewed at the program, division and agency level. Whenever appropriate and feasible, feedback is integrated back</p>

	into the program operations, in order to improve and/or enhance the program
<b>5c</b>	<p><b>How do you collaborate with community partners?</b></p> <p>The program has many community partners –these include local service providers that also serve the needs of families. We work closely with the school systems, local mental health providers and psychiatrists when involved, community faith based programs, local family courts, recreational and mentoring programs and concrete service providers (e.g. the Red Cross when one family lost their home due to a fire, the United Way to access emergency financial assistance etc.). We actively communicate and collaborate with any and all partners, with the family’s permission, to insure comprehensive care rather than duplication, and coordinated care that provides a good base of support for the family. We also provide advocacy as needed and planning for ongoing support after leaving the program if appropriate.</p>

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Children’s Aid and Family Services</p> <p><b>1b Program Name:</b> Post Adoption/Kinship Counseling Program</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, ___ FSS, ___TLFRS, <u> X </u> APSS
<b>1d</b>	<p><b>Program Address:</b></p> <p>(a) 76 South Orange Avenue Suite 209, South Orange NJ 07079</p> <p>(b) 22/08 Route 208 South, Suite 7, Fair Lawn NJ 07410</p>
<b>1e</b>	<p><b>Objective:</b></p> <p>To stabilize adoptive and relative placements, strengthen family functioning, and minimize the possibility of discontinuity. To enable caregivers to meet the unique needs of children who have been removed from birth parents and/or been exposed to abuse and neglect.</p>
<b>1f</b>	<b>Outcome(s) Addressed:</b> ___Safety <u> X </u> Permanency ___Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b></p> <p>The Post Adoption/Kinship Counseling Program (PACS) provides individual and family therapy, for children up to age 21 and their families to address core adoption and kinship issues. Therapy is strengths-based, family focused and largely cognitive in approach. The focus is on helping children overcome the effects of abuse and separation, and provide the support, encouragement and life skills necessary for the family’s longevity and well-being. Therapy is intended to facilitate healing processes, promote family bonding and integration, and foster the development of support systems. Issues related to separation and loss, identity, shame, trust, abandonment, and developmental hurdles are addressed with an</p>

	adoption/kinship and trauma informed approach. Families in PACS therapy can also receive respite funding to offset costs for children’s out of home activities that support stabilization and treatment goal progress. In addition to therapy, adoption support groups are offered to provide teens, pre-teens and parents an opportunity to meet other adopted children, adoptive parents and engage in group discussion.
<b>2b</b>	<b>Population Served:</b> Children up to age 21 and their families, where there is a finalized adoption or Kinship Legal Guardianship agreement.
<b>2c</b>	<b>Geographical Area of Services:</b> The catchment area is Bergen, Passaic and Essex Counties. For kinship families, Newark is excluded from the Essex County catchment.
<b>2d</b>	<b>Referral Sources:</b> All referrals are made by the parent/caregiver seeking services for their child. Referrals are made to the program director in the South Orange office.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<b>Provide a summary of program accomplishments on goals. Include data where available:</b> Both the support groups that carried over from last year dwindled in attendance, eventually ending. A new parent support group began in the Fair Lawn office in September 2016, with 5 parents in attendance. There was no discontinuity in families receiving services during the year of review. Of the children who discharged in this period, 65% (11) achieved all treatment goals, 24% (4) partially met their goals, and 11% (3) withdrew before treatment plans were developed. Thirty thousand dollars in respite funds were paid out to support out of home activities and summer camp; the greatest majority of funds supported summer camp. All felt that the activities supported child and family stability and, especially in the cases of summer camp, that the activities would have been out of reach without support.
<b>3b</b>	<b>How did this improve outcomes for children and families?</b> Parents reported relief at having adoption/kinship informed therapy available for their children and family. In general, parents reported a sense that community therapists lack understanding of the issues in adoption/kinship care, and the differences PACS makes. Therapeutic services improved parent-child interaction patterns and overall stability. Children improved behaviorally and in understanding of their adoption/kinship stories. Parents felt supported and better equipped to manage circumstances in their child’s & family’s experiences. Follow-up post discharge found that parents and children continued to thrive and handle concerns as they arose.
<b>3c</b>	<b>Identify specific factors that contributed to this improvement:</b> All clinical staff with the program during the period of review had completed the Rutgers’ Certificate in Adoption. Stability in clinical staff supports strong clinical relationships and the nurturing of connection for families. Weekly team meetings, with monthly consultation by a clinical psychologist who has been with the program for over ten years, as well as individual supervision, support effective therapeutic intervention. All clinical staff continually self-educate on topics related to therapy, adoption, and kinship and freely share with their teammates. Continuing respite funds offer positive outlets for children and opportunity for restoration and renewal for parents to ease strain on relationships.
<b>3d</b>	<b>Identify significant barriers to goal accomplishment:</b> There were no significant barriers to goal accomplishment.

3e	<p><b>Definition of Level of Service as per contract:</b> Level of service is defined by the number of new, unduplicated children seen in a year.</p>
3f	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> The total contracted level of service is 145 new, unduplicated children served annual, including both pre and post adoption.</p>
3g	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> There is no longer a designated number specified for post adoption services, as the contracted number was collapsed to be all inclusive. Of the 145 unduplicated children for the total contract, 38 (26%) were post adoption/kinship legal guardianship.</p>
3h	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b> # of unduplicated individuals: 38 # of unduplicated families: 36</p>
3i	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> Stakeholder feedback came via client surveys following initial treatment plan development and discharge. There are no referral sources outside of the families. In addition, clinicians conducted three and six month post-discharge follow-up to ascertain family status regarding stability and continuing needs. Surveying and follow-up are conducted the same for pre and post finalized families. Sixty surveys were distributed with 23 (38%) responses received. All reflected overall satisfaction with the services provided. Three and six month follow-up, when families responded to outreach, almost always found families stable, and not seeking to re-initiate services at the time of contact. All 38 post finalized families who discharged were contacted for follow-up.</p>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
4a	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> There are no planned changes to the program at this time.</p>
4b	<p><b>Identify changes you will make that stem from stakeholder feedback.</b> Stakeholder feedback was positive and no areas for improvement or change were identified. There are no targeted program changes at this time.</p>
4c	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> We anticipate that approximately 40 of the contracted 145 unduplicated children served will be post finalization of adoption or kinship legal guardianship.</p>
4d	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: 40</p>

	<b># of unduplicated families: 38</b>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<b>How will you measure progress?</b> We will continue to utilize treatment plans and discharge to measure clinical progress. The program will also continue use of the Strengths and Difficulties Questionnaire, the Attachment Symptom Checklist and the Trauma Symptom checklist to support goal development and measurement of progress. An additional instrument will be used if the Trauma Symptom checklist indicates the possibility of a Post-Traumatic Stress Disorder. We will continue to measure programmatic progress through the surveys described below to assess client satisfaction and needs. We will continue post discharge follow-up to monitor maintenance of change.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> Clients will be given the opportunity to evaluate the program in an initial survey and a survey at the end of treatment. Clinicians will follow up with families at three months and six months post discharge to gauge continued stabilization, ongoing need and satisfaction with services. Clients are offered access to the program director at any time for feedback about services, needs and areas for improvement. This is emphasized on initial contact with the program and through the surveys.
<b>5c</b>	<b>How do you collaborate with community partners?</b> Close collaboration with DCP&P offices and staff is ongoing to support long term stabilization of their families. With family permission, clinicians work collaboratively with any community providers as appropriate to enhance client treatment and success. The program director attends the monthly Children’s Inter Agency Coordinating Council (CIACC) in Essex County to extend collaboration and enhance service provision. Other agency staff attend CIACC meetings in Bergen County, as well. Community outreach through in-community events is continual as appropriate and available.

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Children’s Aid and Family Services, Inc.
	<b>1b Program Name:</b> <u>Kinship Legal Guardianship Resource Clearing House (KinKconnect)</u>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, ___ FSS, ___TLFRS, <u>X</u> APSS
<b>1d</b>	<b>Program Address:</b> Children’s Aid and Family Services, 76 South Orange Avenue, Suite 209, South Orange, NJ 07079
<b>1e</b>	<b>Objective:</b> The purpose of the Kinship Legal Guardianship Resource Clearing House (KinKconnect) is to provide information and resources for those touched by Kinship Care in New Jersey. The program objective is to assist in meeting the needs of kinship care families, whether through Department of Child Protection and Permanency (DCP&P), informally or privately through

	the courts. The program provides information and resources for Kinship families by offering a web site, <a href="http://www.kinkconnect.org">www.kinkconnect.org</a> , phone and e-mail warm line, free lending library as well as training for Kinship Legal Guardian (KLG) /Kinship families and support groups around the state.
<b>1f</b>	<b>Outcome(s) Addressed:</b> ___Safety ___X___Permanency ___Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/14 – 9/30/15)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Kinship Legal Guardianship Resource Clearing House (KinKconnect) is an information center for Kinship families in NJ. KinKconnect provides resources, support and education through the web site, <a href="http://www.kinkconnect.org">www.kinkconnect.org</a> , phone and warm line e-mail support as well as training workshops. The program also includes a free lending library focusing on Kinship Care. The books that focus on kinship care is housed in the same location as the NJ ARCH library which currently consists of 1023 book and 133 video titles, many of which have multiple copies. The topics in the library focus on adoption, foster care, kinship care, parenting and the like. In addition, the library has over 2800 articles on various topics to copy or borrow.
<b>2b</b>	<b>Population Served:</b> All members of touched by Kinship Care and the professionals who work with them.
<b>2c</b>	<b>Geographical Area of Services:</b> State of New Jersey
<b>2d</b>	<b>Referral Sources:</b> We serve as resource to the Kinship Navigator program, Department to Children and Families (DCP&P), Kinship Legal Guardianship (KLG) Subsidy unit, kinship support groups around the state, Foster and Adoptive Family Services (FAFS) for those involved with Kinship Care/ Kinship Adoption, Advocates for Children of NJ (ACNJ), Family Support Organizations (FSO’s), community supports, mental health professionals, various kinship related conferences or events, additional resources when appropriate as well as anyone interested/have questions or request information/resources about Kinship Care.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<b>Provide a summary of program accomplishments on goals.</b> <b>Include data where available:</b> The KinKconnect program officially launched its program and website <a href="http://www.kinkconnect.org">www.kinkconnect.org</a> in March, 2008. The website currently consists of over 635 web pages of information and resource material, which is an increase of 1% from last year’s number of 630 web pages. This website has been a major success as the website Level of Service (LOS) target is 2,000 per month and the website averaged 9,370 per month during the 10/1/15- 9/30/16 time period, which is 368% over the anticipated Level of Service. KinKconnect trained four (4) workshops totaling 80 participants that were offered to Kinship audiences such Grandparent Support Groups sponsored by Family Support Organizations, the yearly Grandparents Forum held in Newark, sponsored by Programs for Parents, Inc. and the DCF/Rutgers sponsored Kinship Care and Family Connections conference.  The Fall 2015 and Spring 2016 issues of the “NJ Kinship Connections” newsletters were created and distributed during this period. During this period we had over 350 contacts who have requested the KinKconnect newsletter in paper form and another 600 requesting it via e-mail. All newsletters can be found on the <a href="http://www.kinkconnect.org">www.kinkconnect.org</a> website. Consumer feedback to the “NJ Kinship Connections” newsletters has been positive.

<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b>          The high number of hits to our website implies that Kinship Care families and children are benefiting from this information and service. With the resource fact sheets and kinship related resources to various community supports (Kinship Navigator, Kinship related support groups, DCP&amp;P KLG Subsidy, etc.), New Jersey Kinship families are receiving additional support and resources.</p>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement:</b>          During this time period, the KinKconnect web hits have continually been higher than anticipated with an average of 9,370 web hits per month compared to the 2000 hits per month originally anticipated. Although the KinKconnect web hits are high, the warm line calls and e-mails are lower than anticipated. We attribute this trend to consumers using the website for information verses contacting the warm line directly. The program has made great strides in working with various kinship related support groups in the state, specifically Grandma KARES located in Essex County; Bergen, Morris and Sussex County Family Support Organizations who offer grandparent support groups as well as various state-wide conferences focusing on relatives raising relative’s children. Numerous outreach presentations have taken place to help spread the word of KinKconnect and KLG Counseling services in the state.</p>
<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment:</b> The warm line e-mails and calls continue to be lower than the anticipated LOS; however the hits to the website are much higher than anticipated as we believe that consumers tend to find resource information on the website rather than contact the warm line. We have also noticed that the warm line inquiries are more complicated to research, therefore taking more time to find the correct resource for the consumer.</p>
<p><b>3e</b></p>	<p><b>Definition of Level of Service as per contract:</b>          A unit of service is defined as one website hit, one warm line call, one warm line e-mail, one service to a support group and one training workshop.</p>
<p><b>3f</b></p>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b>          Per Year: 24,000 website hits, 240 Warm line Contacts, 60 e-mails, one (1) Service to Support Groups, two (2) Training Workshops per year.</p>
<p><b>3g</b></p>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b>          Website Hits for time period: <u>112,440</u>          Warm Line contacts for time period: <u>122 (phone calls)</u>          E-mails per time period: <u>18 (e-mails)</u>          Services to support groups: <u>1</u>          Training Workshops for time period: <u>4</u></p>
<p><b>3h</b></p>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  <b># of unduplicated individuals:</b> 210  <b># of unduplicated families:</b> <u>Unable to differentiate between individual and families due to medium of service provided.</u></p>

	<p>The above number is based on the following: During this period, we received <b>210</b> unduplicated contacts to the warm lines: 112 via phone and 18 via e-mail that were indicated as unduplicated. In addition, 80 who attended the KinKconnect workshops indicated that they were unduplicated as they had not attended a KinKconnect workshop, received services and/or were new to the KLG community, <b>totaling 210</b>. We are unable to differentiate between individual and families, due to the medium of service provided.</p>
<p><b>3i</b></p>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <p>The KinKconnect warm line contact form includes a question whether the contact with the KinKconnect Warm Line had increased the consumer’s knowledge of some aspect of Kinship Care/ Kinship Legal Guardianship. Out of the 140 phone/e-mail warm lines received during the time period of <b>10/1/15 – 9/30/16</b>, 93% stated that their knowledge was increased, 3% stated that it was Somewhat Increased, 0% responded that it was Not Increased, and 4% stated that they were Unsure.</p> <p>There were four (4) training workshops presented during this time period and out of the 80 who attended the training sessions, the 64 who responded via the training evaluations. 87% stated that they were Very Satisfied, 8% stated that they were Satisfied, 5% were Neutral, and 0% were Dissatisfied. Therefore 95% stated that they were either Very Satisfied or Satisfied with the training workshop.</p> <p>Out of the total 204 (140 from Warm Lines and 64 from Training Evaluation Surveys) <u>returned</u> surveys from the above categories reviewed during the <b>10/1/14 to 9/30/15</b> time period, <u>95%</u> were either <b>Very Satisfied or Satisfied</b> with the service, <u>5%</u> were <b>Neutral or Unsure</b> and <u>0%</u> were <b>Dissatisfied</b> with services; there were no Strongly Dissatisfied with services. The feedback that was noted as “Dissatisfied” would be reviewed by Program Assistant Director in collaboration with the Program Director to evaluate any correction needed on our part.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>4a</b></p>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>With the technological and social media advances made since the inception of KinKconnect in 2008, our agency/program is looking into updating the KinKconnect website (<a href="http://www.kinkconnect.org">www.kinkconnect.org</a>) to be the same platform and software as the new NJ ARCH website. The current KinKconnect website was created and currently uses “Front Page” which is no longer supported by Microsoft. There is a need to upgrade this website and targeting to start this upgrade in 2017 so that it has the similar on-line search functionality and enhancements as the <a href="http://www.njarch.org">www.njarch.org</a> website.</p>
<p><b>4b</b></p>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>We will continue to ask the consumer via phone warm line contacts if our services increased their knowledge of some aspect of Kinship Care/ KLG. We received little stakeholder feedback via e-mail or Lending Library surveys; however we will continue to enhance and increase the number of resources available for Kinship Families.</p>
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p>

	Per Year: 24,000 website hits, 240 Warm line Contacts, 60 e-mails, one (1) Service to Support Groups, two (2) Training Workshops per year.
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p><b># of unduplicated individuals:</b> 230</p> <p><b># of unduplicated families:</b> <u>Unable to differentiate between individual and families due to medium of service provided.</u></p> <p>As more and more people call us back on our warm line, the number of unduplicated families will most likely decrease, since consumers are either taking our training workshops and/or calling our warm line more than once (as indicated on our warm line form asking if they have contacted KinKconnect before.</p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b></p> <p>By collecting data via <a href="http://landl.com">landl.com</a> web hosting report (via web host company) to track the number of web site hits, the number and quality of Customer Satisfaction Surveys from the phone and e-mail warm lines, Lending Library Satisfaction Surveys, Training Workshop Evaluations and comments of those who utilize our services.</p>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <p>By sending out Needs Assessments to new consumers and Satisfaction Surveys to identified users of KinKconnect. Returned Satisfaction Surveys will be reviewed by the program Assistant Director and data is entered into the Statistical Database, SPSS maintained by the Program Evaluator. Satisfaction Surveys that are marked lower than satisfactory are followed up individually by the Program Assistant Director and Program Director. Once the cause of dissatisfaction is determined, the Assistant Director will meet with the staff to discuss the issue and develop improved methods of handling the particular issue.</p>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b></p> <p>We work collaboratively with the follow community partners:</p> <ul style="list-style-type: none"> <li>-Kinship Navigator Program by referring consumers to their program. Kinship Navigator refers many consumers to our program as well.</li> <li>-Division of Child Protection and Permanency (DCP&amp;P) Kinship Subsidy Unit for subsidy, payment and possible Medicaid questions.</li> <li>-Foster and Adoptive Family Services (FAFS) for resource families involved with kinship/kinship adoption.</li> <li>-Advocates for Children of NJ (ACNJ) by referring consumers for legal and trend information as well as distribute and promote their materials and services.</li> <li>-Kinship care support groups around the state such as Grandma KARES in Essex County, Grandparents Raising Grandchildren sponsored by various Family Support Organizations such as Bergen, Morris, and other counties, the yearly Grandparents Forum sponsored by Programs for Parents in Essex County, DCF/Rutgers sponsored Kinship Care and Family Connections conference as well as Grandparent/ KLG seminars around the state.</li> <li>-Kinship Legal Guardian (KLG) Counseling Services throughout the state.</li> <li>-Adoption Agency Council of NJ (AACNJ), where the Assistant Director is an active member during the monthly state-wide meetings. Share with Council trends and issues on adoption, foster care and kinship care/kinship adoption.</li> </ul>

<p>-Other kinship related services as listed on the KinKconnect Resource pages.                  -Assist in sharing kinship related community events via the KinKconnect Newsletter and website.                  -Kinship related events, programs and trainings as listed on the KinKconnect Events pages on the KinKconnect website.</p>
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**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Children’s Aid and Family Services</p> <p><b>1b Program Name:</b> <u>NJ Adoption Resource Clearing House (NJ ARCH)</u></p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, ___ FSS, ___TLFRS, <u>x</u> APSS
<b>1d</b>	<b>Program Address:</b> Children’s Aid and Family Services, 76 South Orange Avenue, Suite 209, South Orange, NJ 07079
<b>1e</b>	<b>Objective:</b> The purpose of the New Jersey Adoption Resource Clearing House, <a href="http://www.njarch.org">www.njarch.org</a> is to provide information and resources for those touched by adoption and foster care in New Jersey. The program’s objective is to meet the needs of pre- and post- adoptive parents, adult adoptees, kinship adoption, those who wish to search for their birth relatives as well as information and resources to assist them in their adoption journey. We also provide services to adoption and foster care professionals and those in the community by offering information and resources to help meet the needs of their clients or consumers.
<b>1f</b>	<b>Outcome(s) Addressed:</b> ___Safety <u>x</u> Permanency ___Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The New Jersey Adoption Resource Clearing House (NJ ARCH) provides adoption advocacy, support, education, information and resources through a web site, phone and e-mail warm line, support group support as well as buddy mentoring/ training workshop offerings for adoption support groups, conferences, etc. throughout the state. The program also includes an extensive free lending library. We currently carry 1023 book and 133 video titles, many of which have multiple copies. The topics focus on adoption, foster care, kinship care, parenting and the like. In addition, the library has over 2800 articles on various topics to copy or borrow.
<b>2b</b>	<b>Population Served:</b> All members of the adoption constellation: birth parents, adoptive parents, adopted persons, and the professionals who work with them.
<b>2c</b>	<b>Geographical Area of Services:</b> State of NJ.
<b>2d</b>	<b>Referral Sources:</b> We serve as resource to the Division of Child Protection and Permanency (DCP&P) Subsidy and Search and Reunion units, other state agencies such as Foster and Adoptive Family Services (FAFS), Advocates for Children of NJ (ACNJ), adoption agencies, adoption and foster care support groups, mental health professionals, various adoption-related conferences, outreach and training events around the state, additional resources when appropriate as well as anyone interested in adoption and/or foster care.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
	<b>Provide a summary of program accomplishments on goals.</b>

<b>3a</b>	<p><b>Include data where available:</b></p> <p>During 2015 into 2016 we created and implemented a new NJ ARCH website (<a href="http://www.njarch.org">www.njarch.org</a>). This website was launched in April 2016 with enhanced capabilities and search functionalities. Since this new website now has on-line search capabilities, there is not a certain number of website pages, but a back-end database of information especially for the Resource and Lending Library section pages. This new website has been a major success and has had very positive feedback from stakeholders and consumers alike. The current Level of Service (LOS) is 8,000 web hits per month; during 10/1/15 to 9/30/16 time period; the average web hits per month was 20,141. The NJ ARCH training workshops are approved by the Division of Child Protection and Permanency (DCP&amp;P) Training Academy as Resource Family training hours and during this time period 23 training workshops were presented to various support groups, including Foster and Adoptive Family Services (FAFS) and conferences around the state. During this time period three (3) NJ ARCH “<i>Under the ARCH</i>” newsletter issues were created and each time distributed to over 1,800 consumers; approximately 1400 via e-mail distribution and 400 via US Mail distribution. All past newsletters can be found and downloaded from the NJ ARCH website.</p>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b></p> <p>The increase in hits to our website implies that families and children are benefiting from this information/ resource service. Since the majority of the NJ ARCH training workshops are benefiting NJ resource and adoptive families, both through support groups and/or conference presentations and since the evaluations tend to be very positive, this implies that our program is having a positive impact in increasing the participant’s knowledge of adoption issues as well as stages of child development. The NJ ARCH website and warm line service has helped consumers find mental health services for their children/family, learn about adoption-related events, trainings, conferences, support groups as well as identify various library materials to help educate and/or support their adoptive or foster family. Prospective parents have used the service to obtain information on children needing families as well as adoption professionals in finding appropriate resources requested.</p>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b></p> <p>During this period 23 NJ ARCH training workshops were provided to adoption support groups, conferences and Foster and Adoptive Family Services (FAFS) around the state. The free lending library continues to be popular with 27 book requests submitted via e-mail or phone warm line during this period of time. With the implementation of the new NJ ARCH website, it is now easier for consumers and professionals to find appropriate resources such as mental health professionals, adoption support groups, pre- and post-adoption counseling services, summer camps, etc, sorted by NJ county location. The new NJ ARCH website also offers a more robust method in finding appropriate books, sorted by audience and topic. To assist consumers to select books, this on-line library section also includes a picture of most of the books as well as descriptions, DC numbers and more. This new website also has the capability to translate any of the web pages into Spanish.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b></p> <p>It continues to be difficult to recruit buddy mentors; therefore we continue to offer training workshops to support groups, Family Support Organizations and conferences. The warm line e-mails and calls continue to be lower than the anticipated LOS; however the hits to the website are much higher than anticipated as we believe that consumers tend to find resource information on the website rather than contact the warm line. We have also noticed that the warm line inquiries are more complicated to research, therefore taking more time to find the correct resource for the consumer.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b></p> <p>A unit of service is defined as one website hit, one warm line phone call, one warm line e-mail,</p>

	assist/help start one adoptive family support group, and one buddy families/ training workshop offered.
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b>            96,000 website hits per year, 600 warm line phone contacts per year, 240 e-mails per year, and an average of two training workshops per month (22- none in December).</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b>            Website Hits for time period: <u>241,692</u>            Warm Line contacts for time period: <u>273 (phone calls)</u>            E-mails per time period: <u>108 (e-mails)</u>            Buddy Training/ Training Workshops for time period: <u>23</u></p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  <b># of unduplicated individuals:</b> 611 (warm line contacts plus training participants)  <b># of unduplicated families:</b> <u>Unable to differentiate between individual and families due to medium of service provided.</u>            Above number is based on the following: During this time period the program received at total of 381 unduplicated contacts to the warm line (273 via phone and 108 via e-mails) that were indicated as unduplicated. In addition, the 230 who attended NJ ARCH workshops (identified by returned evaluations) indicated that they were unduplicated as many had not attended an NJ ARCH workshop or received services and/or were new to the adoption / foster care community, <b>totaling 611</b>. In addition, there were 27 book requests completed which included a Satisfaction Survey to the services provided. These 27 are part of the 381 number as they were a “warm line” contact. We are unable to differentiate between individual and families, due to the medium of service provided.</p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>            Satisfaction surveys were distributed to consumers who contact the Warm Line either by phone or e-mail. Satisfaction Surveys were also sent via the free Lending Library service and distributed after each NJ ARCH training workshop. Below are the results from those Satisfaction Surveys:</p> <p>The NJ ARCH <u>Warm Line</u> contact form includes a question asking if contact with the NJ ARCH Warm Line had increased the consumer’s knowledge of some aspect of adoption. Out of the 381 phone/e-mail warm lines received during the time period of <b>10/1/15 – 9/30/16</b>, 94% stated that their “Knowledge was increased”, 5% stated that it was Somewhat Increased, 0% stated Not Increased and 1% stated that they were Unsure.</p> <p>Out of the 27 <u>Lending Library Surveys</u> asking feedback on the book, 10 were returned; 40% stated that they were Very Satisfied with the book, 50% were Satisfied, 10% were Neutral and 0% were Dissatisfied, therefore 90% out of 100% of the surveys stated they were Very Satisfied or Satisfied with the NJ ARCH book.</p> <p>Out of the 230 <u>Training Evaluations</u> distributed, 150 were returned; from the average of all the evaluation questions, 80% stated that they were Very Satisfied, 14% were Satisfied, 6% were Neutral and 0% were Dissatisfied, therefore a total of 94% were either Very Satisfied or Satisfied with the training workshop.</p>

	<p>In summary: Out of the total <u>541 returned</u> surveys from the above categories (381 from Warm Lines, 10 from Lending Library and 150 from Training Evaluations) reviewed during the <b>10/1/15 to 9/30/16</b> time period, <b>94%</b> were either <b>Very Satisfied or Satisfied</b> with the service, <b>6%</b> were <b>Neutral or Unsure</b> and <b>0%</b> were <b>Dissatisfied</b> with services; there were no Strongly Dissatisfied with services. Any feedback noted as “dissatisfied” would be reviewed by Program Assistant Director in collaboration with the Program Director to evaluate any correction needed on our part.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>There has been numerous technological enhancements and capabilities of websites since the initial launch of NJ ARCH in 2003 and since the previous website software was no longer being supported by Microsoft, the agency upgraded and launched the NJ ARCH website (<a href="http://www.njarch.org">www.njarch.org</a>) in April 2016. This new website now has the capability to utilize search tools, lending library search functions, possible e-learning capabilities and now has compatibility with hand-held devices. The new website also has the capability to translate any of the pages into Spanish. Feedback by State stakeholders and consumers has been very positive.</p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>Based on feedback from the new, improved website, there has been little to no changes identified.</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p> <p>96,000 website hits per year, 600 warm line phone contacts per year, 240 e-mails per year, and average of two training workshops per month (22- none in December).</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p><b># of unduplicated individuals:</b> 680</p> <p><b># of unduplicated families:</b> <u>We are unable to differentiate between individual and families due to the medium of service provided.</u></p> <p>As more and more people call us back on our warm line, the number of unduplicated families will most likely decrease, since consumers are either taking our training workshops and/or calling our warm line more than once (as indicated on our warm line form asking if they have contacted NJ ARCH before).</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<b>5a</b>	<p><b>How will you measure progress?</b></p> <p>By collecting data via AWStats hosting reports (via web host company) to track the number of web site hits, the number and quality of Customer Satisfaction Surveys from the phone and e-mail warm lines, Lending Library Satisfaction Surveys, Training Workshop Evaluations, consumer reports and comments of those who utilize our services.</p>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <p>Continue to send Needs Assessments to new consumers and Satisfaction Surveys to identified users of NJ ARCH services. Returned Satisfaction Surveys are reviewed by the program Assistant Director and data is entered into the Statistical Database, SPSS, maintained by the Program Evaluator. Satisfaction surveys that are marked lower than satisfactory are followed up individually by the Assistant Director and Program Director. Once the cause of dissatisfaction is determined, the Assistant Director will meet with the NJ ARCH staff to discuss the issue and to develop improved methods of handling the particular issue.</p>

<b>5c</b>	<p><b>How do you collaborate with community partners?</b></p> <p>We work collaboratively with the following community partners:</p> <ul style="list-style-type: none"> <li>-Division of Child Protection and Permanency (DCP&amp;P) Local Offices including DCP&amp;P Adoption /Subsidiy and Search and Reunion units.</li> <li>-Foster and Adoptive Family Services (FAFS) by offering free NJ ARCH training workshops for Resource Parent training credits around the state.</li> <li>-Advocates for Children of NJ (ACNJ) by referring consumers for legal and trend information as well as distribute and promote their materials and services.</li> <li>-Adoption Agency Council of NJ (AACNJ), where the Assistant Director is an active member during the monthly state-wide meetings. Share with Council trends and issues on adoption, foster care and kinship care. During this period specific issues and information relating to the new Adoptees Birthright Act/Law where adult adoptees may request and obtain their NJ Original Birth Certificates were discussed.</li> <li>-Collaborate with NJ State Vital Statistics in the support of the new Adoptees Birthright Act when adult adoptees may request and obtain their Original Birth Certificates (OBC). Starting January 2017 an NJ ARCH information card is now included with each mailing of the OBCs to offer consumers NJ ARCH as a resource in their next steps in their adoption/ possible search journey.</li> <li>-Adoption support groups around the state such as Concerned Persons for Adoption (CPFA) and Adoptive Parents Committee (APC) by offering guest speakers, training workshops as well as advertise their events and meetings on the NJ ARCH website.</li> <li>-Members of the Adoption Advisory Committee and Post-Adoption Counseling Service providers.</li> <li>-Adoption conference coordinators by listing events and/or hosting resource tables to promote services provided in New Jersey.</li> <li>-Adoption or foster care related events and programs as listed on the NJ ARCH Events pages.</li> <li>-Steering Committee member of the Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG) Federal Grant where Assistant Director offers feedback/trends identified via the NJ ARCH warm line contacts.</li> </ul>
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**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>			
<b>1a</b>	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;"><b>Provider:</b> Center for Family Services</td> <td style="width: 50%;"><b>1b Program Name:</b> FPS Step Down</td> </tr> </table>	<b>Provider:</b> Center for Family Services	<b>1b Program Name:</b> FPS Step Down
<b>Provider:</b> Center for Family Services	<b>1b Program Name:</b> FPS Step Down		
<b>1c</b>	<b>Relevant PSSF Program:</b> <input checked="" type="checkbox"/> FPS, <input checked="" type="checkbox"/> FSS, <input type="checkbox"/> TLFRS, <input type="checkbox"/> APSS		
<b>1d</b>	<b>Program Address:</b> 180 South White Horse Pike Clementon, New Jersey 08021		
<b>1e</b>	<b>Objective:</b> To provide an extended range of services to families that have completed a Family Preservation (FPS) intervention in order to further strengthen family functioning and address factors supporting permanency and improving child and family well-being.		

<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b></p> <p>The Step-Down program provides a community based continuum of care to families that successfully complete an initial Family Preservation Services (FPS) intervention. Program participants receive a comprehensive range of supportive services that extend beyond the short term crisis intervention and stabilization provided by FPS programs. Step-Down services are based on an aftercare model and focus on more enduring issues that impact family functioning and child and family well-being.</p> <p>The overarching goal of the program is to empower and assist families in maintaining a safe and stable home environment. Consistent with the general FPS model, Step-Down programs seek to: ensure child safety by eliminating identified risk factors; prevent out of home placement; improve family functioning; and link families with appropriate community resources.</p> <p>Step-Down programs provide an array of social, health, educational, counseling, and case management support services either directly or through community-based resources. All services are coordinated, individualized, goal-oriented, and adapted to each family's changing needs and circumstances.</p> <p>Participating families receive three (3) to nine (9) months of services provided at differing levels of intensity according to their unique needs and rate of progression in achieving case goals.</p>
<b>2b</b>	<p><b>Population Served:</b></p> <p>The target population is children and families under DYFS supervision who have completed a 4-8 week FPS intervention program and who require continued support and supervision to further reduce or eliminate risk factors identified by the Division and/or FPS</p>
<b>2c</b>	<p><b>Geographical Area of Services:</b></p> <p>Camden and Gloucester Counties</p>
<b>2d</b>	<p><b>Referral Sources:</b></p> <p>Family Preservation Services Program</p>
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b></p> <p><b>Include data were available:</b></p> <ul style="list-style-type: none"> <li>• 9 families successfully completed the FPS/FSS Step Down program</li> <li>• Placement disposition of child (ren) at end of the intervention: 53 children remained with their families, 1 was placed by DCP&amp;P; 1 turn 18, was in a long term psychiatric treatment facility.</li> <li>• Program level of service is 10 unduplicated families per contract year. The program</li> </ul>

	<p>served 20 families</p> <ul style="list-style-type: none"> <li>• Step-Down closed a total of 15 families: 1 family 9 months; 2 families 8 months; 2 families 7 months; 1 family 6 months; 3 families 5 months; 3 families 5 months; 1 family 2 months 3 families 1 month. The average number of days open was 154 days, approximately 5 ½ months. Three families opened during this reporting period are continuing to work with Step Down and are expected to successfully complete the program</li> <li>• Total number of hours (months): Average = 74 hours/family for a Total of 1115 hours</li> </ul>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Children were able to remain in a safe and stable home environment.</p>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> Contributing factors include the provision of in-home therapeutic services in a strength-based, family-focused manner that empowers a family to move toward health and stability.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b></p> <ul style="list-style-type: none"> <li>• Family Preservation Services level of services was high this past contract year. The demand for Step-Down services continues to increase as evidenced by the 20 families served</li> <li>• There is only one staff member on FPS/FSS Step-Down for 2 counties. The demand for her services is great. There is never a down-time period between closing and opening cases</li> <li>• Mental illness and addictions of parents is an issue when trying to teach parenting and problem solving skills.</li> </ul>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> The level of service is a minimum of 10 families per contract year. There is only one Step down Worker and her maximum case load is 8 families at any given time. A family's length of stay can extent up to nine months.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b>  The contracted level of service is 10 unduplicated families per contract year.</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> The actual level of services was 20 families</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:</b> 93 <b># of unduplicated families:</b> 20</p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> The Satisfaction Service is given to families when services are completed. The survey was</p>

	<p>given to 16 families who completed the program during the reporting period. The feedback was positive. DCP&amp;P workers had mentioned that some families had progressed and accomplished their goals and their cases have been closed.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
4a	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>The State has put all the programs up for bid and we will submit a proposal. The new funding will allow the programs to have a Step Down worker in each county.</p>
4b	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>As part of our ongoing commitment to providing the highest quality of services, the FPS/FSS Step Down Program will adapt to meet client’s needs as appropriate based upon Case Record Review Report, NCFAS results and client satisfaction survey. Upon review of these reports and the anticipated new contract an additional Step Down Worker will added if the new contract is awarded to this agency.</p>
4c	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p> <p>At a minimum 20 families will be served during the period of 10/1/17-9/30/18</p>
4d	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p># of unduplicated individuals: 90 # of unduplicated families: 20</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
5a	<p><b>How will you measure progress?</b></p> <ul style="list-style-type: none"> <li>• Information regarding placement outcomes and whether or not there were substantiated incidents of child abuse/neglect will be obtained 12 months after discharge</li> <li>• A family’s successful completion of the program and improved levels of functioning as documented by the NCFAS standard assessment tool will be considered</li> <li>• Consumer satisfaction surveys will be used</li> </ul>
5b	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <p>Center for Family Services reviews charts for quality assurance in a yearly basis. Also, the Step-Down Supervisor conducts utilization reviews of the charts at the closing of each case. Center for Family services also conducts a client satisfaction survey once a year</p>
5c	<p><b>How do you collaborate with community partners?</b></p> <p>Ongoing communication with DCP&amp;P in Camden and Gloucester Counties, the Boards of Social Services, the school systems, the mental health system, the legal system are an integral part of the program</p>

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Ocean Mental Services, Inc</p> <p><b>1b Program Name:</b> FSS/FPS Step Down Program</p>
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <u>X</u> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 122 Lien St. Toms River, NJ. 08753
<b>1e</b>	<p><b>Objective:</b> To provide an extended range of services to families that have completed a Family Preservation (FPS) intervention in order to further strengthen family functioning and address factors supporting permanency and improving child and family well-being.</p>
<b>1f</b>	<b>Outcome(s) Addressed:</b> <u>X</u> Safety <u>X</u> Permanency <u>X</u> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b> The Step-Down program provides a community based continuum of care to families that successfully complete an initial Family Preservation Services (FPS) intervention. Program participants receive a comprehensive range of supportive services that extend beyond the short term crisis intervention and stabilization provided by FPS programs. Step-Down services are based on an aftercare model and focus on more enduring issues that impact family functioning and child and family well-being.</p> <p>The overarching goal of the program is to empower and assist families in maintaining a safe and stable home environment. Consistent with the general FPS model, Step-Down programs seek to: ensure child safety by eliminating identified risk factors; prevent out of home placement; improve family functioning; and link families with appropriate community resources.</p> <p>Step-Down programs provide an array of social, health, educational, counseling, and case management support services either directly or through community-based resources. All services are coordinated, individualized, goal-oriented, and adapted to each family’s changing needs and circumstances.</p> <p>Participating families receive three to nine months of services provided at differing levels of intensity according to their unique needs and rate of progression in achieving case goals.</p>
<b>2b</b>	<p><b>Population Served:</b> The target population is children and families under DCPD supervision who have completed a 4-8 week FPS intervention program and who require continued support and supervision to further reduce or eliminate risk factors identified by the Division and/or FPS.</p>

2c	<b>Geographical Area of Services:</b> Ocean County
2d	<b>Referral Sources:</b> Family Preservation Services Program
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
3a	<b>Provide a summary of program accomplishments on goals. Include data where available:</b> The Step-Down program exceeded its contracted level of service for the reporting period associated with this grant, as 11 families and 27 children received services. Of the 11 families receiving services, 6 families were discharged within this reporting period with 5 families carrying over into the next federal fiscal year. The following data reflects the 6 discharged families. The 6 families comprised of a total of 13 children that received an average intervention of 4 months. All 12 children served or 92% remained safely at home upon completing the program.
3b	<b>How did this improve outcomes for children and families?</b> Children were able to remain in a safe and stable home environment.
3c	<b>Identify specific factors that contributed to this improvement:</b> A key factor to the program’s success is the provision of in-home supportive counseling services that are delivered in a strength based, family focused manner which empowers families to move toward health and stability.
3d	<b>Identify significant barriers to goal accomplishment:</b> Barriers to goal accomplishment include the unwillingness of some families to participate in services once the case has been opened, as participation is voluntary.
3e	<b>Definition of Level of Service as per contract:</b> One family equals one unit of service. Each FPS/FSS Step Down program has one worker who is supervised by the FPS Program Supervisor. At any one time, the maximum caseload is 8 families, depending upon the family’s progress and the intensity of services being provided. A family’s length of stay can extend up to 9 months.
3f	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 8
3g	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 11
3h	<b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  # of unduplicated individuals: 13 # of unduplicated families: 11
3i	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> Families are provided with a Participant Satisfaction Survey at the end of the intervention to complete and return. All surveys were returned with positive feedback on the service provided.

<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>No changes to the program are anticipated.</p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>As part of its commitment to providing quality services, the FPS/FSS Step Down program adapts to meet the needs of its clients based on internal reviews, contract monitoring activities, and client satisfaction surveys. There are no changes anticipated at this time.</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p> <p>10</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p># of unduplicated individuals: 20 # of unduplicated families: 10</p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b></p> <p>Progress is measured through the following methods:</p> <ul style="list-style-type: none"> <li>*A family’s successful completion of the program and improved levels of functioning as documented by the NCFAS standard assessment tool.</li> <li>*Individual supervision provided on a weekly and as needed basis.</li> <li>*Ongoing record reviews by the program supervisor</li> <li>*Follow-up information regarding subsequent incidents of child abuse/neglect and out-of-home placements 12 months after clients are discharged from the program.</li> </ul>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <p>Quality assurance is monitored throughout the course of the contract term via aggregate NCFAS assessment results that indicate trends in services and family needs, feedback from the DCPD local office, DCF contract monitoring processes, and consumer satisfaction surveys.</p>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b></p> <p>The FPS/FSS Step Down program communicates on a regular basis with the Division of Child Protection and Permanency by sending written reports of a family’s progress every 45 days and reaching out to consult with the family’s DCPD case worker as needed. Additionally, the Step Down program works collaboratively with other collateral community services such as DCBH, Perform Care, Schools, Social Welfare Services, local domestic violence shelters, health care providers and others as dictated by the needs of the families with whom we are working. It is important to note that one of the hallmarks of the Step Down program is the empowerment of families to advocate for themselves with various community services. Much work is done to assist families in the navigation of the various service systems.</p>

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Youth Consultation Services
	<b>1b Program Name:</b> FPS Step-Down
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, <input checked="" type="checkbox"/> FSS, ___TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 711 32 Street, 2 <sup>nd</sup> Floor Union City, NJ 07087
<b>1e</b>	<b>Objective:</b> To provide an extended range of services to families that have completed a Family Preservation (FPS) intervention in order to further strengthen family functioning and address factors supporting permanency and improving child and family well-being.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b> The Step-Down program provides a community based continuum of care to families that successfully complete an initial Family Preservation Services (FPS) intervention. Program participants receive a comprehensive range of supportive services that extend beyond the short term crisis intervention and stabilization provided by FPS programs. Step-Down services are based on an aftercare model and focus on more enduring issues that impact family functioning and child and family well-being.</p> <p>The overarching goal of the program is to empower and assist families in maintaining a safe and stable home environment. Consistent with the general FPS model, Step-Down programs seek to: ensure child safety by eliminating identified risk factors; prevent out of home placement; improve family functioning; and link families with appropriate community resources.</p> <p>Step-Down programs provide an array of social, health, educational, counseling, and case management support services either directly or through community-based resources. All services are coordinated, individualized, goal-oriented, and adapted to each family’s changing needs and circumstances.</p> <p>Participating families receive three (3) to nine (9) months of services provided at differing levels of intensity according to their unique needs and rate of progression in achieving case goals.</p>
<b>2b</b>	<b>Population Served:</b> The target population is children and families under DCP&P supervision who have completed a 4-8 week FPS intervention program and who require continued support and supervision to further reduce or eliminate risk factors identified by the Division and/or FPS.

2c	<b>Geographical Area of Services:</b> Hudson County
2d	<b>Referral Sources:</b> Family Preservation Services (only)
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
3a	<p><b>Provide a summary of program accomplishments on goals.</b>  <b>Include data where available:</b></p> <ul style="list-style-type: none"> <li>• 6 families with 11 children received FPS Step Down services.</li> <li>• Placement disposition of child(ren) at end of the intervention: 10 children remained home upon completing the FPS/FSS Step Down program</li> <li>• Length of stay: On average, families participated in the program for 5 months, receiving an average of 40 hours of face-to-face sessions. At the cessation of services, 100% of the children remained home.</li> </ul>
3b	<p><b>How did this improve outcomes for children and families?</b>          Children were able to remain in a safe and stable home environment with their families while continuing to apply the goals worked on during the Step down services were in the home. Family functioning was able to improve through bonding exercises and improved communication within the families.</p>
3c	<p><b>Identify specific factors that contributed to this improvement:</b>          One of the key factors contributing to the success of the program is the in-home therapeutic services provided; families receive services in their home which at times is convenient. Services focus on empowering families to continue building and forming healthy relationship with one another while reaching their goals in a healthy and stable manner, Concrete services is an important factor in the overall improvement of families by providing the support and assistance families are able to continue progressing in other areas.</p>
3d	<p><b>Identify significant barriers to goal accomplishment:</b>          Family Preservation level of services, i.e. if the FPS program level of service is low, then the pool of cases to refer to the Step-Down program reduces</p>
3e	<p><b>Definition of Level of Service as per contract:</b></p> <p>Definition of Unit(s) of Services: One family=one unit of service. Each FPS/FSS Step Down program has one worker who is supervised by the FPS Program Supervisor. At any one time, the maximum caseload is 8 families, depending upon the family’s progress and program phase. A family’s length of stay in the program may be extended up to 9 months.</p>
3f	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b>          A minimum of 10 families per year.</p>

3g	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16: 6 Families</b></p>
3h	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals: 20</b>  <b># of unduplicated families: 6</b></p>
3i	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <p>All Step Down families were provided with Satisfaction Surveys at the end of the intervention to complete and return. Each parent was given a survey, 9 parents in total and 6 children in total. The remaining 5 children were not provided with surveys due to their age, ranging from 1-8 year old. Responses and survey results are monitored by YCS research department, at this time the results are not available. Referrals were low this year since referrals come from families that have successfully completed FPS. The FPS levels were low therefore making referrals to Step down was challenging.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
4a	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <p>No changes to the FPS/FSS Step Down program are anticipated</p>
4b	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <p>FPS/FSS Step Down program has a commitment to provide quality services by adapting to meet the appropriate requirements of each client based upon the review of such reports from YCS client satisfaction surveys; DCP&amp;P case record reviews, and NCFAS results. No changes are anticipated at this time.</p>
4c	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p> <p>A minimum of 10 families will be served</p>
4d	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p><b># of unduplicated individuals: 20</b>  <b># of unduplicated families: 6</b></p>

<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b></p> <ul style="list-style-type: none"> <li>• The family’s successful completion of the program</li> <li>• Client satisfaction survey</li> <li>• NCFAS: North Carolina Family Client Assessment Scale</li> <li>• NCFAS: Assessment tool</li> <li>• Individualized measurable goals</li> <li>• Follow-up information in regards to subsequent incidents of child abuse/neglect and out-of-home placements 12 months after the clients are discharged from the program.</li> <li>• Individual supervision on a bi-weekly or as needed basis.</li> <li>• Programmatic progress will be measured through DCP&amp;P contract monitoring (levels of service achieved, number of clients served and service outcomes)</li> </ul>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <ul style="list-style-type: none"> <li>• Case Record Reviews conducted by YCS.</li> <li>• Client Satisfaction Surveys</li> <li>• Cumulative NCFAS assessment results that indicate trends in service provision and family level of need.</li> <li>• ECR: electronic client record</li> </ul>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b></p> <p>FPS/FSS Step Down program communicates with DCP&amp;P by sending written reports of the progress each family has every 45 days and through contact with the DCP&amp;P case worker as needed to discuss matters concerning such families. DCP&amp;P worker is emailed in reference to the families’ progress or lack of progress on a weekly basis. Meetings held at the clients’ home in order to conference issues within the home are held in a as needed basis.</p> <p>Step Down program works in conjunction with collateral community services such as: local schools, Perform Care, shelters, social welfare services and health care providers or other services dictated by the needs of the families being serviced. Step Down program thrives on empowering each family to advocate for themselves and navigate various community services to ensure and maintain stabilization of the families</p>

### 2017 PSSF Update Report

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Catholic Charities, Diocese of Metuchen
<b>1b</b>	<b>Program Name:</b> FPS Step Down Middlesex
<b>1c</b>	<b>Relevant PSSF Program:</b> <input checked="" type="checkbox"/> FPS, <input type="checkbox"/> FSS, <input type="checkbox"/> TLFRS, <input type="checkbox"/> APSS
<b>1d</b>	<b>Program Address:</b> 26 Safran Avenue, Edison NJ 08837
<b>1e</b>	<b>Objective:</b> To empower and assist families in maintaining a safe and stable home environment.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> Step Down provides a community based continuum of care to families that successfully complete a primary Family Preservation Services (FPS) intervention and need continued supportive services beyond the short term crisis intervention and stabilization services provided by FPS. Step Down services are based on an after care model and focus on enduring issues that impact child and family functioning and well-being. Participant families receive 3 to 9 months of service at differing intensities according to their unique needs and rate of progression on achieving goals.
<b>2b</b>	<b>Population Served:</b> The target population is children and families who have completed a 4 to 8 week FPS intervention who require continued support and supervision to further reduce or eliminate risk factors identified by the NJ Division of Child Protection and Permanency.
<b>2c</b>	<b>Geographical Area of Services:</b> Middlesex County
<b>2d</b>	<b>Referral Sources:</b> Family Preservation Services
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<b>Provide a summary of program accomplishments on goals. Include data where available:</b> 10 unduplicated families were served in this period with a total of 22 children. 95.5% of children remained in the home at the time of discharge. 60% of families made at least partial progress on treatment goals with 30% achieving all treatment goals. Follow up surveys conducted at 12 months post intervention during this period indicated that 100% of children remained in their homes.
<b>3b</b>	<b>How did this improve outcomes for children and families?</b> Family stress factors were reduced and/or resolved in order to stabilize family functioning and preserve children in their homes.
<b>3c</b>	<b>Identify specific factors that contributed to this improvement:</b> Services and interventions are specific to family needs.

<b>3d</b>	<b>Identify significant barriers to goal accomplishment:</b> Several families presented ongoing substance abuse issues which prevented additional progress on individual goals.
<b>3e</b>	<b>Definition of Level of Service as per contract:</b> Families Served
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 8
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 10
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:</b> 35  <b># of unduplicated families:</b> 10</p>
<b>3i</b>	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> Families are given surveys at discharge. Surveys were provided to 10 families and 3 responses were collected. Responses were generally positive, no needed improvements were identified.
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> No planned changes
<b>4b</b>	<b>Identify changes you will make that stem from stakeholder feedback.</b> Responses were generally positive, no needed improvements were identified.
<b>4c</b>	<b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> 8
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p><b># of unduplicated individuals:</b> 25  <b># of unduplicated families:</b> 8</p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<b>How will you measure progress?</b> Progress is evaluated through family goal attainment and follow up placement data.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> Consumer satisfaction

	surveys are provided to all program participants at discharge and data is evaluated quarterly.
<b>5c</b>	<b>How do you collaborate with community partners?</b> Linkage of participants to community service partners is a key piece of Step Down interventions. Families are linked to concrete, financial, health, mental health and other services provided by community partners.

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Oaks Integrated Care
	<b>1b Program Name:</b> FPS Step Down
<b>1c</b>	<b>Relevant PSSF Program:</b> <input checked="" type="checkbox"/> FPS, <input checked="" type="checkbox"/> FSS, <input type="checkbox"/> TLFRS, <input type="checkbox"/> APSS
<b>1d</b>	<b>Program Address:</b> 1138 East Chestnut Avenue, Unit 3-A Vineland, New Jersey 08360
<b>1e</b>	<b>Objective:</b> To provide an extended range of services to families that have completed a Family Preservation (FPS) intervention in order to further strengthen family functioning and address factors that support permanency and improve child and family well-being.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY 10/1/15 – 9/30/16</b>	
<b>2a</b>	<p><b>Overview of Service:</b> The Step Down program provides a community based continuum of care to families that successfully complete an initial Family Preservation Services (FPS) intervention. Program participants receive a comprehensive range of supportive services that extend beyond the short term crisis intervention and stabilization provided by FPS programs. Step Down services are based on an aftercare model and focus on more enduring issues that impact family functioning and child and family well-being.</p> <p>The overarching goal of the program is to empower and assist families in maintaining a safe and stable home environment. Consistent with the general FPS model, Step Down programs seek to: ensure child safety by eliminating identified risk factors; prevent out of home placement; improve family functioning; and link families with appropriate community resources.</p> <p>Step Down Programs provide an array of social, health, educational, counseling, and case management support services either directly or through community-based resources. All services are coordinated, individualized, goal oriented, and adapted to each family’s changing needs and circumstances.</p> <p>Participating families receive three (3) to nine (9) months of services provided at differing</p>

	levels of intensity according to their unique needs and rate of progression in achieving case goals.
<b>2b</b>	<b>Population Served:</b> The target population is children and families under DCP&P supervision who have completed a 4-8 week FPS intervention and who require continued support and supervision to further reduce or eliminate risk factors identified by the Division and/or FPS.
<b>2c</b>	<b>Geographical Area of Services:</b> Cumberland County
<b>2d</b>	<b>Referral Sources:</b> Family Preservation Services
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<b>Provide a summary of program accomplishments on goals.</b> <b>Include data where available:</b> During this time period 20 families were serviced. 13 families achieved at least one of their goals.
<b>3b</b>	<b>How did this improve outcomes for children and families?</b> 97% of the at risk children in the families who completed FPS Step-Down remained in the home 12 months post termination during this timeframe.
<b>3c</b>	<b>Identify specific factors that contributed to this improvement:</b> The provision of in-home therapeutic services in a strength based, family focused manner that empowers families to move towards health and stability are the primary factors that contribute to improved outcomes for children.
<b>3d</b>	<b>Identify significant barriers to goal accomplishment:</b> Out of the 20 families that were services, 7 were interrupted. Out of those 7, 1 went past the minimum of 3 months and was able to work towards goals and achieved at least one.
<b>3e</b>	<b>Definition of Level of Service as per contract:</b> One family = one unit of service.
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> Oaks Integrated Care is contracted to serve 20 families per year.
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16: 20 units</b>
<b>3h</b>	<b>How many unduplicated individuals and unduplicated families were served for this</b>

	<p><b>period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals: 49</b>  <b># of unduplicated families: 20</b></p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>  Out of the 13 full interventions, there were 9 surveys returned.</p> <p>Out of the surveys returned some of the feedback from consumers was as follows: “Janelle was awesome! Thanks for everything!”</p> <p>“Step Down visits were conducted at times that were convenient for me and my family. The Step Down Support Specialist was available 24 hours a day/7 days a week. The Step Down Support Specialist addressed issues related to my family’s needs. My family and I have experienced an improvement in the issues that we were having before the Step Down intervention. I feel satisfied with the services my family and I received.” The above was communicated by 7 families based on respondents selecting a 5 response to each statement listed above using a Likert scale. (The survey indicated that 5 equals a strong agreement with the statements.)</p>
<b>Section 4 – The Year Ahead FFY (10/1/15 – 9/30/16)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b>  The FPS Step Down program service model is standard and will remain unchanged.</p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b>  As per our consumer satisfaction surveys, family stakeholders have reported that they enjoy the service and felt that it was beneficial for their family needs.</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b>  20 families.</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>  <b># of unduplicated individuals: 40</b>  <b># of unduplicated families: 20</b></p>
<b>Section 5 – Evaluating Progress FFY (10/1/15 – 9/30/16)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b></p> <ul style="list-style-type: none"> <li>Information regarding placement outcomes and whether or not they were substantiated incidents of child abuse/neglect will be obtained 12 months after</li> </ul>

	<p>discharge</p> <ul style="list-style-type: none"> <li>• A family’s successful completion of the program and improved levels of functioning as documented by the NCFAS standard assessment tool will be considered</li> <li>• Consumer satisfaction feedback surveys will be used</li> <li>• Quality Assurance calls to the stakeholders during services</li> </ul>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <ul style="list-style-type: none"> <li>• Feedback from the DCP&amp;P local offices</li> <li>• DCF contract monitoring process</li> <li>• Consumer satisfaction surveys</li> <li>• Quality Assurance calls to the stakeholders during services</li> </ul>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b>          Communication with the DCP&amp;P and other collateral supports is an integral part of the program. As part of the program’s case management responsibilities, Step Down staff is in frequent contact with other service providers and community-based agencies that are working with these families.</p>

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> The Bridge</p>
	<p><b>1b Program Name:</b> FPS / FSS Step Down Program</p>
<b>1c</b>	<p><b>Relevant PSSF Program:</b> <input checked="" type="checkbox"/> FPS, <input checked="" type="checkbox"/> FSS, <input type="checkbox"/> TLFPS, <input type="checkbox"/> APSS</p>
<b>1d</b>	<p><b>Program Address:</b>            50 Union Avenue, Suite 305            Irvington, NJ 07111</p>
<b>1e</b>	<p><b>Objective:</b>            To provide an extended range of services to families that have completed a Family Preservation (FPS) intervention in order to further strengthen family functioning and address factors supporting permanency and improving child and family well-being.</p>
<b>1f</b>	<p><b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being</p>
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b>            The Step-Down program provides a community based continuum of care to families that complete an initial Family Preservation Services (FPS) intervention. Program participants receive a comprehensive range of supportive services that extend beyond the short term crisis intervention and stabilization provided by FPS programs. Step-Down services are based on an aftercare model and focus on more enduring issues that impact family functioning and child and family well-being.</p>

	<p>The overarching goal of the program is to empower and assist families in maintaining a safe and stable home environment. Consistent with the general FPS model, Step-Down programs seek to: ensure child safety by eliminating identified risk factors; prevent out of home placement; improve family functioning; and link families with appropriate community resources.</p> <p>Step-Down programs provide an array of social, health, educational, counseling, and case management support services either directly or through community-based resources. All services are coordinated, individualized, goal-oriented, and adapted to each family's changing needs and circumstances.</p> <p>Participating families receive three (3) to nine (9) months of services provided at differing levels of intensity according to their unique needs and rate of progression in achieving case goals.</p>
<b>2b</b>	<p><b>Population Served:</b> The target population is children and families under DCP&amp;P supervision who have completed a 4-8 week FPS intervention program and who require continued support and supervision to further reduce or eliminate risk factors identified by the Division and/or FPS</p>
<b>2c</b>	<p><b>Geographical Area of Services:</b> Essex and Union Counties</p>
<b>2d</b>	<p><b>Referral Sources:</b> Family Preservation Services Program</p>
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b> <b>Include data where available:</b> <u>7</u> families and <u>19</u> children received Step-Down services during FFY '16. <u>1</u> out of the <u>7</u> families and <u>3</u> out of the <u>19</u> children were carried over from FFY '15.</p> <p><b>Cases Closed:</b> <u>5</u> out of the <u>7</u> families completed Step-Down services during FFY '16 <u>15</u> out of the <u>19</u> children completed Step-Down services during FFY '16 Of this figure:</p> <ul style="list-style-type: none"> <li>• <u>15</u> out of the <u>15</u> children remained with their families at end of the intervention; indicating a <u>100</u> % placement prevention rate</li> <li>• On average, each family received <u>148</u> days of service or <u>5</u> months of service</li> <li>• On average, each family received <u>52.5</u> direct face-to-face hours of service</li> <li>• Aggregate data indicates that a total of <u>262.65</u> direct service hours with a range of direct service hours between <u>31.5</u> hours and <u>77.75</u> hours were provided, and <u>306</u> indirect service hours were provided during FFY 2016</li> </ul>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b> Children were able to remain in a safe and stable home environment.</p>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b> The provision of in-home therapeutic services in a strength based, family focused manner that empowers a family to move toward health and stability is a contributing factor.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b> The Level of Service was not achieved as the Step Down Counselor went on maternity leave. The agency was not able to open new cases during this time frame; however, the agency continued to</p>

	provide services to families via case transfer within the program.
<b>3e</b>	<b>Definition of Level of Service as per contract:</b> One family = one unit of service.
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 8 to 10 families per year
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> <u>7</u> families received services and <u>5</u> families completed Step Down services during FFY ‘16
<b>3h</b>	<b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  # of unduplicated individuals: <u>16 children</u> # of unduplicated families: <u>6</u>
<b>3i</b>	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> <u>5</u> surveys were provided; <u>1</u> out of the <u>5</u> families were not available for an exit interview, <u>1</u> family preferred to provide verbal feedback as they spoke Spanish <u>2</u> surveys were returned and <u>1</u> survey was not returned. All clients responded positively and indicated their satisfaction with the services delivered by Step Down. One client commented, “I am in a different place today than six months ago. It was a good experience.” Another client stated, “I have and will recommend this program/agency to others. My experience with my worker and the program has helped me and my family a lot.”
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> No changes to the FPS/FSS Step Down program are anticipated.
<b>4b</b>	<b>Identify changes you will make that stem from stakeholder feedback.</b> As part of the program’s ongoing commitment to providing quality services, the FPS/FSS Step Down program adapts to meet the needs of its clients as appropriate based upon the Case Record Review Report (DCP&P), NCFAS assessment results and client satisfaction surveys. Upon review of these reports, no changes to the program are anticipated.
<b>4c</b>	<b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> 8 to 10 families will be served.
<b>4d</b>	<b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: <u>15 children</u>

	<b># of unduplicated families:</b> <u>    9    </u>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b></p> <ul style="list-style-type: none"> <li>• 12 month follow up information regarding placement outcomes will be obtained 12 months post discharge from the Step Down program</li> <li>• A family’s successful completion of the program and improved levels of functioning as documented by the NCFAS standard assessment tool will be considered</li> <li>• Consumer satisfaction surveys will be used</li> <li>• Achievement of the contracted Level of Service</li> </ul>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <ul style="list-style-type: none"> <li>• The Bridge will conduct utilization reviews of all charts to ensure compliance with programmatic standards and customer satisfaction surveys will be obtained from families who complete the program.</li> <li>• The Step-Down Supervisor will obtain feedback from CP&amp;P Case Managers.</li> </ul> <p>The Step-Down Supervisor will conduct random quality assurance telephone calls to client families in order to obtain their feedback. Based upon responses that are received, the program will make any changes that are necessary to improve services.</p>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b></p> <p>Ongoing communication with DCP&amp;P and other collateral supports is an integral part of the program. The program’s collaborative efforts include: providing Acceptance Letters to CP&amp;P, engaging in Bi-weekly Communication with CP&amp;P, submitting 45 Day Review Reports to CP&amp;P, inviting CP&amp;P workers to family sessions on an as needed basis, and initiating telephone contact with collateral services.</p>

**PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<p><b>Provider:</b> Urban League of Hudson County</p> <p><b>1b Program Name:</b> MENTORS Report</p>
<b>1c</b>	<p><b>Relevant PSSF Program:</b> <input type="checkbox"/> FPS, <input checked="" type="checkbox"/> FSS, <input type="checkbox"/> TLFRS, <input type="checkbox"/> APSS</p>
<b>1d</b>	<p><b>Program Address:</b> 253 Martin Luther King Jr. Drive, Jersey City, NJ 07305</p>
<b>1e</b>	<p><b>Objective:</b> To provide a mentor to referred youth. The mentor’s role is to help youth improve their decision making, social communication skills and, if applicable, academic performance.</p>
<b>1f</b>	<p><b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being</p>
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b></p> <p>To identify and train adult mentors that will be matched with a youth of the same gender. The mentor will provide the youth with companionship and guidance. The youth will</p>

	identify personal goals and the mentor/mentee relationship will assist the youth in achieving the youth identified personal goals.
<b>2b</b>	<b>Population Served:</b> Youth between the ages of 13 to 18
<b>2c</b>	<b>Geographical Area of Services:</b> Hudson County
<b>2d</b>	<b>Referral Sources:</b> DCP&P referrals and referrals from DCP&P funded youth programs.
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<b>Provide a summary of program accomplishments on goals. Include data were available:</b> During the review period, eight matches of an adult to a child were accomplished. The youth involved benefitted from the relationships.
<b>3b</b>	<b>How did this improve outcomes for children and families?</b> The mentors program provides an interested adult for the youth. This interested adult serves as a component of an overall supportive community network.
<b>3c</b>	<b>Identify specific factors that contributed to this improvement:</b> Mentors and mentees were also advised of agency programs, employment and employment training opportunities.
<b>3d</b>	<b>Identify significant barriers to goal accomplishment:</b> The redesigned web site now enables mentors to reach out directly to the Mentors program. Prospective mentors complete an on line inquiry and submit a simple statement. Prospective mentors are contacted within 48 hours.
<b>3e</b>	<b>Definition of Level of Service as per contract:</b> A unit of service is one child/adolescent matched with one mentor.
<b>3f</b>	<b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 12 units
<b>3g</b>	<b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 8 units
<b>3h</b>	<b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b> # of unduplicated individuals: 8 # of unduplicated families: 8
<b>3i</b>	<b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> Only anecdotal information was being collected. Prospective mentors now attend orientation sessions and these sessions have been evaluated. It has shown to be productive and has been a venue to recruit more mentors.

<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b> Orientation sessions are now held every quarter. Prospective mentors that don't follow through – complete an application and sign up for the background check - are now contacted and surveyed. Our match rate is projected to increase.
<b>4b</b>	<b>Identify changes you will make that stem from stakeholder feedback.</b> All mentors are now required to attend periodic training classes. Quarterly.
<b>4c</b>	<b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> 15 – 20 units of service
<b>4d</b>	<b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: 15 – 20 # of unduplicated families: 15 – 20
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<b>How will you measure progress?</b> Number of matches made. Review of match logs, progress reports and report cards. The ULOHC will also track whether or not specific client goals were realized. We will measure mentor satisfaction with the support that the agency provided for the match through satisfaction surveys.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> Written reports, face to face interviews with mentors/mentees.
<b>5c</b>	<b>How do you collaborate with community partners?</b> The Urban League of Hudson County collaborates through membership in social service networks including the Hudson County Human Services Advisory Council (HSAC), the Hudson County Council for Young Children, and a Jersey City Board of Education community partnership network for social services. The agency also tables at resource and health fairs throughout the county.

**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Preferred Behavioral Health Group
<b>1b</b>	<b>Program Name:</b> Family Visitation
<b>1c</b>	<b>Relevant PSSF Program:</b> <input checked="" type="checkbox"/> FPS, <input type="checkbox"/> FSS, <input type="checkbox"/> TLFRS, <input type="checkbox"/> APSS
<b>1d</b>	<b>Program Address:</b> 1200 River Avenue Suite 9D Lakewood, NJ 08701
<b>1e</b>	<b>Objective:</b> Provide supervised and clinical services that will assist families in maintaining and increasing their understanding of childcare basic needs, familial bonds, communication, emotion recognition, anger management, organizational skills, age appropriate boundaries and limits, as well as provide an in-depth understanding of the DCP&P case and the permanency plan when appropriate.
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b></p> <p>Please note that Title IV-B funding accounts for less than 10 % of the program. The information contained within this report evaluates the program in its entirety as there is no way to isolate which 10% of consumers are funded by IV-B.</p> <p>Family Visitation provides an array of services; supervised visitation, therapeutic visitation, and in-home therapy.</p> <ul style="list-style-type: none"> <li>• Supervised visitation provides an avenue for the family to maintain regular, positive contact on a planned basis between children, parents, family members and significant others that will reinforce the plan of reunification, help children to maintain a sense of family identity or determine other permanent plans for the child.</li> <li>• Therapeutic visitation is similar to supervised visitation in that it is designed to maintain regular scheduled contact for families who have an open case with the Division of Child Protection and Permanency (DCP&amp;P) and children in out of home placement. It does differ, however, in that a clinical approach is utilized to guide the family through the permanency process as it pertains to visitation, understanding reason for placement and moving toward reunification/permanency. The goal of the program is to enhance the safety and well-being of children during visitation, while supporting the plan for permanency.</li> <li>• In-home therapy provides home-based clinical interventions for families, whose children are at risk for out of home placement or transitioning back into the family home. The goal is to promote permanency of the family. This is accomplished through interventions that focus on physical and emotional safety and well-being of</li> </ul>

	children.
<b>2b</b>	<b>Population Served:</b> Families with an open DCP&P case in which children are in placement, at risk of placement, or transitioning to reunification.
<b>2c</b>	<b>Geographical Area of Services:</b> Ocean County, New Jersey
<b>2d</b>	<b>Referral Sources:</b> Ocean North and South Local offices
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b></p> <p><b>Include data where available:</b></p> <p>100% of the clients who became invested in the program achieved regularly scheduled contact.</p> <p>100% of the families that participated in therapeutic visitation were provided with trained LAC/LPC/LSW/LCSW level staff to guide communication as it related to the DCP&amp;P case and permanency.</p> <p>100% Families who participated in regularly scheduled visits were provided with the necessary skills and techniques for setting age appropriate limits and boundaries.</p> <p>100% of the children who participated in the program had their basic care needs met.</p>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b></p> <p>Regularly scheduled contacted enhanced the family member’s ability to create a working/therapeutic relationship with staff and provided the time necessary to discuss, understand, and process the family situation.</p> <p>Use of trained clinicians assured family communication remained at a healthy level along with developmentally age appropriate language resulting in clear understanding of permanency, expectations, and outcomes.</p> <p>Children identified as having either no understanding or a broad concept for DCP&amp;P involvement at time of intake gained insight into reasons for their placement outside of the family home, the action steps necessary for reunification and which family member was responsible for achievement. In addition, parents who openly participated in the program were able to identify how their choices and lifestyle factors (substance use, domestic violence, lack of/minimal parenting knowledge, etc) impacted the family unit and the child’s mental/emotional health (also seen and measured through use of progress notes and the interim assessment). The interim assessment specifically measures the consumer’s improvements, understating, and implementation as well as practice of the skills obtained during treatment (for clinical component) and acknowledgement of staff modeling and interventions for supervised components. This, in turn, is evident in the number and frequency of staff interventions.</p>
<b>3c</b>	<b>Identify specific factors that contributed to this improvement:</b>

	<ul style="list-style-type: none"> <li>• Families were available and arrived for scheduled appointments</li> <li>• Parents willingness to accept responsibility for their actions and discuss participation in court ordered or recommended services with their children</li> <li>• Family members participated in treatment, practiced and applied skills.</li> <li>• Collaboration with other service providers to identify focus of each provider’s focus as well as team approach</li> </ul>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b></p> <ul style="list-style-type: none"> <li>• One significant barrier lies within the parameters of the program services as requested by the stake holder. It may be beneficial to provide inclusive services for families involved in therapeutic visitation; i.e. parenting groups, individual therapy, child therapy so as to provide a level of “one stop shopping”. In addition, many of the families have simultaneously participated in the various slots/service which presents a lower actual level of service since the units are counted by families not slots.</li> <li>• A second barrier is the available funding which determines the pay rate of professionals, this only allows for entry level clinicians and frequently results in staff turnover.</li> <li>• A third barrier lies within communication lapse between both, DCP&amp;P workers and other service providers.</li> </ul>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b> A unit of service is defined as the number of families that participate in the program.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> <b>504</b> total units, funding from Title IV-B is equivalent to less than 10%</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 330 was the actual level of service (families) for this reporting period. As noted previously, this is not an accurate reflection of service delivery since multiple families utilized various service slots decreasing the number of families served. The request for families to hold multiple slots came from the local offices.</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals:</b> 172 <b># of unduplicated families:</b> 55 (10% funded by IVB) Please note that this number differs from that submitted with the quarterly reports as that number is duplicated per month.</p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results. The</b></p>

	creation and implementation of new surveys is in progress. Feedback has been minimal, however meetings and conferences have focused on proper use of program with agency attempts to increase knowledge and LOS.
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b>  No changes at this time
<b>4b</b>	<b>Identify changes you will make that stem from stakeholder feedback.</b> There has been minimal feedback from stakeholder. We have conferenced proper use of slots and ongoing vacancies. Preferred Behavioral Health Group will continue to reach out to office managers, resource development specials, case practice specialist to gain insight as to how the program can better serve the target population and local offices.
<b>4c</b>	<b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> 504 units of service are contracted; however receipt of referrals continues to be low. This is an overview of the program which only 10% is funded by IV-B
<b>4d</b>	<b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: depends on number of parents and children per family # of unduplicated families: 126 (estimate that each family will participate for a duration of 4 months, currently DCP&P requests no duration be built into the program)
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<b>How will you measure progress?</b> The program will continue use of intakes, treatment plans, and interim assessments to measure the arc of individual and family improvement. In addition, outcome measures will continue to focus on 6-12 month post discharge for invested families. Emphasis will be placed on measuring success as no new allegations of abuse/neglect or out of home placement.
<b>5b</b>	<b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> <ul style="list-style-type: none"> <li>• Continue conferences with the Resource Development Specialists to determine areas of concern, needs, and focus of program services.</li> <li>• Consideration to re-implement the stakeholder surveys (historically these surveys were not completed)</li> <li>• Consumer surveys will continue to be sent at time of program discharge.</li> <li>• Staff will continue to allow flexibility outside appointments to meet with consumers to address program service delivery and goals</li> <li>• Program suggestion box will remain in the reception area</li> </ul>

<b>5c</b>	<p><b>How do you collaborate with community partners?</b>          Program staff provides intensive, efficient, family friendly case management. They not only assist the family in assessing their strengths and develop a plan, they engage in continuous communication with DCP&amp;P to ensure results. Staff participates in Family Team Meetings when invited by consumers, obtains releases from family/DCP&amp;P to discuss progress with other service providers, participates in clinical team meetings, and participates in scheduled &amp; unscheduled case conferences. Preferred Children’s Services operates several family support programs: TANF Initiative for Parents (TIP), Healthy Families, Mobile Response, Family Friendly Center, School Based Programs, Family Support, and Post TANF services. Each of these programs has a strong case management component with a strong network of collaborators. Preferred not only accesses family support programs for consumers easily, it also utilizes existing relationships to accelerate engagement with other service providers and government entities.</p>
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**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>			
<b>1a</b>	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;"><b>Provider:</b> Family and Children’s Services</td> <td style="width: 50%;"><b>1b Program Name:</b> Family Stabilization Services</td> </tr> </table>	<b>Provider:</b> Family and Children’s Services	<b>1b Program Name:</b> Family Stabilization Services
<b>Provider:</b> Family and Children’s Services	<b>1b Program Name:</b> Family Stabilization Services		
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, __X_ FSS, ___TLFRS, ___APSS		
<b>1d</b>	<b>Program Address:</b> 40 North Ave, Elizabeth, NJ 07208 70 West Grand Street, Elizabeth, NJ 07201		
<b>1e</b>	<b>Objective:</b> To prevent an occurrence of abuse or removal of children from their homes by providing brief psychotherapy that will help increase the family’s level of functioning and diffuse the family’s crisis situations.		
<b>1f</b>	<b>Outcome(s) Addressed:</b> ___Safety __X__Permanency ___Well-Being		
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>			
<b>2a</b>	<b>Overview of Service:</b> The program provides a series of comprehensive assessments that help to determine current levels of functioning and behavioral issues that need to be addressed in order to reduce the potential for abuse, neglect, conflict and disruption of the family through the removal of a child/children from the home. Brief psychotherapy is provided to the family along with case management services, when needed, in addition to referrals to ancillary services.		
<b>2b</b>	<b>Population Served:</b> Families who are at risk of child abuse or neglect. Children who are at risk of being placed out of home or losing their current placement.		

2c	<p><b>Geographical Area of Services:</b> Main location is within Union County, NJ and at times surrounding areas.</p>
2d	<p><b>Referral Sources:</b> Union County Local Offices of the Division of Child Protection and Permanency</p>
<p><b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b></p>	
3a	<p><b>Provide a summary of program accomplishments on goals.</b> <b>Include data where available:</b> All families are asked to participate in initial and closing assessments of adult and child behavioral checklists. Treatment plans are coordinated with each family/individual and at least 2 objectives are achieved in order for successful discharge to occur. 187 families completed assessments</p>
3b	<p><b>How did this improve outcomes for children and families?</b> Families/Individuals who participate in initial and closing assessments are able to report a better understanding of their challenges and become more engaged in their treatment and are able to report an increase in family stability and improved family functioning. During the course of the intervention there were no new allegation of abuse and neglect and families remained intact.</p>
3c	<p><b>Identify specific factors that contributed to this improvement:</b> This program is flexible in its ability to provide services for families both in the office and in the home. Clinicians and case managers both work closely with DCP&amp;P in order to ensure clear and ongoing communication about the needs and the progress of the family. Assessments are provided at the onset and closing, with results shared with family members each time to increase the likelihood of engagement in services. Trauma Informed services are also provided when appropriate.</p>
3d	<p><b>Identify significant barriers to goal accomplishment:</b> Several factors can prove to be a barrier. Clients who view their participation in services as mandatory may not engage well in treatment and therefore may refuse or be reluctant or may be inconsistent in participating in services. Lack of consistent transportation may be an issue for some families who are mandated to receive services in office. Some clients have substance abuse issues and are inconsistent in their substance abuse treatment.</p>
3e	<p><b>Definition of Level of Service as per contract:</b> 1 unit of service = 1 family served every 6 months</p>
3f	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b> 62 families</p>
3g	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 175 families</p>

3h	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p><b># of unduplicated individuals: 223</b>  <b># of unduplicated families: 175</b></p>
3i	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>          Feedback regarding satisfaction of services was acquired through ongoing contact with DCPD via phone and meetings, In addition to client satisfaction surveys which were generally positive.</p>
<p><b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b></p>	
4a	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b>          Evidenced based practices will be incorporated in the treatment through the use of Trauma Focused Cognitive Behavioral Therapy and Attachment Regulation Competency.</p>
4b	<p><b>Identify changes you will make that stem from stakeholder feedback.</b>          None indicated</p>
4c	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b>          62 units</p>
4d	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>  <b># of unduplicated individuals: 186</b>  <b># of unduplicated families: 62</b></p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
5a	<p><b>How will you measure progress?</b>          Levels of functioning are assessed through the use of Child Behavior Checklist and Adult Self Report scores in addition to clinician report of improvement and attainment of treatment goals. Additionally, clients in need of trauma informed services participate in the PTSD reaction index that also measures decreases in reactive symptoms.</p>
5b	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b>          Family and Children’s services works closely with DCPD, uses client record reviews, client satisfaction surveys and communication with other community providers to assess further community needs and enhance current programs to meet those needs.</p>
5c	<p><b>How do you collaborate with community partners?</b></p>

	Clinicians, case managers and supervisors are available to participate in Family Team Meetings and all work together to link families to community resources and additional supports.
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**2017 PSSF Update Report**

<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Robins’ Nest
	<b>1b Program Name:</b> Family Ties
<b>1c</b>	<b>Relevant PSSF Program:</b> ___FPS, ___ FSS, <u>X</u> TLFRS, ___APSS
<b>1d</b>	<b>Program Address:</b> 42 S. Delsea Drive, Glassboro, NJ 08028
<b>1e</b>	<b>Objective:</b> The goal of the program is to help attain permanency for children in out of home placement by facilitating visits between parents and children; assisting parents in their ability to meet their child’s physical, emotional and developmental needs during visits.
<b>1f</b>	<b>Outcome(s) Addressed:</b> ___Safety <u>X</u> Permanency <u>X</u> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b> This program assists with permanency planning in a manner consistent with the Adoption and Safe Families Act (ASFA). The program provides services that address the goals of: supporting parent/child relationships; providing parents with opportunities to learn and practice new skills; decreasing the length of time children remain in out of home placement; successfully reunifying children with parents or relatives; and providing documentation to support permanency planning.</p> <p>Services provided include: transporting children to and from visits; supervising visits; coaching parents on their parenting skills, debriefing after each visit to reinforce what went well and to plan ways to meet their child’s needs during future visits, collaborating with those involved and providing comprehensive relevant documentation regarding our observations and interactions.</p> <p>During visits, staff assess and document the parent's parenting skills and interaction with their children. Staff utilize Visit Coaching which supports the parents in meeting their children’s needs and building upon their strengths. Staff intervene as needed to ensure the child's physical and emotional safety and to teach, model, and coach parenting skills. Staff utilize feelings exploration while transporting the children to and from visits to help the children process their feelings.</p> <p>A therapist may become involved, partnering with the visit coach to effectively address the families’ needs related to their child’s permanency. The therapist can work with the parent</p>

	<p>and/or children; addressing a variety of topics, including issues that are impacting the progression of visits, preparing for successful reunification, educating parents on the impact out of home placement has on children, as well as exploring ways to reestablish trust and a sense of security and stability for their children. The degree of involvement of the therapist is determined through the assessment process and collaboration with the Division and the Family Ties Program Director and visit coach.</p> <p>The progressive nature of our visits allows parenting responsibilities to be gradually shifted back to the parent. Typically visits begin with two-hour fully supervised visits in the parent’s home and may progress to partially supervised day visits, overnight visits, and extended visits.</p> <p>If the family is reunified during the visitation component of the program, they can receive up to three months of in-home post-reunification services. Once post-reunification services end, families receive follow-up phone calls at 6 and 12 months post reunification. Throughout the entire program, the parent has access to their FT visit coach and therapist (if applicable) 24 hours a day, 7 days a week. The parent is encouraged to call for assistance before a problem or situation escalates, placing the children at risk.</p>
<b>2b</b>	<p><b>Population Served:</b>                  DCP&amp;P involved parent whose children (birth to 18) are in an out of home placement in our service area and in the legal custody of DCP&amp;P.</p>
<b>2c</b>	<p><b>Geographical Area of Services:</b>                  Parents and children who reside in Burlington, Camden, Gloucester, Salem, Cumberland, Atlantic, and Cape May counties in New Jersey.</p>
<b>2d</b>	<p><b>Referral Sources:</b> The Division of Child Protection and Permanency local offices from within our geographic coverage area refer to our program.</p>
<p><b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b></p>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b>  <b>Include data where available:</b>                  A primary goal of the program is: 85% of the cases will achieve permanency within 12 months of case assignment. Between 10/1/15 - 9/30/16, FT provided visits to 134 families. Forty-eight families reached a permanency disposition by 9/30/16, 45 (<b>94%</b>) achieved permanency. Of the 45, 36 families were reunified.</p> <p>Another goal of the program is for 90% of parents to achieve or partially achieve their service plan goals. Of the 57 families who reached a case disposition by 9/30/16, 211/229 (<b>92%</b>) of their service plan goals were either achieved or partially achieved.</p> <p>A third goal of the program is for 95% of reunified children/families to have no new substantiated allegations of abuse or neglect within twelve months after reunification. Between 10/1/15 – 9/30/16, <b>95%</b> (36 of 38) had no new substantiated allegations after 6 months of being reunified and <b>91%</b> (42 of 46) had no new substantiated allegations after 12 months of being reunified.</p> <p>A fourth goal of the program is for 90% of parents to improve in readiness/parental capacity as measured by the North Carolina Family Assessment Scale – for Reunification (NCFAS-</p>

	<p>R). Of the 54 families with pre and post NCFAS-R results, 49 (<b>91%</b>) improved in readiness/parental capacity, with <b>97%</b> of reunified families improving in readiness/parental capacity.</p>
<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b></p> <p>By helping children achieve permanency, the children were able to begin to heal from their past and move forward in planning for their future in a safe, stable home environment.</p> <p>By helping parents improve their parental readiness and parental capacity, more families reunify and parents are able to meet the physical, emotional and safety needs of their children so they remain reunified.</p> <p>By maintaining reunification without further substantiated allegations of abuse and neglect, we help support the child’s emotional and developmental needs for continuity and stability in family and community relationships and help reduce the trauma that is caused when children live in abusive environments or have continual placement disruptions.</p>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement:</b></p> <p>The progressive nature of our visitation is tremendously beneficial. It allows for extended assessment, opportunities to practice learned parenting skills and provides comprehensive documentation of the parents’ abilities and parent-child interactions as we work with DCP&amp;P to gradually shift parenting responsibilities back to the parent. Our use of Visit Coaching provides families with a strength-based approach to identifying their children’s needs and meeting them all on an individual basis. Staff provide support, empowerment, modeling and feedback throughout each visit.</p> <p>Family Ties conducts a monthly therapeutic/support group for reunified families and families about to reunify. The group is conducted by a Master’s Level therapist and provides families with peer support. Peer support and treatment in a group setting have been found to increase the likelihood of families maintaining success.</p> <p>Our therapeutic component to the program allows families to engage in individual and family therapeutic interventions during the process of visitation and during post-reunification. The therapeutic component partners with the Visit Coaching by addressing the families’ needs around the child’s permanency, such as the impact of separation and rebuilding trust and security.</p> <p>Our three months of in-home post-reunification services provide support to recently reunified families through their transition home, helping them stabilize and preventing placement recurrence.</p>
<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment:</b></p> <p>Many parents have a history of severe and chronic mental health issues. Many parents also have a history of or currently use substances, both prescription and illegal. Parents also have a history of domestic violence. Any of these concerns could delay or prevent visits from progressing or may cause progressed visits to regress.</p> <p>We are addressing these issues by helping parents advocate for appropriate diagnosis and treatment, as well as utilizing the therapeutic component of the program to educate parents on their diagnosis and what it means for their future. We are also looking at their cases through a trauma lens. This trauma lens is helping to set realistic goals with clients and</p>

	<p>better define effective intervention techniques. FT visit coaches are also collaborating with case workers in order to link parents to necessary services. Staff also utilize the DCP&amp;P Domestic Violence Liaison as needed. Staff also have unlimited access to My Learning Point, a web-based training system in which training is readily available. Some of the many relevant topics include foster care, trauma, child development, domestic violence and substance abuse.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b>  Units of service are defined as visits for the visit coach and session hours for the therapist. A visit is defined as one hour with the visit coach observing the parent and their children. The same definition applies if the parent does not attend the visit, but the visit still takes place so siblings who do not reside in the same out of home placement can visit with each other. If a visit coach picks up a child for a visit and the visit does not take place, the visit coach will get credit for the visit due to the time invested in transporting the child.</p> <p>If the travel time for one visit coach to transport more than one child exceeds 2.5 hours because the case involves multiple counties, then two visit coaches may be assigned and each visit coach will count one visit for each hour spent in the visit. In addition, there will be a ratio of one visit coach to three children unless all three children are under the age of five. If the ratio is exceeded, then additional visit coaches will be assigned and each visit coach will count one visit for each hour spent in the visit.</p>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b>  (42% of contract is Title IV-B funded)  3800 contracted visits; 1596 Title IV-B funded visits  850 contracted therapeutic hours; 357 Title IV-B funded therapeutic hours</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b>  1521 (95%) visits and 379 (106%) therapeutic hours provided with Title IV-B funding.</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  <b># of unduplicated individuals:</b> 358  <b># of unduplicated families:</b> 134</p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>  -100% of families surveyed were either very satisfied or satisfied with their relationship with the Family Ties visit coach.  -100% of families surveyed were either very satisfied or satisfied with the program services.  -100% of referral sources surveyed were either very satisfied or satisfied with the Family Ties visit coach.  -100% of referral sources surveyed were either very satisfied or satisfied with the program services.</p>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p>

	<p>Family Ties staff will engage in a Visit Coaching training to enhance their visit coaching skills, as well as their documentation. Visit coaching will continue to be used to empower parents to successfully meet their children’s individual needs.</p> <p>Family Ties staff will continue to engage in trauma-focused training in order to be more informed and equipped in addressing trauma that families have experienced, not only in the past but the trauma related to the removal as well.</p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b>                  We are training staff on new progress note documentation in order to better provide DCP&amp;P concise and relevant visit information. Staff will attend a training on utilizing a GIRP note (Goal, Intervention, Response, Plan), which will link the Family Interaction Plan goals to the progress of the parent in meeting their child’s needs during visits.</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b>                  (42% of contract)                  1596 visits and 357 therapy session hours</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>                  # of unduplicated individuals: 120                  # of unduplicated families: 50</p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b>                  The parent’s customized family interaction plan identifies specific and measurable needs and objectives that drive staff’s interventions. Families with therapeutic involvement have a family interaction plan not only with their visit coach, but a coordinating treatment plan with their therapist to address therapeutic issues. Goals are reviewed and tracked after 90 days and at the end of services to determine the areas of progress the family made.</p> <p>Follow up phone calls with the reunified families provide data on whether the family is stable and still reunified at 6 and 12 months post reunification.                  The NCFAS-R will continue to be used as a pre and post assessment tool in order to determine improvement in significant life domains, including readiness/parental capacity from the beginning of our services to the end.</p>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b>                  All agency programs track performance outcomes on a monthly basis, using a Program Performance Scorecards, highlighting areas where outcomes have been exceeded, met or fall short of the benchmark. This data get reviewed at the Quality, Risk and Compliance meeting with upper management. The agency’s Child Protection and Permanency Department Director meets quarterly with the program director and program staff to review program performance results and discuss how to maintain successes and improve areas in need of enhancement.</p> <p>During opening paperwork, parents are given the opportunity to participate in a confidential phone survey during the visit component of the program. Parents are randomly selected and contacted for their feedback. Receiving feedback while we are still providing services to</p>

	<p>the parent allows us to adapt our services and improve customer satisfaction.</p> <p>Internal record reviews are conducted quarterly to monitor and enhance quality of services and documentation.</p> <p>At the end of the program, the parent is given a confidential self-administered mail survey with a pre-stamped envelope to provide their feedback. A percentage of randomly selected DCP&amp;P caseworkers receive an e-mail asking them to participate in a confidential survey. These surveys ask the parent and caseworker to indicate their level of satisfaction with the visit coach/therapist and program services.</p>
<p><b>5c</b></p>	<p><b>How do you collaborate with community partners?</b></p> <p>In addition to a strong DCP&amp;P-Family Ties partnership, staff has established relationships with community providers involved in the family’s treatment. Staff recognizes that family’s outcomes are better when there is timely open communication and collaboration amongst those involved with the family. Staff willingly participates in Family Team Meetings when requested and encourage families to enhance their formal and informal support system. Our relationship with these community providers helps us link families to the community services and resources they need.</p> <p>The Family Ties program also collaborates with the community Family Success Centers. Through this community partner, families are able to get connected to information, support and programs in their county.</p>

Section C  
Populations at Greatest Risk of  
Maltreatment  
&  
Services for Children under the  
Age of Five

## **Services to Populations at the Greatest Risk of Maltreatment to include Children under the age of Five**

DCF has done extensive analysis through the Manage by Data Fellows program and through the Office of Research, Evaluation and Reporting to identify risk and protective factors related to post reunification maltreatment. DCF has found that in addition to children under 5 being at risk for future maltreatment, children who are frequently encountered by the child welfare system are also at highest risk. These are children that had three or more reports (either CWS or CPS) in the year prior to their placement into foster care. Additionally, children with caregivers struggling with substance use, mental health challenges and domestic violence were all at increased risk of post reunification maltreatment. In fact, children whose caregivers were struggling with both substance use and mental health challenges were more than twice as likely to experience maltreatment after reunification.

However, DCF was able to identify an important protective factor, formal kinship involvement with the child's case as either a resource caregiver or discharge to a relative. When kin are involved in the child's case, children were half as likely to experience post reunification maltreatment, even with parents who were struggling with multiple complex challenges such as substance use and mental health challenges. Moving forward, DCF will focus the work of the Manage by Data Fellows program to look at children receiving services in their own home after experiencing abuse or neglect. DCF will examine risk and protective factors toward understanding why some children experience subsequent maltreatment and require placement into foster care. For information regarding outcomes please see the New Jersey Child Welfare Outcomes Report:

<http://www.nj.gov/dcf/childdata/exitplan/Outcomes.Report.and.Executive.Summary-2017.pdf>

The Division of Family and Community Partnerships' (FCP) goal is to build a continuum of child abuse prevention and intervention programs that are culturally competent, strengths-based and family-centered, with a strong emphasis on primary child abuse prevention. The Standards for Prevention Programs developed by the New Jersey Task Force on Child Abuse and Neglect, defines prevention efforts as follows:

**Primary Prevention** targets the general population and offers services and activities **before** any signs of undesired behaviors may be present; there is no screening.

**Secondary Prevention** is directed at those who are "**at risk**" of possibly maltreating or neglecting children. Determining who is at risk is based upon etiological studies of why maltreatment may occur. Secondary prevention efforts and services are provided before child abuse or neglect occurs.

**Tertiary Prevention** is provided **after** maltreatment has occurred, to reduce the impact of maltreatment and to avoid future abuse. Tertiary Prevention is treatment, working with children who have been abused, or working with families where abuse has occurred.

FCP is committed to provide the resources and technical assistance needed to maintain a robust network of public/private partnerships and programs. Schools and community-based organizations are two prime locations for prevention and intervention services. These two portals are the broadest access to services for families. FCP and the Division on Women (DOW) provide services to all of the priority populations identified by the Child Abuse Prevention and Treatment Act (CAPTA); including parents of young children, racial and ethnic minorities, children with disabilities, parents with disabilities, homeless families and those at risk of homelessness, unaccompanied homeless youth, adult former victims of child abuse and neglect and/or domestic violence, and members of underserved or underrepresented groups such as fathers. These populations live in and access services in all 21 counties in New Jersey.

### **The Division of Family and Community Partnerships Offices**

Assembled of three primary offices, the Division of Family and Community Partnerships (FCP) strives to carry out the priorities of the NJ Task Force on Child Abuse and Neglect Statewide Prevention Plan, the DCF Strategic Plan, and the Standards for Prevention Programs. Division Administrators and staff actively engage community stakeholders through ongoing prevention activities at the state and local level. Collaborations with public agencies, private non-profit organizations, faith-based groups, parents, and additional consumers assist in building a comprehensive continuum of family centered prevention services for children and families. FCP offices include:

#### **Office of Early Childhood Services (OECS):**

OECS has been integrally involved in New Jersey's development of a comprehensive and seamless system of care to link pregnant women and parents with necessary health and social support services. OECS works across State Departments and with state and local advocates to ensure that services and supports effectively reach families early, before birth, to prevent child neglect and abuse. Prevention focused initiatives including Evidence Based Home Visiting, Central Intake, Strengthening Families, County Councils for Young Children, The Early Childhood Comprehensive Systems Grant/Help Me Grow, and Project Linking Actions for the Unmet Needs in Children's Health (LAUNCH), are housed in OECS.

#### **Office of Family Support Services (OFSS)**

OFSS collaborates with community entities in an effort to coordinate and consolidate services provided to families and children. Responsible for the long term development of New Jersey's Family Success Centers and Kinship Navigator Program, OFSS ensures the prosperity, growth, and adaptability of these programs to ensure children and families are receiving appropriate and beneficial services.

#### **Office of School Linked Services (OSLS)**

New Jersey school districts and various non-profit organizations provide a wide array of prevention and support services to youth in public elementary, middle, and high schools. Capitalizing on these services, OSLS contracts and works in partnership with a number of these districts and organizations throughout the state. As a result, young people, and at times their families, are able to access services such as mental health services, employment assistance, substance abuse counseling, preventive health care, violence prevention programs, learning support, mentorship, teen parent skill development, and recreation programs. Initiatives such as School Based Youth Services, Child Assault Prevention, 2<sup>nd</sup> Floor Youth Helpline, Adolescent Pregnancy Prevention, Traumatic Loss Coalition, Family Friendly Centers, Parent Linking Program, Prevention of Juvenile Delinquency, and Newark School Based Health Centers are based in OSLS.

### **The Division on Women Offices**

Also aiming to align services with New Jersey's established prevention priorities, the Division on Women (DOW) continues the tradition of advocating for women's rights and opportunities through funding and collaborating with organizations, agencies and programs that provide a variety of services to the women and families of New Jersey. The staff develop, promote and expand women's rights in the areas of poverty and welfare, employment and wages, work and family, economic and social aspects of healthcare, violence against women, and women's civic and political participation in their communities. Offices within DOW consist of:

#### **Office of Domestic Violence Services (ODVS)**

ODVS works with community stakeholders in an effort to improve and enhance services that are culturally-competent, strength-based, empowering, accessible, and non-stigmatizing to those who voluntarily request services. ODVS core services were identified in collaboration with the New Jersey Coalition for Battered Women, now the NJ Coalition to End Domestic Violence (CEDV), and the provider community. These services are regarded as essential program components to meet clients' needs on a short and long-term basis. In addition to the domestic violence shelters, legal services and statewide hotlines, the Safety and Accountability Assessment, the Domestic Violence Liaisons, Peace: A Learned Solution, and the Batterers Intervention initiatives are implemented by ODVS.

#### **Office of Support, Employment and Training (OSET)**

With the implementation of the Displaced Homemakers program, OSET offers women opportunities to learn self-sufficiency skills through furthering their education, learning job and computer skills, and eventually obtaining gainful employment.

#### **Office for the Prevention of Violence Against Women (OPVAW)**

Focusing on victims and survivors of sexual violence, OPVAW provides primary, secondary, and tertiary prevention efforts throughout New Jersey communities. Funding is provided to domestic violence programs and sexual assault programs for research and projects that aim to prevent violence against women and to improve delivery of services to domestic violence and sexual violence survivors. Primary prevention efforts are provided through Rape Prevention and Education (RPE) services and the Sexual Offense Set Aside (SOSA) grant program. Secondary and tertiary prevention efforts are funded with various state and federal funding sources and include the Sexual Assault, Abuse and Rape Care (SAARC), Sexual Assault Services Program (SASP), and the Address Confidentiality Program (ACP).

#### **Division of Family and Community Partnerships Initiatives**

FCP, in collaboration with DOW, is leading child abuse and neglect prevention activities in the State of New Jersey through the implementation of a wide array of initiatives. FCP and DOW Administrators and staff continuously strive to identify and implement programs and initiatives which will strengthen families and promote child well-being. Collaboration and partnerships in addition to activities with a focus on Prevention Plan priorities allow for a continuum of holistic services to be offered throughout the State.

#### **Office of Early Childhood Services Initiatives**

In FFY 2016, Strengthening Families Child Care, the Cumberland County Council for Young Children, ECCS/Help Me Grow NJ, and the Early Childhood Outcomes Initiative in the Office

of Early Childhood Services' (OECS) received CBCAP funding. CBCAP funding also supported the Bringing the Protective Factors to Life Training of Trainers in FFY 2016.

**Strengthening Families (SF)** is implemented through lead agency FCP and with a Memorandum of Agreement (MOA) with the Department of Human Services' (DHS) Division of Family Development (DFD). **SF** targets all 21 counties in New Jersey through collaborations with Child Care Resource and Referral Agencies (CCR&R's). The initiative receives blended funding from CBCAP and state funds. The main objective of **SF** is to facilitate, monitor, expand, and enhance community-based prevention focused programs and activities designed to strengthen and support families to prevent child abuse and neglect. **SF** is an approach to preventing child abuse and neglect by strengthening families through early care and education settings. The Center for the Study of Social Policy (CSSP) developed the **Strengthening Families Protective Factors Framework (SF-PFF)** with the fundamental principle that certain protective factors contribute to family resiliency and strength.

The Child Care Resource and Referral Agencies staff responsible for the implementation of **Strengthening Families** must complete New Jersey's **SF** trainer requirements prior to working with child care providers. Once training is complete, the CCR&R **SF** staff member is able to work with participating child care providers, both in centers and family child care settings, to train staff in the **SF-PFF** and offer on-site technical assistance for integrating the protective factors into their work with families. Trainers are required to provide a minimum of twelve hours of training to child care staff and parents, conduct monitoring visits, and ensure all requirements of a participating **SF** center are complete. Additional trainings and stakeholder meetings are offered by CCR&R staff for community service providers. Trainers assist child care providers in developing innovative means to incorporate the **SF-PFF** in everyday actions and interactions with families and children. Currently there are 30 Strengthening Families trainers in all CCR&Rs throughout New Jersey. Integrating the **SF-PFF** allows parents to grow confident in parenting skills and abilities to develop socially and emotionally healthy children. Participating child care providers conduct a self-assessment of the center, including staff and family interactions, and develop a work plan to improve communication, collaboration and interaction with children and families. This work plan also provides opportunities for parents to participate in planning and implementing activities with their childcare provider. Child care providers collaborate with local partners, local school districts, public libraries, the Division of Child Protection and Permanency (DCP&P) and other community agencies to ensure that parents and families are connected to needed resources.

The Office of Early Childhood Services (OECS) **SF** staff provides oversight of the training and technical assistance grants issued to the CCR&Rs in each county. OECS staff provide program development and management, data collection, evaluation and analysis; facilitate training and technical assistance meetings with the CCR&R staff to introduce new community partners at least quarterly; conduct periodic site visits to county level grantees; and offer informal technical assistance as needed.

**Strengthening Families** continues to progress in New Jersey. FCP collaborates with other Early Childhood partners such as the Department of Human Services, Division of Family Development, Department of Education, NJ Council for Young Children (NJCYC), NJ Head Start/Early Head Start Collaboration Office, college-level early childhood educators, Department of Health Prevent Child Abuse NJ, Montclair State University, Center for Autism and Early Childhood Mental Health and Professional Impact New Jersey (PINJ), NJ's designated early childhood state registry; resulting in the infusion of the protective factors and family support

principles into NJ's early childhood credentialing curriculum. In FFY16, the Strengthening Families initiative served 649 children.

Offering the “**Bringing the Protective Factors Framework to Life in Your Work**” training to early childhood professionals throughout the State allows for further integration of the **Strengthening Families Protective Factors Framework** in various early childhood systems. **SF** is implemented in 126 childcare centers and family child care homes in all 21 counties. An estimated **5,281 children and 4,540 families** received information and support from **SF** this year. In addition, centers that enrolled in the Grow NJ Kids Quality Rating Improvement System are also learning about **SF** and the **Protective Factors Framework** through the technical assistance of the Quality Improvement Specialists. This initiative is being implemented through the Department of Human Services' (DHS) Division of Family Development (DFD). Similarly, the DOE's Community and Parent Involvement Specialist are assigned to the 32 school districts that are state funded preschools to develop relationships with parents and encourage their participation in activities in the school and community.

**County Councils for Young Children** as stated earlier is a partnership of DCF, DOE, DOH, DHS and the New Jersey Council for Young Children (NJCYC). The goal of the **CCYCs** is to facilitate active, strong and successful community engagement with input from parents and other interested community members. Parents and community members are encouraged through participation on the **CCYC** to come together as active partners to share and learn about issues that affect the health, education and well-being of pregnant women and their children; offer ideas, opinions and solutions for ways to build stronger connections for children and families through the lens of the Protective Factors Framework; and build a successful collaboration while achieving the identified objectives. The **CCYCs** throughout the state identified employment and transportation as major obstacles for families and they are working to find ways to support the needs of the parents/caregivers so that they are able to meet the need and provide for the children that are in their care. DCF will connect with our state partners to help facilitate a platform for the **CCYCs** to connect with these state entities at the local level within the next fiscal year. The Protective Factors Framework will continue to be infused in the work of the **CCYCs** so that parents and practitioners alike will become grounded in the Protective Factors framework. There are seven core elements of the County Councils for Young Children which each of the 21 councils will strive to attain. These priorities include:

- **Shared Leadership:** Parents, caregivers, and agency or organization representatives share the leadership roles of the **CCYC** to ensure success.
- **Recruitment:** Each council is required to recruit and retain parents, caregivers, and agency or organization representation as active members. This is an ongoing responsibility of all members. Special consideration should be given to recruit families with children (birth-age eight), early learning programs, education systems, health services, and Early Intervention services.
- **Parent Leadership:** Councils must select a parent leadership curriculum which will guide the process of training for parents and providers to collaborate and accomplish the goals of the **CCYC**.
- **Committees:** Working committees must be established which will accomplish the work of the council, with a steering committee at the lead.
- **Election of Leader:** Council members will elect co-chairs for committees.

- **Environmental Scan:** Councils will conduct a joint needs assessment, environmental scan, and strategic planning process in order to identify gaps in services to inform priorities for the work of the CCYC.
- **Consultation:** CCYCs will provide input to improve early childhood service coordination and systems integration through collaboration with Central Intake, Community Health Workers, and Grow NJ Kids.

Successfully achieving all of the core elements of the **CCYCs** will allow for members to inform, impact, and develop local and state policies, services, and/or practices for improved responsiveness to the needs of families and children in the county and state. Efforts of the **CCYC** will also inform professional development and training opportunities for the local workforce to support proposed policies, services, and practices.

The **CCYCs** utilize local data to guide the work of the councils. They are encouraged to use state, county and municipal census data, NJ Kids Count, NJ Department of Education – NJ School Performance Reports and the Department of Health vital records to name a few resources. The **CCYCs** served 1,609 unduplicated parents/community residents and 839 professionals/community stakeholders in FFY 2016.

**Grow NJ Kids** is a collaborative effort among DCF, the Department of Education (DOE), and the Department of Health and Human Services (DHS) which aims to raise the quality of early care and education for infants and children from birth through pre-school. This quality rating and improvement system hosts a two-pronged approach to quality improvement. It will assist early care and education providers in continuously improving the quality of their programs, and provide parents and caregivers information to guide them to make informed decisions when selecting child care. **Grow NJ Kids** provides the framework for child care programs to continue to meet high quality standards. **SF** principles and the Protective Factors Framework are included in the Family and Community Engagement standard of **Grow NJ Kids** and are integrated into child care centers with the assistance of CCR&R **SF** trainers.

Since April 2012, OECS has been the lead office for **Early Childhood Comprehensive Systems (ECCS) Grant** and an affiliate of the Help Me Grow National Center. **Help Me Grow (HMG)** promotes development of an integrated early childhood system that supports women beginning at pregnancy, children up to age eight and families to achieve optimal wellness. **HMGNJ** is building upon New Jersey's strong foundation in early childhood services to improve coordination and integration, and streamline services across systems of care that encompass four core departments: Health; Human Services; Education; and Children & Families. As a result, pregnant women and parents and families of infants and young children will have easier and earlier access to a range of prevention, early identification, early intervention, and treatment services to promote healthy pregnancies and births, positive infant/child growth and development, and nurturing parent-child relationships. Through the work of various workgroups, **ECCS/HMGNJ** goals are to focus on promoting a comprehensive, coordinated preventative health and early childhood system that addresses the physical, social-emotional, behavioral and cognitive aspects of child wellness from pregnancy to three. **Help Me Grow NJ** continued to expand partnerships and provided additional services throughout FFY 2016 with the support of CBCAP funding.

The **Early Childhood Outcomes (ECO)** initiative began in June 2015 in Newark, New Jersey; a location which displays a high risk for child maltreatment and high rates of substantiation of

child maltreatment. Seeking to provide DCP&P frequently encountered families of infants and young children with services from a prevention and strengths based perspective, an enhanced case model has been developed, emphasizing improved assessments, planning, and service access while also building systems integration. Offering the “Bringing the Protective Factors Framework to Life in Your Work” training to CP&P staff in Essex County was a first step in the implementation of **ECO**. This initiative is a profound effort in strategically improving the child protection and permanency work in New Jersey and could potentially improve policies, practices and procedures for investigating and supporting families within the CP&P system. To support the objectives and reach the anticipated outcomes of the **ECO** initiative, FCP OECS hired an Early Childhood Liaison to provide oversight, recommendations and general consultation regarding the families who are referred to DCP&P. The Early Childhood Liaison is located in Essex County and serves the six local DCP&P Offices participating in this initiative. The overall goal of the Early Childhood Liaison is to provide consultation to the DCP&P intake unit staff to guide the assessment of the family and to recommend services that will strengthen the family and the parent/child relationship. The short term outcomes of staff development, enhanced planning, assessment, and service access, and systems collaboration are achieved through an enhanced case conferencing model and significant collaboration with various early childhood providers. Improved systems access and collaboration is achieved through partnerships with local community agencies and resources. This case consultation can be provided for any family with young children under the age of five, not solely those families who are identified by the initiative. The Liaison works with both the DCP&P staff and community partners to provide a “warm handoff” for families to the resources and services recommended, and to enhance teaming and collaboration.

An additional component to the ECO initiative is the enhanced group case conferences. Each week, one family within each Essex County DCP&P Local Offices participants in an Enhanced Conference. Conference participants include the DCP&P intake staff, Early Childhood Liaison, Domestic Violence Liaison, Mental Health Consultant, and Certified Alcohol and Drug Consultant. The Essex central intake and other community partners are invited to participate, as applicable. During the conference, there is an in-depth assessment of risk and Protective Factors and an initial service plan is developed. The enhanced case conferences that included an Early Childhood Liaison( Level IV endorsement in Infant Mental Health) and the control group ( no enhancements provided).

The overarching goal of this initiative is to improve outcomes for infants, young children and their families (primary focus on children birth to age 3,) who come to the attention of CP&P. The focus of the initiative is to decrease risk of child maltreatment and decrease multiple CP&P investigations; increase protective factors; and improve physical, intellectual, social, and emotional health of children and caregivers; decrease out-of-home placements, support timely reunifications, and decrease rates of re-entry where applicable; and use quantitative and qualitative data for decision-making and increased use of evaluation approaches to measure effectiveness for Continuous Quality Improvement.

#### Findings to date:

The case conference intervention did result in improved exploration of family risk and protective factors, services and supports for families, and improved service plans. Specifically, the case conference process had a greater influence on perceptions of risk and protective factors, as well

as services, than traditional supervision. CP&P staff felt the case conferences were beneficial and had an impact on their approach with families in at least half of the cases. Lastly, families in the intervention group were connected with more services than those in the control group.

Other Findings:

The case conference intervention did result in improved teaming and collaboration between CP&P staff and early childhood community-based providers in the form of assistance with referrals. Home visits were not likely to occur and intervention cases were no more likely to receive these than control cases. Early-childhood community-based services were more likely to become part of the case plan for families in the intervention group than the control group. Parents in the intervention group were more willing to participate in services, although the differences between groups were not statistically significant. Cases in the intervention were more likely to open for CP&P services following the investigation process.

FCP supported seven **Central Intake** sites. By FFY 2014, the Department of Health (DOH) supported **CI** in eight additional counties. MIECHV formula and competitive funding was utilized to support **CI** in the seven counties supported by FCP. In August 2014 DOH, utilizing Race to the Top Early Learning Challenge funding out of the Department of Education (DOE) released an RFP to expand **CI** in the remaining six counties. **Central Intake** is now in all 21 counties and has integrated healthcare, child care, education, and family support services using a life course model. Seven **CI** sites continued to be funded through FCP and 15 are funded through DOH, which has led to enhanced collaboration across all three State Departments.

**OECS Central Intake** sites utilize the Single Point of Entry and Client Tracking System (SPECT), which is designed to integrate the users of prenatal providers, MCOs, and community organizations that rely on the Perinatal Risk Assessment (PRA) and CHS form to provide comprehensive care to pregnant women. In July 2016 the Early Childhood Outcomes Initiative was added to the SPECT system, allowing better tracking and monitoring methods for referrals made by the Division of Child Protection and Permanency to the Early Childhood Liaison. While 73 successful connections to services were documented, another 48 referrals were made throughout the fiscal year. SPECT will continue to be used by the ECO initiative to document future referrals.

In order to measure the projected outcomes and the successful implementation of this initiative, FCP received a grant through Casey Family Programs to contract with Rutgers School of Social Work to complete an evaluation. The evaluation will entail interviews, focus groups and surveys of families and program staff. While any family with children under the age of five can have a case conference and consultation with the Early Childhood Liaison, families must give consent to be included in the evaluation of this initiative. Though the initial report of findings was expected in summer 2016, Rutgers continues to finalize the findings of this evaluation.

**Project LAUNCH (Linking Actions for Unmet Needs of Children's Health)** is an essential initiative in OECS for the prevention of child abuse and neglect efforts. The mission of **New Jersey Project LAUNCH (NJPL)** is to link and enhance efforts to improve overall young child wellness in Essex County. With the support of the Substance Abuse and Mental Health Services Administration (SAMHSA) and DCF, **NJPL** brings together culturally competent, evidenced-based programs that address the physical, social, emotional, behavioral and cognitive well-being of children birth to eight years old, along with targeted training for providers, families and early

childhood partners across sectors statewide. By providing targeted training and the necessary tools for families and early childhood partners across sectors; health/behavioral health, home visiting, childcare and early childhood education, early intervention, infant-child mental health, child welfare and family support; a comprehensive, coordinated system that supports child and family health and eliminates racial and ethnic disparities is created. In September 2013 OECS received a five year federal grant from SAMHSA to confirm the sustainability of **NJPL** and ensure New Jersey's children are thriving in safe, supportive environments.

### **Office of Family Support Services Initiatives**

**Family Success Centers (FSCs)** are a primary focus of OFSS. **FSCs** provide community-based, family-centered neighborhood gathering places where community residents can go for family support, information, referrals and access to services at no cost to them. State and CBCAP funds support a network of **FSCs** as “one stop” sites to provide wrap-around resources and supports for families before they find themselves in crisis. Services provided by **FSCs** include, but are not limited to:

- Providing information and referrals for local services
- Advocating for families to receive services
- Providing opportunities for families to make social connections
- Participating in annual Strengthening Families event
- Offering group activities regarding topics such as:
  - Parent education/parent child activities
  - Life Skills
  - Family Health
  - Housing
  - Employment
  - Caregiver and Senior Outreach

New Jersey's statewide network of **Family Success Centers (FSCs)** continues to expand through funding and support from the Division of Family and Community Partnerships (FCP). These “one-stop shops” provide wrap-around resources and supports to keep families from experiencing crisis. **FSCs** are neighborhood-based gathering places which offer community residents an array of resources and services at no cost. New Jersey has one of the only statewide systems in the United States with publicly supported **Family Success Centers**.

The primary goal of **FSCs** is to strengthen families and empower individuals to acquire the knowledge and skills necessary to build successful families and raise healthy, happy children. **FSCs** offer primary and secondary child abuse prevention services, and bring together community agencies, residents, parents, and leaders to address issues which compromise the safety and stability of families and the community. With the overarching goal of preventing child maltreatment, the activities and services provided by **FSCs** strengthen individual and family functioning, enhance parental capacity for growth and development, increase the stability, health and well-being of children and families, and empower community residents to acquire the knowledge, skills and resources required to succeed and provide optimal outcomes for children and families.

Six **FSCs** operated with CBCAP funding in FFY 2016. Though 58 **FSCs** operate to date, each operates at varying levels of capacity. Well established **FSCs** are balanced with numerous **FSCs** at the beginning stages of development and operation. CBCAP funding was distributed to **FSCs** across the spectrum of development. Providing insight to **FSCs** in high functioning capacities, as well as those in beginning stages of operation, offers the opportunity for CBCAP funded **FSCs** to display varying levels of barriers and improvements. CBCAP funded **FSCs**, as with all **FSCs**, are encouraged to continue evaluating and enhancing their practice.

CBCAP funded **FSCs** in FFY 2016 included those in Cape May County, Somerset County, Hunterdon County, Morris County, Cumberland County, and Gloucester County. Monthly **FSC** reports which grantees submit to OFSS staff are cleaned and compiled to develop a comprehensive report of the **FSCs** level of service, types of services and activities provided and basic demographics. In FFY16, the six **FSC** provided services to 2,553 children.

The following is a breakdown of children served by location:

- Cape May **FSC** (Cape May) totaling 515
- Commercial Township **FSC** (Cumberland) totaling 403
- Empower **FSC** (Somerset) totaling 885
- Harvest **FSC** (Hunterdon) totaling 225
- Morris County **FSC** (Morris) totaling 68<sup>1</sup>
- Woodbury **FSC** (Gloucester) totaling 457

In addition to **FSC**'s, OFSS also provides oversight for the **Kinship Navigator Program (KNP)**. **KNP** was established to assist caregivers raising non-biological children in “navigating” through various government systems to find local supports and services. The complete program encompasses Wraparound Services, Kinship Legal Guardianship Services, Kinship Care Subsidy Services, and Information and Referral Services. The program provides financial assistance, support, information and referral services, and a wide range of other services available to caregivers through four agency providers serving all 21 counties.

**KNP** case managers help determine eligibility for special services, such as Kinship Child Care Subsidy or Kinship Wrap Around services. Linkages for support services may include grandparent/family support groups, insurance coverage and health services, child support collection, housing, legal and financial services, and special items/services related to the child's needs. The program can also assist with obtaining kinship legal guardianship. **KNP** served 740

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<sup>1</sup> The Office of Family Support Services reviewed the data and determined that after checking their records – there were 68 children received services as members of registered participants between October 1, 2015 and September 30, 2016. That number is based on intake forms filled by their parents and sign-in sheets from different programs and services for children and families that we provided during the federal fiscal year 2016. The staff from OFSS contacted the Morris **FSC** Director and provided technical assistance related to data gathering, recording and submission via Survey Monkey. The staff will closely monitoring their data to make sure that this mistake does not happen in the future.

unduplicated families in Kinship Legal Guardianship (KLG), and 3,216 unduplicated families in Wraparound for a total of 3,956 unduplicated families in FFY 2016.

**CBCAP Funded Initiatives in the Office of School-Linked Services**

**School-Based Youth Services (SBYS)** are collaborative efforts developed and implemented by OSLS. OSLS **SBYS** contract with various private non-profit organizations and school districts in order to provide prevention and support services to students and their families. Youth in NJ's public schools are able to access a wide variety of services through the implementation of **SBYS**. Services provided by **SBYS** include group and individual counseling, healthy youth development services, life skills and social skills groups, relationship management, employment readiness, academic support, pregnancy prevention, substance abuse prevention, conflict resolution, violence prevention, recreational activities, preventative healthcare services, summer programs, and promoting volunteerism and community service for youth.

The New Jersey Child Assault Prevention Program (NJCAP), Bergen Family Center Middle School Based Youth Services Program (SBYSP), Dwight Morrow High School Fatherhood Program, Promoting Success for Expectant and Parenting Teens NJ (PSNJ), and marketing campaigns for the 2<sup>nd</sup> Floor Youth Helpline and the Traumatic Loss Coalition (TLC) implemented through the Office of School-Linked Services (OSLS) operated with full or partial CBCAP funding in FFY 2016.

The **New Jersey Child Assault Prevention (NJCAP) Project** is a statewide community based child physical, verbal and sexual assault prevention program. **NJCAP** seeks to reduce children's vulnerability to abuse, neglect, and bullying through prevention workshops for school-age children, parents and teachers. **NJCAP** staff work closely with local school districts, parent/teacher associations, home school groups and other community groups. **NJCAP** has a threefold educational approach to prevention which includes staff in-service, parent programs and individual classroom workshops for children and teens. CBCAP funding provides **NJCAP** the opportunity to continue to expand services and supports to school districts throughout the State. NJCAP reached 82,222 youth and 11,022 adults in FFY 2016.

On April 14<sup>th</sup>, 2016, the **NJCAP** project along with ICAP( International Center for Assault Prevention), and **NJCAP**'s host agency EIRC (Educational Information Resource Center) held its first "International Child Assault Prevention Conference," celebrating 30 years of prevention education and empowerment since 1985. Over 400 child abuse prevention specialists from around the world gathered at Caesar's in Atlantic City, NJ for this one day extraordinary learning event. Some of the nations represented were Japan, Korea, Croatia, Canada, and Dominica and U.S. local CAP projects from Iowa, Massachusetts, and Colorado. Activists Erin Meryn, the initiator of "Erin's Law" and Yuri Morita, founder of the Japan CAP project were keynote speakers. There were numerous workshops in a variety of topics from human trafficking to home grown terrorism. Attendees were engaged and provided positive feedback on conference evaluations.

Through one-time funding provided by CBCAP, the Bergen Family Center was able to expand services and offer a new School Based Youth Services Program (SBYSP) in Janis E. Dismus Middle School (JDMS) in Englewood New Jersey beginning in September, 2016. The SBYSP, "ZONE", staff work in full partnership with the JDMS administration, teachers, and faculty. Ongoing outreach efforts through ZONE seek to engage teachers in program implementation and service referrals. The administrative team relies on the ZONE to co-facilitate risk/suicide assessments and to provide appropriate intervention and referral services. Parent workshops are

facilitated monthly and are well attended by both parents and teachers. Since its inception, ZONE has provided services to **358** unduplicated students. A breakdown of services students participate in is below:

- 25 Unduplicated Individual Counseling 79 Individual Counseling Sessions
- 50 Unduplicated Students enrolled in Group Counseling
- 8 Risk Assessments
- 16 Mediations
- 65-70 students participate in daily lunchtime programs
- 20-25 students participate in after school programs

The following programs and many more have been implemented at JDMS:

- Setting SMART Goals
- Organization and time management
- Healthy and Unhealthy relationships
- Domestic Violence Awareness
- 7 Habits of Highly Effective Teens
- Bullying Prevention

In an effort to enhance the outreach efforts and reach more youth throughout NJ, CBCAP funding was provided to the **2<sup>nd</sup> Floor Youth Helpline (2<sup>nd</sup> Floor)** and **Traumatic Loss Coalition (TLC)** to improve marketing materials. 2<sup>nd</sup> Floor has several new marketing materials circulating throughout New Jersey.

**2<sup>ND</sup> FLOOR Youth Helpline** is a statewide, 24-hour interactive telephone line for youth and young adults (ages 10-24), staffed by professional counselors and specially trained volunteers. The goal of **2<sup>ND</sup> FLOOR** is to promote healthy youth development by providing immediate, interactive, respectful, and professional helpline services with linkage to information and services that address the social and health needs of youth. During FFY 2016, the Helpline received 18,690 calls. In FFY 2016, **2<sup>ND</sup> Floor** also utilized a text communication option, bringing in an additional 816 youth and young adults. The **2<sup>ND</sup> Floor** Message Board had 29,550 views from youth and young adults seeking information and services. One component of the 2<sup>nd</sup> Floor marketing campaign is “Steps for 2<sup>nd</sup> Floor”. “Steps” encourages Youth Advisory Groups throughout the State to participate in the campaign through creating messages of hope and support with chalk on the sidewalks leading into middle and high schools. Students then take pictures of their pictures and messages and the pictures are posted on the 2<sup>nd</sup> Floor website. There are almost 100 schools participating in the “Steps” campaign. Additionally, 2<sup>nd</sup> floor produced 12 page coloring books that are supplied with crayons to schools throughout New Jersey. Research shows that coloring is positive for mental, emotional and intellectual health, and the coloring books encourage youth to not only use the books for their well-being, but also utilize the 2<sup>nd</sup> Floor Youth Helpline for additional support. Utilizing CBCAP funding, 2<sup>nd</sup> Floor has also updated posters and palm cards to focus on the new texting capabilities of the program.

The **Traumatic Loss Coalition’s (TLC)** primary focus is to provide suicide prevention services to public schools throughout the State. The **TLC** model utilizes a holistic approach in building an

informed and competent community by offering training and technical assistance to school administrators, teachers, and parents in NJ's public, charter and private schools, faith based organizations, social service & mental health agencies, law enforcement, primary care physicians. Basic components of all **TLC** curricula include: suicide prevention, intervention and post-intervention, and trauma incident training and technical assistance to schools and communities for the benefit of school age youth. The primary focus of the **Traumatic Loss Coalition (TLC)** is to provide suicide prevention services to public schools throughout the State. TLC utilized CBCAP funding in FFY 2016 to increase awareness of their services and resources. TLC identified social media as an increasingly recognized method in the field of suicidology for preventing and responding to suicide events. With suicide being the second leading cause of death for people ages 10-24, efforts to connect and inform young people with information on prevention, help seeking behaviors and resources need to be supported. In many ways, youth may identify with and also be closer to other peers rather than parents or adult figures. They also use social media as a way to interact with each other informally. With this knowledge, TLC updated their website and use this format as an opportunity to engage young people.

The web provides 24 hour access, along with the element of anonymity, which is attractive to this population. The funds allowed TLC to design:

- A secure unique URL domain for website - [www.TLC4Teens.org](http://www.TLC4Teens.org)
- Design/Update/Maintenance of the Website (youth input will be solicited)
- New content, including videos and updated resources for suicide prevention and trauma
- Safe messaging guidelines for teens

The website will be updated regularly and serve as a message board to announce upcoming youth events, linkages to other existing resources such as 2<sup>nd</sup> Floor, the NJ HopeLine, and Trevor Project. New Jersey High School and College/University suicide prevention efforts and programming will be highlighted. The website will also serve as a forum for collaboration between entities that provide support and guidance for those who have experienced trauma and loss. Safe messaging will be structured within the framework of the SAMHSA approved Best Practices. Additionally, The TLC newsletter and listserv will be utilized to reach thousands of school personnel who can assist in disseminating information about the website.

The goal of **Family Friendly Centers (FFC)** is to offer a wide range of services to enhance after school programming for elementary and middle-school students and their families. There is an emphasis on parental participation as well as collaboration among school and community stakeholders to meet the needs of students and parents. OSLS strives to continually enhance collaborations between schools and communities to provide the most appropriate services for families.

DCF was awarded funds by the US Department of Health & Human Services' Office of Adolescent Health to strengthen the supports for expectant teens, teen mothers, young fathers and their children. This work is identified as the **Parent Linking Program (PLP)** expansion project **Promoting Success for Expectant and Parenting Teens NJ (PSNJ)**. Through the implementation of **PSNJ**, programs were educated about the importance of including young fathers. Programs developed a specific component of their service offerings to specifically address the needs of young fathers. At this time, each program is expected to demonstrate that 20% of their enrolled students are young fathers. In addition, prior to this funding, the **PLP** sites did not systemically address intimate partner violence with adolescents. Through a partnership with Prevent Child Abuse-NJ PCANJ, the **PLP** sites received training in the evidence- based

curricula Safe Dates to promote healthy relationships. This training was also extended to the staff of Project TEACH, a comprehensive alternative education program for pregnant and parenting teens (13-21 years old) operated by the DCF's Office of Education (OOE). Furthermore, OSLS implements the **Adolescent Pregnancy Prevention Initiative (APPI)**. The goal of **APPI** is to reduce the birth risk of adolescent boys and girls enrolled in the contracted school sites that are most at risk of adolescent pregnancy.

OSLS also delivers the **Prevention of Juvenile Delinquency (PJD)** initiative in four designated high schools in New Jersey. The goal of **PJD** is to integrate and coordinate services, both in and out of the school setting, with a focus on the prevention of juvenile delinquency and/or intervention for students who have a first time contact with the juvenile justice system for a misdemeanor.

DCF has made significant progress in establishing a core set of prevention services which have expanded to reach all 21 counties of New Jersey, including:

- 66 Evidence-Based Home Visiting Programs
- 58 Family Success Centers
- Domestic Violence Services in all Child Protection and Permanency Offices
- School-Based Youth Services in 67 high schools, 19 middle schools and 6 elementary

#### **CBCAP Funded Initiatives in the Office of Domestic Violence Services**

DOW's Office of Domestic Violence Services (ODVS) applied CBCAP funding to the **Domestic Violence Liaison (DVL)** program evaluation. A **DVL** works to assist victims of domestic violence who are also involved in the child protective services system. The **DVL Program** is a partnership of the Department of Children and Families (DCF), Office of Domestic Violence Services (ODVS), Division of Child Protection and Permanency (DCP&P) and New Jersey Coalition to End Domestic Violence (NJCEDV) at the State level, and the DCP&P local offices and domestic violence lead agencies at the county level. A total of 32 **DVLs** are co-located in 46 DCP&P local offices four days per week. Services are provided on site in DCP&P Area/Local Offices, client homes, family team meetings and at the domestic violence lead agency within the county. The goal of this program is to strengthen and enhance the service coordination between New Jersey's child protection and domestic violence systems. This coordination aims to improve safety and wellbeing outcomes for women and children experiencing the co-occurrence of child abuse or neglect and domestic violence. **DVLs** assist DCP&P casework staff in assessing and responding to domestic violence, and making referrals and connections to domestic violence services. **DVLs** also assist domestic violence services providers in the identification of protective service cases that should be referred to DCP&P. Daily activities provided by the **DVLs** include:

- **Referral:** All services are initiated by CP&P case managers via the DVL Referral and Case Practice Form
- **Confidential Client Communications:** And/or team interviews with CP&P and adult victim. Minimum of 500/year
- **Case Consultation and Planning:** Assess Domestic Violence, Domestic Violence Safety Planning and Referrals for services. Minimum of 100 per year to include:

- DVLs assisting caseworkers in assessing domestic violence in co-occurring cases of dv and child abuse for adult victims.
- DVLs participating in developing CCP&P case plans for non-offending parents, and consistent with the DCF DV Protocol, may assist with separate case planning for batterers.
- Developing domestic violence safety plans with non-offending parents and children when age appropriate.
- **Education, Training and Mentoring:** DVL provides education, mentoring and training that builds capacity of at least 1500 CP& P intake, permanency and other staff to understand the unique needs of adult victims and their children and safe interventions that will produce the best outcomes for adult victims and their children .
- **Collaboration:** Collaborate with CP&P caseworkers during protective service investigations, home visits, case planning, FTMs for families under CP&P Supervision
- **Face to Face Contact:** On-going face-to face contact with both DCF staff and the non-offending parent

The Office of Domestic Violence Services (ODVS) started a comprehensive evaluation of the DVL program in September 2015 with The Center on Violence Against Women & Children (VAWC) at Rutgers University School of Social Work. CBCAP funding supported the continuation of this extensive evaluation in FFY 2016. The Domestic Violence Liaison (DVL) program evaluation has three phases:

- Report on the best practices and policies on addressing domestic violence in child welfare systems across the U.S.
- Review the current practices in place across DCP&P offices regarding the DVL program.
- Determine the impact of the DVL program on families experiencing domestic violence in order to suggest implications for improvement of policy and practice strategies within the domestic violence agencies and child welfare agencies when addressing the safety of families.

The Center on Violence Against Women and Children (VAWC) collaborated with DCF and the NJ Coalition to End Domestic Violence (NJCEDV) to select nine diverse counties to participate in the evaluation. All nine counties were then engaged directly to participate in the study and to aid VAWC in the recruitment of 200 women. In addition to posting fliers in these counties to promote and recruit survivors to participate in the evaluation, each county's DCP&P offices and domestic violence program staff were asked to personally recruit women to participate. DCP&P held space in their offices for VAWC researchers to conduct interviews with survivors on site. Once interviews are complete, VAWC will complete data analysis and complete a final report detailing the results of all three phases of study as well as implications and recommendations for improvements. The evaluation will be completed by June 30, 2017. Additional details regarding this evaluation can be found in section 8.

ODVS collaborates with the CEDV and the Department of Children and Families Division of Child Protection and Permanency (DCP&P) to implement the **Domestic Violence Liaison**

**(DVL)** initiative. **DVLs** are domestic violence professionals co-located at DCP&P local offices to provide on-site case consultation to DCP&P staff as well as support and advocacy for domestic violence victims and their children. The purpose of this collaboration is to increase safety and improve outcomes for children and their non-offending parents/caregivers in domestic violence situations and to strengthen DCP&P capacity to provide effective assessments and intervention for families in domestic violence situations.

Developed specifically to promote the well-being of children who have witnessed domestic violence, the **Peace: A Learned Solution (PALS)** initiative is a research based, intensive therapeutic program model of creative arts therapy. Utilizing unique therapeutic strategies such as art, dance, movement and drama, children ages 4 – 12 years old experience creative counseling and healing. **PALS** also offers services for the non-offending parent, and operates in 11 counties in New Jersey.

The **Batterers Intervention Program (BIP)** was developed in an effort to encourage, assess, and engage fathers into responsible fathering behaviors. **BIP** provides services to fathers who perpetrate domestic violence in households where children are present with the goals of reducing or eliminating the safety and risk concerns posed by batterers, increasing safety within households and setting clear boundaries to prevent future violence. A safety plan must be in place for the victim as well as the children. **BIP** has two primary components: training for DCP&P caseworkers and implementation of a new intervention with male perpetrators of domestic violence, administered by community domestic violence providers. **BIP** is being piloted Sussex, Middlesex, Morris and Atlantic Counties. In FFY 2015, **BIP** enrolled 299 fathers/intimate partners with 264 of those enrolled known to child protection. **BIP** providers held 704 group sessions, and 3,500 units of case management services were provided.

Within ODVS, state legislation was passed in January 2014 is the **Safety and Accountability Assessment (SAA)**. This initiative seeks to create holistic and coordinated community responses to domestic violence to ensure safety for all survivors and victims of regardless of race, ethnicity, sexual orientation, or culture, and to hold offenders accountable. Through training, technical assistance, and coaching, local community organizations will implement assessments of the domestic violence response in their communities, identify gaps in services, and develop and implement solutions to these gaps. This will provide an enhanced response system for domestic violence victims and survivors. ODVS is currently planning for initial assessments to begin.

While CBCAP funding is not utilized for all initiatives in FCP and DOW, each initiative described plays an active and imperative role in New Jersey's child maltreatment prevention efforts. Implementing various initiatives through FCP and DOW, as well as through collaborations with local communities, allows New Jersey to continuously promote protective factors, support and strengthen families, and prevent child abuse and neglect.

#### **Additional CBCAP Funded Partnerships/Initiatives**

Within the Office of Communications at DCF, the Safe Haven program provides various services with funding from CBCAP. The NJ **Safe Haven Program**, a program implemented through the Office of Communications receives partial CBCAP funding. In June 2000, the State Legislature passed the New Jersey Safe Haven Infant Protection Act. The **Safe Haven** law allows a parent,

or a parent's designee, to anonymously surrender an infant 30 days old or less to any hospital emergency room or police station in the State and without threat of criminal prosecution as long as the infant shows no signs of abuse or neglect. It was initially believed that pregnant teens were responsible for the majority of unsafe abandonment of infants. However, information from **Safe Haven** surrenders and abandonment cases where the mother was identified displayed a range of ages from young adolescents to women in their forties. This suggests that the primary target audience for this program is all females of childbearing age. Two confirmed Safe Haven Surrenders occurred in FFY 2016. CBCAP funds supported the following Safe Haven public awareness campaigns in FFY 2016:

- **Safe Haven Video:** DCF produced a video educating the public and stakeholders about the state's Safe Haven program and its expansion to fire stations and first aid, ambulance, and rescue squads staffed 24 hours a day. The video was emailed to stakeholders, constituents, and staff and is available on YouTube.
- **Safe Haven Signs at Hospital Emergency Rooms:** DCF produced and distributed eighty 18 inch by 18 inch metal Safe Haven signs to 80 hospital emergency rooms throughout the state. The signs clearly identify these emergency rooms as Safe Havens, which furthers the public's awareness of the program and reassures parents visiting an emergency room to surrender an infant.
- **Safe Haven Signs at Fire Stations, Ambulance, First Aid, and Rescue Squads:** 70 fire stations and ambulance, first aid, and rescue squads staffed 24 hours a day have responded to the department's offer to provide a Safe Haven sign for their buildings. The signs will soon be manufactured and distributed to requesting sites.
- **Publication Distribution:** DCF continues to fulfill requests for Safe Haven materials. Items are free to the public and available in English and Spanish.

During FFY 2016, DCF distributed Safe Haven awareness material at the following conferences and conventions:

- NJ American Academy of Pediatrics Pediatric Mental Health Collaborative, October 6, 2015
- NJ School Counselor Association Fall Conference, October 11-12, 2015
- NJ American Academy of Pediatrics 24th Annual School Health Conference, October 14, 2015
- NJ State Nurses Association, October 14, 2015
- NJ School Boards Association, October 27-28, 2015
- NJ Education Association, November 5-6, 2015
- ASAH, November 13, 2015
- NJ League of Municipalities, November 17-19, 2015
- NJ International Child Assault Prevention Project Conference, April 14, 2016
- NASW, May 1-3, 2016
- NJ American Academy of Pediatrics, Special Practice Groups, May 4, 2016
- NJ American Academy of Pediatrics/NJAAP Annual Conference, May 11, 2016

- NJ Alliance for Children, Youth and Families, May 20, 2016

Additionally, one-time CBCAP funding was provided to Prevent Child Abuse NJ (PCANJ) to support the expansion of the Enough Abuse Campaign (EAC). The Enough Abuse Campaign is a research-based strategy focused on the prevention of child sexual abuse. EAC focuses on educating adults about steps to protect children before child sexual abuse occurs and the development of new policies and practices at a state and national level. EAC was originally developed with funding from the U.S. CDC and now has been expanded to seven states across the U.S. It is based on a public health model that combines community mobilization, broad-based consumer education, policy reform, and environmental strategies focused on prevention. The Enough Abuse Campaign was initiated in 2011 by PCANJ. Accomplishments in the past five years include development of community coalitions in four sites, serving five NJ counties, development and publication of the “Safe Child Standards for Youth Serving Organizations”, co-hosting a symposium on youth offenders with the CARES Institute, support for an initiative to involve pediatricians in child sexual abuse prevention and exploration of reforms related to adolescents with sexually inappropriate behavior.

One-time CBCAP funds provided to PCANJ in FFY 2016 provided PCANJ the opportunity to:

- Expand the Enough Abuse Campaign to up to two additional counties.
- Develop and institute new management infrastructure to ensure quality assurance, data development, monitoring and reporting from all participating sites in NJ.
- Develop a new e-learning tool for schools.
- Train PCANJ staff in eight prevention programs, using a “Train the Trainer” format, in updated EAC curricula for schools and youth-serving organizations, to reach community partners in the next 12 months.
- Develop materials to educate policy makers about the distinct circumstances and science behind child sexual abuse prevention, which would strengthen advocacy efforts in the future needed to sustain the Campaign.

### **Additional Prevention Work- Children’s Trust and Prevention Fund**

The NJ Children’s Trust Fund funded a collaboration with Rutgers University Institute for Families (IFF) to offer a face-to-face training to professional and families throughout the state for the Standards for Prevention Programs. This training built on the webinars developed and provided by PCANJ for the Prevention Standards in FY 2015. Programs within the Division of Family and Community Partnerships (FCP) were encouraged to complete a self-assessment of their current implementation methods for the Standards for Prevention Programs prior to attending the training. Programs invited to complete the survey and participate in the training included Home Visiting, County Councils for Young Children, Family Success Centers, School Based Youth Services Programs, and the Kinship Navigator Program. The self-assessment responses informed the curriculum for the training, which was tailored to meet the needs of each program type. In addition to the prevention program curriculum designed for professionals, IFF also developed a curriculum for parents and caregivers. The curriculum intended to educate parents and caregivers about the Standards for Prevention Programs, including how to identify community-based programs which endorse and integrate the standards into daily practices with families.

Eleven face-to-face trainings were offered to professionals throughout the state and were provided by individuals with expertise in the field of prevention. The trainings offered participants the opportunity to develop implementation methods for integrating the Standards into their daily practices. Participants provided feedback about how the Prevention Standards are integrated into program practices and also what supports are needed to further integrate the Prevention Standards into practice. Pre and Post tests were completed by participants at all trainings. In addition to the face-to-face trainings, IFF also developed webinars which will be available for all community-based programs to access at any time. These webinars provide additional insight to the Standards for Prevention Programs, particularly regarding participatory planning with families and continuous quality improvement when integrating the Prevention Standards. Two webinars were developed specifically for parents and caregivers. These webinars are meant to be implemented in coordination with the parent handbook developed by IFF. These caregiver webinars followed three face-to-face trainings which were provided for parents and caregivers at community-based programs in the Northern, Southern and Central regions in New Jersey. Further detail regarding the Standards for Prevention Programs training will be described in section 7.

With CBCAP funding distributed so widely to various offices and programs, many opportunities arise for all of New Jersey's diverse populations to obtain necessary services and supports. The prevention programs described above are able to thrive and expand to reach additional families and children each year with the assistance of CBCAP and CTF funding. These initiatives have displayed an effort and ability to align with New Jersey's Statewide Prevention Plan, and the Department of Children and Families Strategic Plan. CBCAP funding is strategically provided to initiatives which support the mission of enhancing community based child maltreatment prevention efforts and which align activities and services with New Jersey's priorities in prevention.

New Jersey's wide array of services provide families and children vast opportunities for support, education, and growth. Decisions impacting the prevention service array, supported by CBCAP, will be determined by Department of Children and Families (DCF) Leadership in alignment with established strategic priorities. The location or county in which services are placed are determined through a review of DCP&P referral and substantiation data, population density, poverty levels, or based on a need voiced by community members. CBCAP funds are issued to support primary and secondary prevention services for diverse population needs within local communities in New Jersey. The programs and initiatives implemented by the Division of Family and Community Partnerships (FCP) and the Division on Women (DOW) primarily focus on priority populations defined by CBCAP, such as parents of young children, parents and children with disabilities, racial and ethnic minorities, and underserved or underrepresented populations. Funded programs address the core services of parent education, mutual support and self-help, leadership services, outreach, community and social service referrals, follow-up services, voluntary home visiting and respite care services. In addition, CBCAP funded programs are encouraged to use evidence-based and/or evidence-informed or promising practices in their work to prevent child abuse and neglect.

# Section D

## Services for Children Adopted from Other Countries

### **Services for Children Adopted from Other Countries**

Children adopted internationally do not usually interface with the public system as the families interested in adopting children from other countries work in concert with the private adoption agencies. The Department of Children and Families' (DCF) Office of Licensing has established a protocol that requires New Jersey adoption agencies to maintain information regarding the number of their inter-country adoptions and the countries from which the children originate. This information is accessible by the Office of Licensing

Though the New Jersey Division of Child Protection and Permanency (DCP&P) is not involved in the initial adoption proceedings for children placed internationally, the agency funds a network of post adoption support services that any adoptive family in the state may utilize. Thus the Department of Children and Families (DCF) does make post-adoptive services accessible to any adoptive family living in New Jersey with a minor child, regardless of the source of the adoption. In addition, inter-country adoptive families can also access a multitude of services provisions through DCF e.g., help with adolescence, child behavioral health, and educational services.

New Jersey maintains a statewide Post Adoption Counseling (PAC) program that is administered locally by a network of contract agencies with adoption expertise. Through this program, adoptive families can access a variety of adoption-related supports. The PAC services are covered by contractual agreements between DCF and the specific agency and thus are offered to the adoptive family free-of-charge. The vast majority of program resources are devoted to a few core services: (1) in-home therapeutic services; (2) child and family counseling; (3) behavioral supports to adoptive families; (4) education, resource and referral services through an online adoption clearinghouse ([www.NJARCH.org](http://www.NJARCH.org)), as well as, a warm line for immediate support; and (5) family respite through structured child activity.

These services are directed towards:

- Preventing adoption disruption and dissolution
- Preventing the residential placement of adopted children
- Promoting the successful reunification of children to their adoptive families from residential placement
- Providing therapeutic support and guidance to adoptive families where dissolution or disruption is not a threat

In the event of an inter-country adoption disruption, DCF will work with International Social Services (ISS) to determine if there is a kinship home in the child's country of origin. If so DCF will work with ISS to facilitate the placement

### **Inter-Country Adoptions**

During the FY 2016, only 1 child experienced an inter-country adoption disruption, and entered in state custody. The child's adoption disruption was court ordered due to concerns with adoptive parent's inability to safely handle adolescent's severe mental health challenges. The adolescent is residing in a treatment home that provides services to address the adolescent's specialized needs. Currently, the adolescent has a goal of Select Home adoption, and has been assigned a Child Specific Recruiter who will refer the child to the Adoption Exchange.

On-going recruitment efforts for this small cohort continue with the local child specific recruiters.

# Section E

## Program Support

DCF has continued work with consultants at National Resource Center for Diligent Recruitment (NRCDR) at Adopt US Kids around Market Segmentation through onsite visits, teleconferences and via e-mail. With the assistance of the consultants at the NRCDR, we have been able to build our capacity to translate the data and use the information to better inform our recruitment efforts. As a result, our targeted recruitment efforts have become more strategic as we take into account lifestyle characteristics, population densities as well as the locations of where children in need of placement are coming from.

In FFY 2016, we implemented or continued the following statewide and local retention initiatives:

- NJ developed a new methodology of identifying local needs that focuses on engagement and retention of current licensed families
- We continue to work with consultants from the National Resource Center for Diligent Recruitment at Adopt US Kids (NRCDR) on-site and through teleconferences
- NJ continues to have a statewide taskforce that was comprised of staff, resource parents, youth and outside stakeholders.
- Continue to work with the Rutgers University School of Social Work to conduct a study on the perspectives of NJ resource families. The study will give resource families a voice and us the ability to better understand the causes of attrition from the foster care program
- Continue the practice of bi-monthly Group Engagement orientations with inquiries in each County.
- In an effort to enhance the expertise of our recruitment staff, we have developed workshops that addressed their ability to communicate more successfully, build coalitions and enhance their networking potential as well as strategies to break down communication barriers in the context of recruitment
- Training by national experts to enhance our competency skills among staff and allow us to be more effective with our outreach efforts to LGBT communities statewide was completed

For further information to include impact please see Attachment A: Diligent Recruitment plan

The Office of Research Evaluation and Reporting supervises all research related activities and the following represents those ongoing study activities during the reporting period:

<p>Mother and Infant Childhood Home Visiting Program Evaluation (MIHOPE)</p>	<p>The purpose of the study is to identify the effects of home visiting programs on parent and child outcomes to better understand how local programs operate and to investigate the link between the features of local programs and their effects.</p>
<p>Home visitation enhancing linkages project (HELP): Enhancing evidence based home visitation to address substance abuse, mental health and DV.</p>	<p>The purpose of the study is to evaluate a standardized protocol for home visiting services that will aid home visitors in better identifying substance abuse, mental health and domestic violence problems with their clients and provide linkages to needed services. It compares treatment and control groups on risk identification and treatment engagement outcomes.</p>
<p>The Assessment of Parent Linking Programs Project</p>	<p>This project will help determine the efficacy of the Parent Linking Program (PLP) for the current teen parent participants of the program. It will describe the resources, logistics and activities of each PLP site and assess knowledge of parenting skills and healthy child development, as well as reductions in involvement with child protection services.</p>
<p>NJ Project LAUNCH</p>	<p>The evaluation of Project LAUNCH consists of two parts: measuring systems change (implementation and outcomes) and measuring the four goals from the Essex Strategic Plan (increased screening/referrals, improved IECMH knowledge, more evidence based programs and increased family strengthening/parent leadership opportunities).</p>
<p>NJ Home Visiting Local Program Evaluation</p>	<p>The purpose of the study is to:</p> <ul style="list-style-type: none"> <li>• Assess and promote each EBHV program and components of the Central Intake system in achieving the NJ-HV’s explicit process and outcome performance indicator targets;</li> <li>• Assess and promote each EBHV</li> </ul>

	<p>program’s success in achieving fidelity to its EBHV model and to reaching NJ-HV’s performance indicator targets;</p> <ul style="list-style-type: none"> <li>• Assess the impact of the NJ-HV on maternal and child outcomes (e.g. birth outcomes, infant health, and maternal health and behavior outcomes); and,</li> <li>• Assess and promote development of the infrastructure for integration of home visiting within the system of health and social services.</li> </ul>
<p>Evaluation of a Human Trafficking Prevention Program: The Empowering Young Men to End Sexual Exploitation Curriculum</p>	<p>The purpose of the study is to analyze the pre and post surveys provided to participants receiving this curriculum, to determine “trends and rates” of increased knowledge, attitudes, and behaviors about Human Trafficking.</p>
<p>Child and Family Nurse Program Evaluation</p>	<p>The purpose of this study is to evaluation the effectiveness of the New Jersey Child and Family Nurse Program, which provides care coordination to target families involved with the Division of Child Protection and Permanency.</p>
<p>Evaluation of a Service Provision Program for Victims of Sex Trafficking</p>	<p>The purpose of the study is to evaluate a psychoeducational group designed to reduce youths’ risk for being sexually exploited. The study will assess outcomes such as knowledge about sexual exploitation, dating violence experiences, alcohol and drug use, and future aspirations over time and will also include a cost effectiveness analysis.</p>
<p>Quick Cents for Youth</p>	<p>The purpose of this study is to evaluate a number of project outcomes regarding financial literacy for participants in the Quick Cents program.</p>
<p>Batterers’ Intervention Program Evaluation</p>	<p>The purpose of this study was to explore the effectiveness of the Batterers’ Intervention Program (BIP) intervention, which was piloted by the New Jersey Department of Children and Families in four counties between July 2013 and October 2015.</p>

<p>Improving Outcomes for Families of Infants and Young Children in Newark, NJ: Integrating Best Practices of Child Protection and Early Childhood</p>	<p>The study is an evaluation of case conferences with CP&amp;P workers, supervisory staff, and system partners (i.e. child health unit nurse, substance abuse counselor, domestic violence specialist, early childhood services coordinator). The purpose of the case conference is to identify appropriate services, with an emphasis on better utilizing early childhood services that address protective factors. This research will determine whether there is value for CP&amp;P in using case conferences routinely and at this stage of the case.</p>
<p>Domestic Violence Liaison Program Evaluation</p>	<p>The purpose of the study is to evaluate the Domestic Violence Liaison (DVL) program, an interagency collaborative model developed to address domestic violence among families involved in DCP&amp;P. The study will seek to determine the factors which support an interagency collaboration or create barriers to such collaboration, to determine the impact of the DVL program on families experiencing family violence, and to suggest implications for improving policy and practice strategies within child welfare agencies and domestic violence service providers when addressing the safety of families experiencing domestic violence.</p>
<p>National Quality Improvement Center for Adoption and Guardianship Supports and Preservation (QIC-AG)</p>	<p>The primary goals of the QIC-AG are to build evidence for promising permanency planning models and post-permanency services and support and to utilize the information to implement effective models to increase post-permanency stability, improve behavioral health for children and youth, and improve child and family well-being. The purpose of this portion of the study is to gain information regarding the needs as well as the supports available to families who have adopted or obtained legal guardianship over a child, or are planning to.</p>

In addition to the research activities, RER provides on-going training and technical assistance at the local, area and statewide level to DCF staff on performance indicators, data and outcomes. RER further engages with external stakeholders when requests are made for performance data outcomes and/or explanation of published data. RER frequently attends collaborative external stakeholder meetings to review and educate on DCF performance data indicators. RER provides on-going technical assistance to the Federal Monitor who oversees NJ Sustainability and Exit Plan.

NJ DCF provides several opportunities of Training and Technical Assistance to internal staff as well as external partners at the local, area and statewide level. Several training opportunities are described in detail in Attachment D: Training Plan Update.

Local Resource Development Specialists provide training and technical assistance to community partners regarding CP&P policies and practices.

CP&P Executive leadership along with Area Office and local leadership continue to provide on-going training and assistance to all local office sites on a variety of areas to support the mission, vision and values of the department. One example is monthly Key Performance Indicator reviews that occur in every area to review relevant data indicators to identify local trends, strengths and barriers.

The Office of Adolescent Services provided the following program support to DCF staff as well as community partners:

- Through the Adolescent Practice Forums which includes CP&P, Children's System of Care, Care Management Organizations, Child Health Nurses, and the DCF Office of Education staff, several informational presentations and mini trainings were held on a variety of topics including Medicaid Extension, educational initiatives, youth engagement, trauma informed care, employment resources, expectant and parenting youth and permanency initiatives.
- OAS provided the Got Adolescents? Training to CP&P staff. The training covers adolescent policy, practice and resources.
- The Post BA Certificate in Adolescent Advocacy was offered to 40 DCF staff. The program at Montclair State University is a fifteen credit certificate focused on adolescent advocacy and case practice. It is designed to provide students with a multidisciplinary understanding of the role of the adolescent advocate seen through the disciplines of law, sociology, and psychology.
- DCF provided human trafficking prevention trainings to community contracted providers and youth through a contracted provider.
- OAS provided in-service training to the Safe Space Liaisons on a variety of topics including New Jersey's anti-bullying bill of rights, holistic LGBTQI services for youth, and working with LGBTQI families.

- DCF provided the Value of Permanency training in conjunction with the Permanency Roundtables which included information on the importance of legal permanency for older youth.
- DCF partnered with Rutgers to hold an Adolescent Networking Conference to provide training on various topics to CP&P staff and service providers.
- OAS provided training on the Transitional Plan for YOUth Success and the Casey Life Skills Assessment for adolescent serving CP&P staff.
- OAS provided training on the NJ Career Assistance Navigator web based resource to CP&P staff as well as contracted providers.
- OAS provided training to CP&P staff on the new debit card/direct deposit process (Q Card) and financial literacy module mobile application (Pay Perks).
- OAS administered 2 one-day trainings titled “Understanding the Importance of Permanency “for CIC Judges, Deputy Attorneys General (DAGs), Law Guardians, the Office of the Public Defender and CASA Advocates to complement NJDCF’s efforts towards permanency for older adolescents.

OAS provides ongoing adolescent case practice technical assistance to all CP&P staff, service providers, youth, DAGs, Law Guardians, and other youth advocates statewide.

Other areas for further exploration of T/TA from the Capacity Building Collaborative are:

- Talk to and learn from other jurisdictions who provide services to youth 18-21
- NYTD data collection
- Supervisory level transfer of learning
- Savings accounts for youth in care (including minors)
- Serving expectant and parenting youth

# Section F

## Consultation and Coordination between States and Tribes

### **Tribal Consultation - Indian Child Welfare Act (ICWA)**

New Jersey has no federally recognized tribes. The Ramapough Mountain, Nanticoke-Lenape, and Powhatan-Renape, as well as Inter-tribal peoples who lack a formal tribal affiliation are members of the New Jersey Commission on Indian Affairs. The Department of Children and Families may provide services to children who are members of these tribes, as well as to children who currently reside in New Jersey but are members of, or eligible for membership in, tribes outside of New Jersey. New Jersey seeks to appropriately serve Indian children within the requirements and spirit of the Indian Child Welfare Act, regardless of their tribal affiliation. In an ongoing effort to build collaborative relationships with the community throughout New Jersey, DCF has solicited feedback from the Commission on Indian Affairs, which is administered through the New Jersey Department of State. Although the Commission has not provided any feedback, communication with the Commission continues.

DCP&P implemented the New Rule to the Indian Child Welfare Act (comprehensive regulations which provide the first legally-binding federal guidance on how to implement ICW) in December 2016. The policies and procedures were updated to include new definitions, determining if a child is an Indian Child, processes around notice requirements, emergency removal, voluntary proceedings, transfer of jurisdiction, involuntary and voluntary proceedings, notification letters, etc. Although the number of Indian children who come into services through DCP&P continues to be small. DCP&P also assigned a NJ Central Liaison to the Bureau of Indian Affairs (BIA) and Tribes. The Liaison will send notification letters to the Tribes and BIA, track and monitor responses/information between the Division, the Tribes and BIA.

DCP&P continues to address the provisions of ICWA relative to identifying a child as of Indian heritage; addressing removal and placement; and selection of a resource home, including an adoptive home. The NJ Commission and BIA continue to provide advice on a case specific basis, as well as consultative services in order to meet the requirements set forth. BIA continues to provide training as needed to the Liaison.

All new adoption workers are trained on the rules and guidelines of ICWA. With this, an integrated practice guide is available to assist staff in appropriately identifying any tribal affiliations of youth within the first five days of placement. Concurrent planners also regularly discuss a child's possible tribal affiliation to ensure staff is continually following up on the issue and appropriately collaborating or transferring cases to tribes when necessary.

The Administrative Office of the Courts and DCP&P are working together to strengthen its protocol to handle cases under ICWA's New Rule. In ongoing practice, the courts and the Deputies Attorney General apply the provisions of the Indian Child Welfare Act successfully. They require that tribal affiliations be included in all final adoption papers. Matters which must be transferred to tribal jurisdiction are handled appropriately, focus on the law, and their interactions with staff are maintained as necessary.

The Division's case practice reform efforts continue to expand throughout the state, offering opportunity to address two ongoing concerns about the identification of tribal members and the provision of culturally sensitive services to families with a tribal affiliation. Key components of

this initiative are the engagement of families and their ability to share their own background and history. The model of practice focuses on services customized for the family's needs, the use of self-selected family supports and community resources, and the use of family meetings as a planning mechanism. All offer tribal members a means to keep children within their communities and enable them to receive supports that fit their needs. DCF has presented information regarding these reforms, and on the process of relatives and kin becoming caregivers to tribal leaders and the larger community.

The Commission and/or the BIA continue to be available to help the child welfare agency to resolve a child's status.

Commission representatives have been involved in the CFSR process, participating in discussion groups as part of the Statewide Assessment process focusing on Systemic Factor F, Agency Response to the Community, and were invited to participate in the on-site stakeholder interviews. Their input will continue to be sought in child welfare processes.

# Section G

## Monthly Caseworker Visit Formula Grants

<b>Funding to Support Casework Visits</b>
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DCF continues to utilize mobile solutions to document visitation in a timely manner to support casework visits. DCF piloted VENUE tablet devices in the Burlington West, Morris East and Monmouth North Local Offices to continue with increasing the documentation related to monthly caseworker visits. Due to the success, this pilot has expanded to all afterhours operations. Additional local offices are being explored and leadership staff as well. The tablet has broadband capabilities for staff to connect to the DCF network via a secure VPN connection, using cisco any connect. This allows them to view and complete casework in real time while in the field. This advanced technology provides staff opportunity to document quality case work in a timely manner.

### **New Jersey Monthly Caseworker Visits Data for APSR**

#### ***Procedure to Track and Report Caseworker Visit Data***

DCF utilizes NJSPIRIT, its SACWIS system, as its source for reporting Monthly Caseworker Visits and Visits-In-Home. The calculations for this requirement are done in compliance with the Federal methodology to provide the aggregate number of children served in foster care, the number and percentage of child contacts made with children in foster care for each reporting month, and the total number of visit months in which at least one visit occurred in the child's residence. The procedure for reporting on monthly visit compliance is to archive the data after a selected period and to use that data for compilation.

In addition to data from NJSPIRIT, New Jersey uses SafeMeasures as a reporting tool to track numerous outcome measures. This allows DCF to track and report on compliance in several outcome measures at various points and at different levels of the organization – worker, supervisor, Local Office, Area Office and statewide.

SafeMeasures reports for complete months. The compliance rating is based on having a contact in the selected month with children who are in care. Children without contacts who have exited care during the selected month, or who entered care during the selected month in conjunction with the opening of a new case, are not included in the compliance reporting for that month.

Since FFY 2012, DCF has exceeded the federal targets for both Monthly Caseworker Visits (MCV) and Visits In Home (VIN).

Below is the data for Monthly Caseworker Visits with children in placement and Visits –in-Home for FFY2016:

- Aggregate number of children in the data reporting population = **9,669**
- Total number of Monthly Caseworker Visits made to children in the reporting population = **75,906** (*Numerator*)

- Total number of complete calendar months children in the reporting period spent in care: **76,681** (*Denominator*)
- Percentage of Monthly Caseworker Visits made to children in the reporting population = **99%** (*MVC Compliance*)
- Total number of Monthly Visits made to children in the reporting population that occurred in the child's residence = **74,395** (*Numerator for VIH*)
- Percentage of Monthly Visits made to children in the reporting population that occurred in the child's residence = **98%** (*VIH Compliance*)

New Jersey's compliance level of 99% exceeded the federal MCV target of 95% for FFY 2016. New Jersey's compliance level of 98% also exceeded the federal VIH target of 50% for FFY 2016.

Section H  
Adoption & Legal Guardianship  
Incentive Program  
&  
Child Welfare Demonstration  
Activities

<b>Adoption Incentive Award</b>
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NJ was awarded the Adoption and Legal Guardianship Incentive Grant in October of 2015. NJ recognizes that these funds need to be obligated by 09/30/2018 and expended by 12/31/2018. NJ is utilizing this grant award to supplement existing Adoption programs such as the Post-Adoption Counseling services (PACs).

PACS provides individual and family therapy, and support groups for children up to age 21 and their families to address core adoption and kinship issues. Therapy is strengths-based, family focused and largely cognitive in approach. The focus is on helping children overcome the effects of abuse and separation, and provide the support, encouragement and life skills necessary for the family's longevity and well-being. Therapy is intended to facilitate healing processes, promote family bonding and integration, and foster the development of support systems. Issues related to separation and loss, identity, shame, trust, abandonment, and developmental hurdles are addressed with an adoption/kinship and trauma informed. Families in PACS therapy can also receive respite funding to offset costs for children's out of home activities that support stabilization and treatment goal progress. In addition to therapy, adoption support groups are offered to provide teens, pre-teens and parents an opportunity to meet other adopted children, adoptive parents and engage in group discussion.

<b>Child Welfare Demonstration Projects</b>
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We currently do not have child welfare demonstration project.

# Section I

## Quality Assurance System

## Continuous Quality Improvement Plan Implementation Update

New Jersey's Department of Children and Families (DCF) has made the development of a robust and fully functional Continuous Quality Improvement (CQI) system a priority through both its department-wide Strategic Plan for 2014-2016 as well as its Child and Family Services Plan (CFSP). DCF has laid the groundwork to ensure the integrity and quality of DCF's CQI system is measurable and informs internal and external stakeholders of the results and outcomes achieved. The goal is to make CQI a seamless part of the way DCF works each day.

The DCF has embraced the five key components of the CQI system and is actively designing, planning and implementing an array of activities in order to have a fully functioning system in the near future. For example, one of our first steps is to engage the leadership and raise basic awareness of CQI activities occurring at DCF while simultaneously continuing to strengthen the foundation of CQI within the department.

In this update each of the five components will be addressed to provide an update of the DCF's identified strengths, concerns and enhancements.

### **I. Foundational Administrative Structure:**

*Goal: Administrative structure requires that every CQI system have a strong administrative oversight to ensure that its CQI system is functioning effectively and consistently, and is adhering to the process established by its leadership. There is a systemic approach to review, modify, and implement any validated CQI process. Additionally, it requires that the state has established written CQI standards, approved training process for CQI, written policies, procedures, and practices and has resources to sustain an ongoing process.*

#### **Strengths**

- New Jersey established the Office of Performance Management and Accountability (OPMA) as the foundational structure having oversight, coordination and guidance of numerous CQI activities statewide. OPMA has staff within the Office of Quality and in the Office of Research Evaluation and Reporting (ORER) dedicated to CQI projects which encourages sustainability of initiatives as well as gives the agency personnel resources to assist with implementation of new or existing projects.
- DCF has established designated CQI roles to support information sharing across all levels. The designated CQI roles help DCF create awareness, educate, engage and generate buy-in for CQI from staff and stakeholders

### Designated CQI Roles to Support Information Sharing:

- *Executive Leadership.* Executive Leadership stays informed of CQI activities at every level of the Department and ensures that NJ DCF has the resources and infrastructure in place to carry out formal CQI activities. In addition, Executive Management is responsible for providing relevant CQI information to key DCF partners and external stakeholders.
- *State CQI Steering Committee.* The State CQI Steering Committee oversees the continuous development and implementation of NJ DCF's CQI system and ensures that executive management and state leaders stay abreast of important CQI related information. The committee works to monitor policies, improve documentation of CQI related standards and procedures, support implementation of CQI training and coaching programs, and monitor the implementation of the major components of the CQI plan. The State CQI Steering Committee is chaired by the Assistant Director of PMA. The additional members will likely change over time, but currently include representatives from the Office of Quality, the Child and Family Services Review Unit, the Office of Research Evaluation and Reporting, Child Protection & Permanency, Policy and Regulatory Development, Office of Training and Professional Development, and Office of Information Technology.
- *Office of Quality CQI Administrator.* The CQI Administrator tracks the implementation of Steering Committee directives, and communicate results, lessons learned, and recommendations in written and verbal form, as needed, to the CQI Steering Committee and other NJ DCF stakeholders. The CQI Administrator manages the Office of Quality website to provide real time information about the enhanced CQI plan and CQI activities. In addition, the CQI Administrator assists with the development and training of staff.

### Designated CQI Roles to Support Information Sharing in CP&P:

- *CQI CP&P Statewide Collaboration Team.* The CQI Statewide Collaboration Team ensures that the CQI communication plan is

fully functioning, develops strategies to meet staff training and information needs related to implementing CQI activities and implements and monitors activities that support organizational learning at all levels. The CQI Statewide Collaboration Team consists of representatives from the Office of Performance Management and Accountability, CP&P's Central Office and each of the Area Offices. The primary function of the team is to ensure that the CQI communication plan is fully functioning, to develop strategies to meet staff training and information needs related to implementing CQI activities and to implement and monitor activities that support organizational learning statewide.

- *Office of Quality QR Administrators.* The QR Administrators participate in the development of CQI training; provide guidance for the development of local CQI teams; and manage the process of synthesizing information gained from the local CQI activities.
- *Area Quality Coordinators.* Nine Area Quality Coordinators manage CQI teams and the program improvement plan process at the county level and ensure that information gained from the local CQI activities is shared with the CQI Liaisons.
- *CP&P Deputy Directors.* These leaders use information from all levels to guide their efforts in ensuring the Case Practice Model is sustained through ongoing CQI processes and CQI activities align with the Case Practice Model.
- *Data Analysts.* The Data Analyst from the Office of Research Evaluation and Reporting produce quantitative & qualitative information and outcome reports that can be used effectively by front-line staff, management, administration and stakeholders.
- *County CQI teams.* The County CQI teams develop, implement and support the evaluation of interventions outlined in the program improvement plans (PIPs). Members of the county CQI teams also share information related to any additional CQI activities with the Area Quality Coordinators. County CQI teams develop and support implementation of the performance improvement plans (PIP) following the Qualitative Review (QR). The County CQI teams are lead by Area Quality Coordinators and Team Leads. The members of County CQI teams include staff, at all levels. The

team members can also include stakeholders such as service providers.

- *Office of Quality Team Leads.* The Team Leads work closely together to support CQI activities at the local office and area levels across the state. The QR Administrator and Team Leads are responsible for providing technical assistance to support to the local CQI Teams in development and monitoring of the program improvement process. QR Administrators are staff members from the Office of Quality and provide supervision to Office of Quality Team Leads. In addition, QR Administrators serve as The Office of Quality Team Leads are responsible for facilitating case practice reviews and for providing technical assistance to support the development, implementation and monitoring of the program improvement process. Area Quality Coordinators manage county/local CQI activities and serve as liaisons between the Office of Quality and CP&P county/local CQI Teams. Area Quality Coordinators submit local program improvement plans, facilitate evaluation efforts and submit progress updates to the Office of Quality.

- OPMA requires specialized training with a certification process for staff who participates in Qualitative Reviews (QR). New Jersey provides training for reviewers participating in QR reviews that cover elements of the review tool, policies, protocol and an evaluation process which is standardized. The process includes stakeholders as reviewers and invites stakeholders to the Exit Presentation and the resulting Program Improvement Plan development. NJ also provides training for staff who participates in Targeted reviews during the year.
- New Jersey makes data available, on a yearly basis, to both internal and external stakeholders on the QR process and results are available via the OPMA website and the DCF website.
- New Jersey recently implemented a section of the DCF public web site, the DCF Policy Manuals, devoted to communicating the policies and procedures by which DCF provides its services. Policy and procedures are issued by the Department and its divisions and offices.
- New Jersey continues to build clear written policies, procedures and practices for all activities within CQI. New Jersey has drafted a robust CQI plan which sets consistent expectations across the state regarding CQI activities. The underlying principal at the core of all DCF's CQI activities is the

understanding that our work should be informed by systematic processes that ensure quality implementation of all services. As a result, DCF has adopted a CQI approach rooted in a scientific reasoning framework. The purpose of the framework is to drive the Department's way of thinking about how we study our own practices, systems and processes. This approach consists of five stages; identify, explore solutions, develop initiatives, implement & evaluate and learn & plan. DCF developed this framework to help shape and formalize its ongoing strategies for developing and learning from CQI activities. The integration of this approach establishes a common language as well as shared expectations for how DCF goes about planning, implementing and learning. The framework is used to guide the QR PIP development process and more broadly, this way of thinking strengthens daily practice of field staff, area and local leaders in developing and implementing solutions.

- DCF leadership holds monthly Data Quality and Compliance phone calls with local DCP@P staff during which data is used to inform decision making and to focus on CQI activities.
- DCF has drafted a CQI plan and established the Department Wide CQI logo and supporting documentation for posting on the DCF website.
- DCF held Area data meetings with 10 DPC&P Areas including both Area and Local Office leadership. These meetings utilized outcome, longitudinal, qualitative and quantitative data. The Area Data Meeting is now referred to as the Area Data Story. Following a Qualitative Review (QR), both an Area and Local Data Story occur. The Area Data, with a leadership audience and Local Data story, with a frontline staff audience, are the same. The Area Data story precedes the Local data story to allow leadership the opportunity to hear the data story first. The data story, presented by the Office of Quality staff, combines QR results with quantitative data including longitudinal data, Key performance indicators (KPI) and case practice performance trends to link quantity and quality measures. The data story explains the results of the QR and incorporates other data to provide a holistic “story” of the quality, performance and outcomes measures. The data presentation is combined with case examples, or the story behind the data, to reinforce the connection between data indicators and case practice. The data story allows for a question and answer period to ensure staff has an understanding of the data presented. The data story is the start of the QR PIP process and ensures decisions about the PIP are not based solely on the results of the QR.

- DCF is collaborating on several Federal and statewide projects (i.e. YARH, Dept. of Agriculture, Dept. Of Education, MIECV) with different stakeholders to build a stronger partnerships on behalf improving outcomes for our families, children and youth
- DCF understands the importance of developing its staff to support its CQI system. In addition to continuing traditional CQI related, QR Reviewer training and supervisory QR training, DCF, in partnership with Rutgers University, is in the process of developing and implementing a suite of CQI training programs that will reflect the latest advancement in CQI for child welfare and support the integration of the Department's enhanced approach to CQI.
  - ▶ *Traditional CQI Related Training.* The Professional Training and Development Center trains new and seasoned workers in child protection and permanency practice. In addition to the case practice model curriculum, training includes instruction on how to navigate DCF information management systems and how to develop and maintain automated records management, case planning, service planning, and data tracking. Additional DCF data-related training programs include, yet are not limited to, Data Skills for Supervisors, Documentation for Child Welfare Professionals, Excel Training, New Worker Pre-Service Training, and Qualitative Review training.
  - ▶ *Qualitative Review Reviewer Training.* DCF staff and external stakeholders participating the in the QR as reviewers must complete a two day classroom training program before participating in a review. After completing the training, reviewers use a standard protocol in a shadowing/mentoring sequence involving two consecutive case review situations conducted in the field with an inter-rater agreement check made with the second case. The trainee's first case analysis and ratings, feedback session with frontline staff, oral case presentation, and first case write-up are coached by a qualified Qualitative Review Mentor.
  - ▶ *Supervisory QR Training.* In 2016, a liaison from PMA partnered with Training Academy and trained 623 staff in the QR Supervisory Seminar. The training provides an opportunity to understand the QR process and its impact and connection to case practice. Supervisors develop an understanding of the rating and debriefing process of the QR and begin to integrate the QR Protocol as a supervisory tool. The QR Supervisory Seminars have been completed. A total of 623 individuals were trained.

A representative from each Local Office was trained. Representation ranged from 1 to 20 persons per office.

► *Enhanced CQI Training:*

*Level 3. CQI Training* DCF implementing the pilot of an extensive 8 part training course and coaching-model to support the Office of Quality staff, Area Quality Coordinators and other key CQI staff in the Department in carrying out their roles as CQI champions within the organization. The purpose of the training is to strengthen PIP facilitation guidance, provide professional development in interpreting and using data to support CQI activities, and outline enhanced procedures for developing PIPs and reporting progress. Rutgers University is working with DCF in institutionalizing the Advanced CQI curriculum. The Advanced CQI curriculum is an in-person, onsite training developed by the Office of Quality. There is an existing curriculum for the 8 day training which is informed by DCF's CQI plan and based on the work of the Children's Bureau CQI Academy e-learning and Focused CQI services courses.

*Level 2. CQI Training.* DCF is also working with Rutgers to develop the curriculum for the CQI training for managers. The purpose of this training will be to provide managers with an opportunity to learn about implementation science and gain additional skills in using data to support management strategies. DCF anticipates that the training content and web design features will be completed by December 2017.

*Level 1. CQI Training.* DCF will implement training for the all staff to support CQI awareness and integration of DCF's CQI vision in daily practice. DCF anticipates that the training content and web design features will be completed by October 2017. In addition, DCF and Rutgers are developing the curriculum to accommodate contracted service provider trainees.

## Needs

- New Jersey developed draft policy and procedures to ensure consistency and uniformity across the state specifically for CQI related activities. Once finalized, this policy will be incorporated in the DCF Policy Manuals and available on the DCF public website.

## II. **Quality Data Collection:**

*Goal: Quality data collection is the collecting of both quantitative and qualitative data from a variety of sources and is the foundation of CQI systems. The data must be accurate complete and timely and must be used and defined consistently across the state. Quality data collection can identify areas of strengths, concerns, establish targeted strategies for improvement.*

### **Strengths**

- NJ's SACWIS system, New Jersey Spirit (NJS) is the system of record for the Division of Child Protection and Permanency (CP&P). NJS has system edits and validations, required fields, supervisory approvals, ticklers, and an Exception window all of which are utilized in various ways to ensure accurate, timely, data entry and supervisory oversight.
- Data from NJS is extracted via batch code to meet federal reporting requirements for AFCARS, NCANDS, and NYTD submissions.
- The State AFCARS and NCANDS Coordinator reviews ongoing periodic reports designed to monitor the timely entry and compliance. The Coordinator then works directly with the Area Office Quality Coordinators to improve the accuracy of this data as applicable. The Coordinator provides training as needed for new system functionality and for ongoing data quality improvement initiatives.
- New Jersey is in an AFCARS Improvement Phase (AIP) and making steady progress in mitigating findings rendered including identifying and implementing activities, tasks, and system changes directed at on-going data quality improvement.
- NJS data is also transformed through the SafeMeasures (SM) software application into a reporting system available as a case management tool. SM is available to frontline caseworkers, supervisors, and managers throughout the agency. SM contains over 100 screens with child level data and displays data monthly to casework and administrative staff and is used to guide workflow, track timely data entry, ensure data quality, and measure performance.
- Key Performance Indicator calls (KPI) are facilitated by Area Office Leadership, previously OPMA facilitated these calls but in being a transparent learning organization DCP&P Area Leaders now facilitate these calls focused on both quantitative and qualitative data. These calls are enormously successful in refining focus on several critical areas of practice as well as providing a tool for performance management. Some areas of practice reviewed in the KPI calls include: Case Plan timeliness, caseworker contacts

with children in placement and their parent(s), parent/child visits, sibling visits, and Family Team Meetings. The focus is on current and upcoming work, overdue work and outliers in performance. The KPI calls allow Local Offices to identify and address local and systemic issues and are solution focused in nature.

- New Jersey has a mechanism for tracking staff training through the Office of Training and Professional Workforce Development that includes an electronic transcript available and staff and supervisor electronic notifications of class related information.
- DCF has expanded its efforts to be more transparent by posting Department wide data on its public website. We also share our data via requests from other stakeholders. This includes data through specified data collections from Children's System of Care and Family and Community Partnerships.
- New Jersey continues to build capacity through training, the Fellows program, and the use of identified positions to ensure that data is current and when needed training is occurring to share strategies for improving data accuracy.
- DCF has initiated the 3 year Needs Assessment to look at the needs of children, youth and families and the services that are contracted to assist them. In addition DCF completed the DCF Trauma Needs Assessment and the Youth Needs Assessment.
- The Office of Performance Management and Accountability (PMA) launched the Caseload Verification Review Process in February 2017. The Caseload Verification Review Process assesses the quality of the intake assignment process and caseload data using a combination of administrative data, in depth case record reviews and qualitative interviews as necessary. The verification process consists of multiple levels of review beginning with administrative data and moving into more intensive qualitative processes as needed.

## Needs

- New Jersey continues to work on steps to improve data accuracy through ongoing training, oversight, and incorporation into CQI process. In particular, New Jersey is piloting a process to engage front line staff in a learning opportunity aimed at improving documentation and the overall quality of data input.
- New Jersey is in an AFCARS Improvement Phase and working toward completing all tasks/revisions with the approval by the Children's Bureau. DCF will need to demonstrate that the quality of the data has improved and been maintained.

- New Jersey is developing a sustainable process for internal audit process. DCF utilizes various proactive, systematic processes to address data quality.

DCF has staff positions dedicated to ensuring data quality. AFCAR and NCANDS Coordinators are data analysts that review ongoing periodic reports designed to monitor timely entry and compliance of data. The coordinators then work directly with the Area Quality Coordinators to improve the accuracy of this data, as applicable. The coordinators provide training as needed for new system functionality and for ongoing data quality improvement initiatives.

The Office of Performance Management & Accountability (PMA) launched the Caseload Verification Review Process in February 2017. The verification process assesses the “real time” quality of the intake assignment process and caseload data using a combination of administrative data, in-depth case record reviews and qualitative interviews, as necessary. The verification process consists of multiple levels of review.

Data from New Jersey Spirit, NJ’s SACWIS system, is transformed through the SafeMeasures (SM) software application into a reporting system available as a case management tool. SM is available to frontline caseworkers, supervisors, and managers throughout the agency and assist with ensuring data quality. SM contains over 100 screens with child level data and is used to monitor upcoming work, guide workflow, track timely data entry, verify data quality and measure performance. Staff can utilize SM to ensure case level data is accurate and report discrepancies to supervisors and the NJ Spirit Help Desk.

### **III. Case Record Review and Data Process**

*A CQI system that has ongoing case review components that includes reading case files that are served by the agency under the title IV-B and IV-E plans and interviewing parties involved in the cases is present. Case reviews help states understand what is behind the safety, permanency and well-being numbers in terms of day to day practice in the field and how the practice is impacting child and family functioning and outcomes.*

#### **Strengths**

- New Jersey operates a case review process called the Qualitative Review (QR). QR sampling is stratified to include a proportion of cases that reflects key geographic and demographic population factors, families who receive in home and out of home services, and the range of children served of different ages. The Quality Review is county-based in New Jersey’s twenty-one counties, with a rotating schedule of reviews. The QR sample is stratified to include a proportion of cases that reflect different

age groups including a group of children 0-17 years old and a group of youth 18-21 years old. The sample includes permanency goals of reunification, family stabilization, independent living, adoption, and kinship legal guardianship. Following each QR, the Office of Quality issues a final report which outlines key themes from the review and notes the specific strengths and areas needing improvement that were identified in the review process. After the review, a Program Improvement Plan (PIP) is developed locally for each county using team of both Area and Local office CP&P staff. The PIP builds on strengths while addressing areas and domains needing improvement. The PIP is subsequently tracked for implementation by the Area and Local Office CP&P staff and updates are provided to the Office of Quality.

- Each qualitative review (QR) sample includes a minimum of 10 cases and a maximum of 30 cases depending on the percentage of children and youth served in the county under review. This is a change from previous years when each county had the same number of cases reviewed despite differences in population served. The QR sample size was right-sized so that the sample size for each county is proportional to the percentage of children served resulting in larger counties having larger sample sizes. The total cases for review per year will be 195 in 2016 and 193 in 2017 which total 388.
  
- New Jersey finds consistent themes in strengths and areas needing improvement across multiple years through the QR. New Jersey assessed its case review process by comparing the CFSR and QR tools to determine difference in outcomes between the existing QR process tool and the CFSR on-sight review tool. Lessons learned from the study include; the tools measure similar content, both tools incorporate scoring strategies that are nimble enough to account for the complexity of the cases, and although the tools address similar content, the tools differ in what they measure. For example, the CFSR scoring rubric guides the reviewer to consider the “concerted effort” of the case workers more often than the QR. The QR score is more heavily influenced by the actual progress made toward outcomes and tends to include indicators that reflect the efforts of the family. There were no changes to the QR instrument or PIP process as a result of the study.

- New Jersey has detailed procedures and processes in place related to the QR. Procedures are reviewed and updated annually. There is a manual for the QR which is posted on the DCF internet. Internal forms and tools are also posted on the intranet to encourage transparency and consistency. There is training and a certification process for all QR reviewers and Team Leads from PMA who lead the review process and perform quality assurance processes during the review. Reviewers are also paired to provide mentorship to less experienced reviewers as well as to provide inter-rater reliability.
- New Jersey conducts multiple targeted reviews and audits and uses the results to inform and enhance practice and child and family outcomes. For example, New Jersey has reviewed its practice with older adolescents to see what that process outcomes are achieved with this population. Results are disseminated broadly.

### Needs

- New Jersey will work to develop specific plan for Title IV-E and Title IV-B sampling and a have continuous training for Title IV-E and Title IV-B staff.
- New Jersey continues to assess the case review process as part of the CSFR and how it relates to the QR process in existence. The federal OSRI was explored with two sample cases at each QR during 2016 to determine difference in outcomes between the existing QR process tool and the CFSR OSRI tool. As noted above there were no changes to the QR instrument or PIP process as a result of the study as both yielded similar results.
- New Jersey is working on policies to clarify areas like reviewer conflicts of interest.
- New Jersey continues to develop capacity to conduct targeted reviews on a variety of practice areas. Currently, staff resources are a combination of PMA and local field staff with expertise in the area of review. Such a practice has been beneficial in dissemination of lessons learned quickly. This process needs further refinement to ensure expectations are clear and targeted reviewer staff can translate their experience into CQI activities on a local level.
- New Jersey is in the process of developing a monthly Compliance Case Review that will team Office of quality staff with Local Office Staff hoping that his will enhance the shared responsibility of CQI on many different levels. New Jersey is

in the process of developing a monthly compliance case review. This ongoing CQI activity will allow the Office Of Quality to complete case record reviews to ensure timely completion of key case planning and permanency activities such as completion of case plans, contact with parents/children, and worker/supervisory conferences. The compliance case review can be utilized not only by the Office of Quality but also by designated area and local office staff to collect statewide data that will be used to make improvements to casework processes.

#### IV. **Analysis and Dissemination of Quality Data**

*The state should have the ability to collect data from various sources, and have varying capacities to track, organize, process and regularly analyze information and results. The state should have a consistent and well defined mechanism in place for collecting and analyzing data.*

##### **Strengths**

- Data from NJS is extracted via batch code to meet federal reporting requirements for AFCARS, NCANDS, and NYTD submissions. DCF routinely incorporates the use of the federal validation tools such as the AFCARS Compliance, Frequency, and Quality Utility reports in assessing the quality and accuracy of AFCARS data, and the Enhanced Validation and Analysis Application (EVAA) used to validate and analyze NCANDS Child File data.
- ORER provides DCF with quantitative and qualitative information necessary to measure and support organizational performance; report on the outcomes of service delivery to children and families; and to comply with state and federal requirements. It strives to produce information that can be used effectively by front-line staff; management and administration; and stakeholders.
- SafeMeasures (SM) software application is available to frontline caseworkers, supervisors, and managers throughout the agency and is used to guide workflow, track timely data entry, ensure data quality, and measure performance. DCF contracts with Hornsby Zeller Associates (HZA) to transform data recorded in NJ Spirit into longitudinal data reports. All CP&P managers and key support staff have been trained on the use of the reports. Measures in these reports include: number of entries, placement stability, number of exits, exits of older children, quartile lengths of stay, re-entry, discharge to permanency percentiles, permanency outcomes, and timeliness of adoption.
- Hornby Zeller Associates, Inc., transform data recorded in NJS into longitudinal data reports. DC&P, OPMA, and ORER management staff meet regularly to review and discuss longitudinal child welfare outcomes data to assess strengths and challenges, and for program and case practice planning and analysis. Management staff from OPMA, ORER, and CP&P held meetings with Area and Local Office staff to present the longitudinal data and provided guidance on

interpreting and utilizing the data in their day to day work. RER and HZ staff also presented the longitudinal data to the Area Quality Coordinators with guidance on interpreting and utilizing the data.

- The Manage by Data Initiative (DCF Fellows Program) enables managers to learn how to better use data to support improved case practice and outcomes for children and families with a focus on data analysis skill building and dissemination of data via presentations to management and case practice staff statewide.
- New Jersey is committed to improving stakeholder engagement through the regular posting on the DCF internet page of various child welfare related reports. These reports are used to guide decision-making as well as to manage workloads. Reports have been well received by stakeholders.
- New Jersey QR has a consistent mechanism in place for gathering, organizing and tracking information and results regarding safety, permanency, and well-being.
- New Jersey's Office of quality has begun presenting a robust data story to offices following the QR that includes Safe Measures data, Hornsby Zeller data and QR data to assist offices in developing and enhancing the PIP process. The Office of Quality began presenting data stories in February of, 2016. The Office of Quality wanted to ensure that local office staff members were also aware of the findings presented in the data story. As a result, the Office of Quality staff implemented local office data story presentations. These presentations ensure that local office staff gain insights from the reviews, but also provide an initial opportunity for the local offices to provide insight as we explore the root causes of identified problems. A robust data story begins with using data to identify areas of good practice and areas of challenge, and ends with hypothesizing its causes. The county qualitative data measures from the QR are presented to staff and leadership, including a focus on challenging areas that did not score a strength rating of at least 70%. Stories from the QR or Stories Behind the Data (SBTD) are shared to help staff link the QR indicators to case practice. The focus of the presentation then turns to linking qualitative measures from the QR with quantitative measures from SafeMeasures administrative data. The areas of practices that are determined to be both a qualitative and quantitative strength are given positive recognition. For example, if the QR determined the child and family planning process to be a strength, and the quantitative data determined case plans are completed timely, then positive recognition is provided. However, if the QR determined the child and family planning process to be an area of challenge, and the quantitative data determined case plans are completed timely, than feedback is elicited from staff as to why the problem exists. The initial feedback from staff is the beginning of the QR PIP development. In addition, case practice performance trends, longitudinal and outcome data is shared with

staff to provide an understanding of areas of practice that have improved or declined over time and since the last QR. Staff are provided the opportunity to ask questions and are invited to participate on the county CQI team to help develop the QR PIP. The data story and county QR PIP team are part of DCF's CQI approach rooted in scientific reasoning. This framework helps shape and formalizes ongoing strategies for developing and learning from CQI activities.

### **Needs**

- New Jersey acknowledges there is still work to be done to help stakeholders use the available data for analysis as well as to make more data available.
- New Jersey makes reports and recommendations from targeted reviews available on the internet and more work is needed to improve the timeliness of the dissemination of the reports.
- DCF is in the process of a more complex statistical analysis to look at family risk and protective factors to predict outcomes for children and families.
- DCF is engaged in a 3 year Needs Assessment to look at the needs of children, youth and families and the services that are contracted to assist them. In addition DCF completed the DCF Trauma Needs Assessment and the Youth Needs Assessment.

## **V. Feedback to Stakeholders**

*Goal: A functioning CQI system demonstrates the state's ability to share critical information and data collected with stakeholders, and agency staff. This is a critical component to driving change within the organization. Such collaborative efforts are critical to improving outcomes for children and families.*

### **Strengths**

- New Jersey is committed to sharing results of its assessment processes publically with internal and external stakeholders. For example, results from the QR process, prior CFSR rounds and targeted reviews are shared with staff and the results are placed on the DCF website in an effort to help inform all of strengths and areas of improvement.
- New Jersey has successfully piloted monthly conference calls with local leadership and staff from PMA to track and monitor key areas of performance to improve outcomes. On-going work is reviewed, upcoming work is anticipated and barriers to performance are identified through the calls.

- Using a SharePoint site, monthly reports are routinely posted for local leadership to access. Reports have recently included data on local key child welfare outcomes. The reports available on SharePoint include Monthly Screening & Investigation Report, Worker Caseload Report, and Key Performance Indicators.
- Stakeholders are invited to participate in a range of CQI activities including development of local QR PIPs, attendance and participation at ChildStat as well as providing input and feedback on the DCF Strategic Plan.
- New Jersey also has implemented a process by which resource (foster) parents can offer feedback on the system on an annual basis through a survey. The survey is analyzed and actionable next steps are formulated.
- DCF is a learning organization and committed to transparency in sharing critical data with agency staff and stakeholders. This commitment is evidenced by the multitude of data reports made available on the public website, some of which include:
  1. The Commissioner's Dashboard - a monthly report of selected data points that helps us understand the families we serve and how we are doing. It reflects work across the department. The Commissioner's Dashboard helps guide our efforts as we strive daily to fulfill our department-wide vision and mission.
  2. Caseworker Visits for Children in Foster Care - a critical indicator of performance that we monitor very closely.
  3. Foster Care Entry Rate per 1,000 children - significant changes in the entry rate may reveal trends that require further analysis to understand the fluctuations, point to the need to consider changes to the services available, and provide important trend information for planning and budgeting purposes.
  4. Time To Reunification – one of the various ways we can use data to examine our performance from a broad perspective.
  5. Exits to Reunification – informs whether efforts made to improve reunification outcomes are improving over time as new initiatives are put in place.
  6. Absence of Maltreatment While in Foster Care - continually monitors performance relating to the small percentage of children who are harmed while in placement so that we can take further steps to further insure the safety of those individual children, while also potentially learning from the situation to inform our future work.
  7. Children Re-Entering Foster Care Within 12 Months of a Previous Episode - re-entry rates to help us further examine issues such as assessment processes that precede reunification, as well as the effective of services delivered to the family to assist with reunification. The rate of re-entry is also valuable information to our system partners, such as the Family Courts who also involved in determining whether children should be reunified.

8. Children Without a Recurrence of Maltreatment Within 6 Months of a Previous Incident - Being able to assess the recurrence of maltreatment within a short period of time is important feedback for quality improvement systems.
- DCF is engaged in a 3 year Needs Assessment to look at the needs of children, youth and families and the services that are contracted to assist them and is utilizing an external stakeholder advisory boards to assist with recommendations and improvement input.
  - DCF introduced leadership to CQI and received critical feedback via focus groups and survey monkey.
  - New Jersey uses ChildStat to offer technical assistance and feedback to staff on how data results link to practice change. The goal is to help staff understand the meaning behind the data as well as the larger outcomes that are the most meaningful.
  - OPMA and CP&P are hosts to data meetings aimed at examining long term outcomes for the children, youth and families served. Practice trends and data are shared and discussed to determine areas in need of focus, planning and implementation steps.
  - Special Reports on Targeted Case Reviews such as DCF Investigations Review, Measuring Services for Youth 18-21 and others: see link for other reports and details <http://nj.gov/dcf/about/divisions/opma/>
  - DCF Office of Advocacy gathers feedback from Constituents and identifies issues and trends to help DCF work in collaboration with its partner agencies to improve services to children and families.
  - New Jersey will uses ChildStat forums to offer training and technical assistance to staff on how data results link to practice change. The goal is to help staff understand the meaning behind the data as well as the larger outcomes that are the most meaningful.
  - The Office of Quality held its first QR summit to assist staff in making that link between qualitative data and quantitative data and identify additional strategies to support leadership in learning what is needed to enhance CQI across the department.

### Needs

- New Jersey will also hold a yearly CQI summit that will assist staff to make that link between qualitative data and quantitative data while helping leadership learn

what is needed to enhance CQI across the department. The purpose of the annual CQI Summit is to review the implementation of the CQI system with diverse stakeholders. DCF will use this opportunity to review its CQI philosophy, system and processes to ensure well established oversight is in place and well-functioning mechanisms for collecting, analyzing, disseminating and using data are operating to improve the quality of service provided to children and families.

# Section J

## Child Abuse Prevention and Treatment Act State Plan Requirements & Update

CAPTA Coordinator/State Liaison Officer:

New Jersey Department of Children and Families  
Division of Child Protection and Permanency  
John Ramos Jr., MSW  
P.O. Box 0717  
Trenton, NJ 08625-0717  
(609) 888-7000  
[John.ramos@dcf.state.nj.us](mailto:John.ramos@dcf.state.nj.us)

Since the submission of the NJ State CAPTA Plan as well as subsequent APSR, there have been no significant changes to the way in which funding to support the program areas under CAPTA have been used. Currently NJ identifies the following program areas to fund under CAPTA:

1. Intake, assessment, screening and investigation of report of children abuse or neglect
  
3. Case management, including ongoing case monitoring and delivery of services and treatment provided to children and their families

10. Developing and delivering information to improve public education relating to the role and responsibilities of the child protection system and the nature and basis for reporting

Under these three program areas, funds are used for a variety of different programs to include but not limited to the DCF Family Success Centers

(<http://www.nj.gov/dcf/families/support/success/>), collaborative training opportunities for investigative workers as well as community stakeholders such as Finding Words (<http://www.nj.gov/dcf/providers/boards/njtfcaw/work.html>); services to assist with high risk factors for families such as Domestic Violence (<http://www.nj.gov/dcf/women/domestic/>), public awareness services such as the Child Assault Program (<http://www.nj.gov/dcf/families/assault/>). Substance abuse issues are a predominant high risk factor for families in NJ, similar across the nation. That is why funding towards substance abuse services and programs remains a critical resource.

Additional information related to these funded areas are listed within this section to include CAPTA Community Based Child Abuse Prevention programs & Children's Trust Fund (listed under "populations at greatest risk of maltreatment" section), Child Protection Substance Abuse Initiative as well as the three citizen review panels. Additional funds coordinated from other programs such as the Children's Justice Act and Court Improvement Program are listed as well.

#### **Update of Services to Substance-Exposed Newborns**

New Jersey, similar to the rest of the nation, continues to see an increase in substance abuse by adults and youth as well as an increase in neonatal drug exposure. The effects of substance exposed infants can have lasting and devastating effects well into adulthood. The New Jersey Department of Human Services, Division of Mental health and Addiction Services reports that the primary drug reported for treatment services is Heroin with about 40% on average over the past 5 years (<http://www.nj.gov/humanservices/dmhas/publications/statistical/>). As such, NJ recognizes the need for early identification of substance exposed newborns as well as the identification of necessary interventions to provide safe care to them.

[DCF has submitted the Governor's Assurance statement for CARA as referenced in attachment F which includes additional reference information to support New Jersey's compliance with this legislation to include the following descriptions.](#)

NJ has policies and procedures in place to ensure that any infant born substance exposed or diagnosed with Fetal Alcohol Spectrum Disorder are reported to DCF through the Division of Child Protection and Permanency. NJ state statute defines an abused child and also identifies that any person with reasonable cause to believe any child has been subjected to abuse is a mandated reporter ([http://lis.njleg.state.nj.us/cgi-bin/om\\_isapi.dll?clientID=195252&Depth=2&depth=2&expandheadings=on&headingswithhits=on&hitsperheading=on&infobase=statutes.nfo&record={3818}&softpage=Doc\\_Frame\\_PG42](http://lis.njleg.state.nj.us/cgi-bin/om_isapi.dll?clientID=195252&Depth=2&depth=2&expandheadings=on&headingswithhits=on&hitsperheading=on&infobase=statutes.nfo&record={3818}&softpage=Doc_Frame_PG42))

The CP&P allegation based system policy defines specific reportable criteria for accepting reports on abuse and neglect which include the risk of harm due to substance abuse by a

parent/caregiver. Under certain circumstances, this allegation can be identified as either abuse or neglect and policy outlines the circumstances, investigating this allegation and requirements to include medical consultation and information ([http://www.nj.gov/dcf/policy\\_manuals/CPPII-E-1-1300\\_issuance.shtml](http://www.nj.gov/dcf/policy_manuals/CPPII-E-1-1300_issuance.shtml))

Policy also requires that any child under 3 years of age who is involved in a Substantiated or Established incident of child abuse or neglect must be referred by CP&P to the New Jersey Early Intervention System (EIS) for assessment of services

([http://www.state.nj.us/dcf/policy\\_manuals/CPPII-V-A-5-200\\_issuance.shtml](http://www.state.nj.us/dcf/policy_manuals/CPPII-V-A-5-200_issuance.shtml)). NJ SACWIS system has been upgraded to automatically prefill a referral to EIS when a child victim matching the criteria has been identified in the system. Policy also guides CP&P staff on referrals to EIS when absent of a Substantiated or Established finding or in non-CPS matters to refer any child under 3 when there are identified concerns noted for the child's development. CP&P makes up about 14% of the referrals to EIS, the second largest referral source to this intervention in SFY 2015 ([http://nj.gov/health/fhs/eis/documents/system\\_data/sfy15\\_all\\_referral\\_source.pdf](http://nj.gov/health/fhs/eis/documents/system_data/sfy15_all_referral_source.pdf))

NJ EIS is the statewide system of services for infants and toddlers, birth to age three, with developmental delays or disabilities, and their families through the NJ Department of Health, Division of Family Health Services. Majority of referrals stem from a diagnosis of delayed developmental milestones (95.59%) with a small referral source for FAS (0.02%)

[http://www.nj.gov/health/fhs/eis/documents/system\\_data/referral\\_count\\_diagnosis.pdf](http://www.nj.gov/health/fhs/eis/documents/system_data/referral_count_diagnosis.pdf). There are eleven Child Evaluation Centers statewide that provide comprehensive multidisciplinary evaluations and individualized service plans for children, six of which provide specific diagnostic services for children with or suspected of having FAS

<http://www.nj.gov/health/fhs/sch/cec.shtml>

For children under the CP&P supervision in out of home placement, the Office of Child and Family Health & Clinical Services (OCFH & Clinical Services) Child Health Unit coordinates all of their health care needs. The OCFH & Clinical Services participates on a statewide interdepartmental team to include NJ Department of Health (DOH), Department of Human Services (DHS) and the Attorney General's Office and has formed the Interagency Opioid Workgroup which focuses on addressed opioid use in pregnancy, Neonatal Abstinence Syndrome (NAS) and Substance Exposed Infants (SEI). DCF is also partnering with DOH, DHS and the National Center of Substance Abuse and Child Welfare (NCSACW) technical assistance to develop practice guidelines to address the multi-faceted problems of NAS and SEI. Progress updates for this can be reviewed under Attachment B: Health Care Oversight and Coordination Plan Update as well as an overview at DCF collaborative partners at DHS:

[http://www.nj.gov/humanservices/dmhas/information/provider/Provider\\_Meetings/2015/IDTA\\_SEI\\_NAS\\_Quarterly\\_Provider.pdf](http://www.nj.gov/humanservices/dmhas/information/provider/Provider_Meetings/2015/IDTA_SEI_NAS_Quarterly_Provider.pdf)

NJ DCF continues to be committed to combating human trafficking and ensuring that youth and adolescent victims receive the appropriate care, treatment, and services needed to heal and recover.

Using a multi-disciplinary approach, DCF works with law enforcement, health care providers, community organizations and other interested parties to support human trafficking awareness, prevention and service programming while ensuring that services to human trafficking victims are trauma-focused, strength-based, culturally sensitive, gender and developmentally appropriate, and informed by comprehensive evaluation that includes physical and mental health assessments.

NJ has implemented policies and procedures as it relates to Victims of Human Trafficking legislation and submitted the signed Governor's Assurance statement and supporting documentation on May 25, 2017. Please see attachment G as a reference.

## **NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES**

### **The State of New Jersey**

### **CHILDREN'S JUSTICE ACT**

#### **Performance Report – Federal Fiscal Year (FFY) 2016**

The New Jersey Task Force on Child Abuse and Neglect (NJTFCAN) and the New Jersey Department of Children and Families (DCF) is pleased to submit a program report for the Children's Justice Act (CJA) grant. In FFY 2016, CJA funds were used to develop, implement and administer programs designed to improve:

- the handling of child abuse and neglect cases, particularly cases of child sexual abuse
- and exploitation, in a manner which limits additional trauma to the child victim;
- the handling of cases of suspected child abuse or neglect related fatalities;
- the investigation and prosecution of cases of child abuse and neglect, particularly child sexual abuse and exploitation; and,
- the handling of cases involving children with disabilities or serious health-related problems who are victims of abuse or neglect.

#### **CJA FFY 2016 Grant Activities**

In FFY 2016, CJA funds were used for child-centered programs and designed to prevent additional trauma to child victims. Since its inception, NJTFCAN has advocated for a statewide multidisciplinary approach to the investigation, prosecution and treatment of cases of child physical and sexual abuse. Model programs funded through CJA provided state-of-the-art training in the identification, investigation and prosecution of child abuse and neglect and improved diagnostic and therapeutic services to child victims and their families.

#### **Model/Demonstration Programs**

##### ***NJTFCAN Professional Development & Training Programs***

Each year, NJTFCAN sponsors multidisciplinary training programs to improve the handling of cases of child abuse and neglect. All NJTFCAN sponsored professional training programs are child-focused and designed to promote skills that prevent additional trauma to child victims and their families.

In FFY 2016, CJA funds were used to support the following professional development projects to enhance the knowledge of persons involved in the investigation, prosecution, assessment and treatment of child abuse and neglect.

## **\$84,000 - Finding Words-New Jersey: Forensic Interviewing Training**

### Statement of Purpose

Since 2002, the DCF and NJTFCAN have supported Finding Words-New Jersey, a forensic interviewing program originally developed in collaboration with the American Prosecutors' Research Institute (APRI) and based on the national Corner House protocol RATAAC and subsequently disseminated by the National Child Protection Training Center (NCPTC). The goal of the project is to train frontline professionals involved in the investigation and prosecution of child abuse to conduct an effective and legally defensible interview of alleged child sexual abuse victims of various ages and prepare children for court. At the completion of the five day training, participants have a meaningful understanding of important concepts and practices including: child abuse dynamics, children's language and development, memory and suggestibility, the impact of questions on the process of abuse disclosure and factors associated with a credible and reliable child statement.

Forensic Interviewing is one of the steps in most child protective services investigations, including those conducted by DCF's Child Protection & Permanency (CP&P). A professional investigator interviews a child to ascertain whether that child has been abused or neglected. Forensic interviewing not only brings out information that is needed to determine if abuse or neglect has occurred, it may also provide evidence that is admissible in court should the investigation lead to criminal prosecution. A legally sound forensic interview relies on interviewer objectivity, the use of non-leading questioning techniques and precise documentation.

### Target Population

- Prosecutors, CP&P child abuse investigators, law enforcement, multidisciplinary teams, and professionals involved in interviewing alleged child victims of maltreatment.

### Approach

- Intensive classroom curriculum provided by professionals with expertise in civil and criminal cases of child abuse.
- Lecture, group discussion, role play and videotaped mock interviews.
- Videotaped interviews are critiqued by the teaching faculty with suggestions for improvement.
- Participants evaluate the training and make suggestions for improvement.

### Outcome

In FFY 2016, the following trainings were conducted throughout the State:

- March 14-18, 2016 Training - Held in Camden County
  - 40 participants\* and 1 observer\*\*:
  - Atlantic County: 2 from CP&P, 1 from police, 2 from the prosecutor's office
  - Burlington County: 2 from CP&P, 3 from the prosecutor's office, 1\*\* observer
  - Camden County: 4 from CP&P, 5 from the prosecutor's office
  - Cape May County: 1 from CP&P, 1 from the police, 4 from the prosecutor's office
  - Cumberland County: 2 from CP&P, 2 from police, 1 from the prosecutor's office

- Gloucester County: 2 from CP&P, 1 from police, 2 from the prosecutor's office
- Salem County: 1 from CP&P, 1 from the police, 3 from the prosecutor's office
- June 6-10, 2016 Training – Held in Passaic County
  - 40 participants\*, 11 observers\*\*:
  - Bergen County: 2 from CP&P, 4 from the prosecutor's office, 1 observer
  - Cumberland County: 1 from the prosecutor's office
  - Essex County: 6 from CP&P, 5 from the prosecutor's office, 1 from Wynona's House, 1 observer
  - Hudson County: 4 from CP&P, 2 from the prosecutor's office
  - Hunterdon County: 1 observer from the prosecutor's office
  - Morris County: 2 from CP&P, 1 from police, 2 from the prosecutor's office, 2 observers
  - Passaic County: 2 from CP&P, 2 from the prosecutor's office, 2 observers
  - Sussex County: 2 from CP&P, 1 from the prosecutor's office, 2 observers
  - Somerset County: 1 observer
  - Warren County: 1 from CP&P, 2 from the prosecutor's office, 1 observer
- October 17-21, 2016 Training – Held in Middlesex County
  - 39 participants\*, 18 Observers\*\*:
  - Bergen County: 7 observers
  - Essex County: 1 from DCF, 1 observer
  - Hunterdon County: 1 from CP&P, 3 from the prosecutor's office, 1 observer
  - Mercer County: 2 from CP&P, 1 from DCF, 3 from the prosecutor's office
  - Middlesex County: 3 from CP&P, 8 from the prosecutor's office, 3 observers
  - Monmouth County: 2 from CP&P, 2 from the prosecutor's office, 3 observers
  - Ocean County: 2 from CP&P, 2 from the prosecutor's office, 1 observer
  - Somerset County: 1 from CP&P, 1 from the prosecutor's office, 1 observer
  - Union County: 3 from CP&P, 2 from the prosecutor's office, 1 observer
- December 12-16, 2016 Training – Held in Passaic County
  - 24 participants\*:
  - Atlantic County: 1 from the prosecutor's office
  - Bergen County: 5 from the prosecutor's office
  - Camden County: 1 from the prosecutor's office
  - Essex County: 5 from DCF, 1 psychologist
  - Mercer County: 3 from the police, 2 from the prosecutor's office
  - Middlesex County: 2 from the police
  - Morris County: 3 from the prosecutor's office
  - Passaic County: 2 from the prosecutor's office
  - Union County: 2 from the prosecutor's office

*[\*Actual number of attendees reported]*

*[\*\* Observers do not conduct the mock interviews with both the child (non-abuse event) and actor (portraying a child victim and using the interview protocol). They attend all the lectures, sit in on the break-out room discussions and take the post test. Observers receive a certificate of attendance while participants get a certificate of completion.]*

### Impact of the Program on the Child Protection System

The *Finding Words-New Jersey* child-focused forensic interviewing project continues to reform the investigation and prosecution process and improve civil and criminal court proceedings. To date, over 2,000 professionals involved in investigating child sexual abuse have been trained in the *Finding Words-New Jersey* protocol and have demonstrated, through role play, effective child sensitive interviewing skills. Multidisciplinary team members are more knowledgeable about the process of disclosure, age appropriate guidelines in questioning, child development, barriers to disclosure, memory, perpetrator/victim relationships, suggestibility and problems encountered during the interview.

Some of the outcomes of the training are:

- Prosecutors have adopted Finding Words - NJ as their protocol of choice when interviewing alleged child abuse victims.
- Criminal cases are strengthened with accurate information to withstand legal scrutiny and child victims are better prepared for courtroom testimony.
- Child victims experience fewer traumas during the investigation and prosecution process
- Prosecutors are more sensitive to the special needs of child victims and actively support the development of Child Advocacy Centers (CAC).
- The project is in compliance with the goals of the Task Force CJA Three-Year Assessment to reform the investigation and prosecution process and improve civil and criminal court proceedings.
- NJTFCAN continues to work with DCF to facilitate child-focused forensic training for CP&P child abuse investigative units.

### **\$28,000 - Multidisciplinary Team (MDT) Training**

#### Statement of Purpose

In FFY 2016, CJA funds were used to support one or more statewide training conferences for members of multidisciplinary teams (MDT), child welfare/protection workers and prosecutors' child abuse units.

In 1990, NJTFCAN collaborated with the New Jersey Department of Children and Families' CP&P to develop a training curriculum and implement a multidisciplinary case management approach to handling criminal cases of child abuse. Children's Justice Act funds provide annual training to multidisciplinary teams made up of professionals in law enforcement, prosecution, child protective services, mental health, medicine, and victim witness advocacy.

MDTs provide case supervision from the initial criminal and civil investigation to case disposition. The MDT coordinator ensures that members are informed about changes in the case and that child victims receive the appropriate physical and mental health assessments and support services to prevent additional trauma during the investigation and prosecution process. (See Appendix B – Agenda)

#### Target Population

- Statewide multidisciplinary teams and professionals in law enforcement, child protection, social work, mental health, domestic violence, and juvenile justice.

### Approach

- Classroom training in a multidisciplinary case management approach to facilitate investigations, prosecution and treatment of child physical and sexual abuse from investigation to case disposition.
- Training seminars conducted by State and national experts in joint investigations, child deaths, psychological and medical evaluations, child safety, prosecution issues, expert witness testimony, victim witness advocacy and issues related to the MDT process.
- Ongoing evaluation of training needs by the NJTFCAN, and partners.

### Outcome

May 26, 2016 – The “*MDT Response to High Tech Crimes and Resilience in the 21<sup>st</sup> Century*” conference held at the New Brunswick Theological Seminary in New Brunswick, New Jersey was attended by 200 child protection professionals. Attendees included prosecutors, law enforcement, child protective service workers, medical professionals, mental health professionals, victim advocates, CAC Directors, MDT Coordinators, RDTC professionals, guidance counselors and advocates. The professionals came from 21 counties throughout New Jersey, as well as from some state-wide agencies. Presenters included Francoise Mathieu, M.Ed., RP, who presented “Understanding Compassion Fatigue in Child Welfare” and Justin T. Fitzsimmons, J.D., who presented “Technology-Facilitated Child Sexual Exploitation: A Primer”. Social work CEUs were provided by the Rutgers Office of Continuing Professional Education. Also, this conference offered New Jersey Continuing Legal Education (CLE) credits under the approved provider status of the Camden County Prosecutor’s Office.

### Impact on the Child Protection System

- County prosecutors continue to embrace the MDT case management approach to the prosecution of child abuse.
- Child victims are referred to regional diagnostic treatment centers for medical and mental health assessment.
- Ongoing training enables law enforcement, social workers; medical and mental health providers to learn about changes in the law, prosecution issues, forensic interviewing, and treatment protocols.
- The MDT supports the expansion of child advocacy centers throughout the State where child victims can be interviewed and receive support services in a neutral setting.
- Prosecutors’ cases are strengthened through the MDT case management approach.
- Child victims and their families are better informed about the progress of the case and children are emotionally strengthened for courtroom testimony.
- Ongoing training strengthens MDT best practice standards and education about child abuse issues, and team functioning

- Child death cases will be investigated to identify child abuse factors.

### **\$62,000 - Biennial Conference**

#### Statement of Purpose

NJTFCAN, in collaboration with DCF, and with the logistical assistance of Rutgers University, Office of Continuing Professional Education, will host a statewide conference for up to 600 professionals in the field of child welfare on Friday, September 8, 2017 at the centrally located Westin Princeton at Forrestal Village in Princeton, NJ entitled, *“Implementing Evidence Supported Services for Children and Families.”* This interdisciplinary conference will provide professionals and advocates working with children and families an opportunity to learn from experts in child welfare/protection issues and disciplines serving children and families. The speakers for this event will include national and local experts in evidence supported practice and implementation: Allison Metz, Ph.D., Evelyn Kappeler, Kimberly DuMont, and Esther Deblinger, Ph.D. (See Appendix C – Agenda)

#### Target Population

- Professionals in child welfare, law enforcement, social work, educators and daycare providers, mental health, medicine, juvenile justice, domestic violence, law guardians, and CASA volunteers.

#### Approach

- Workshops will be conducted by experts in their respective fields.

#### Impact on the Child Protection System

- Front-end child welfare professionals, community partners, volunteers and advocates will be better informed and learn new strategies for responding to child maltreatment.
- Children and families will be better served by the child protection system.

#### Outcome

- This event focuses on building professional knowledge and collaborative partnerships to improve the effectiveness of New Jersey’s child maltreatment protection and prevention efforts and sought to encourage working relationships among volunteers and professionals in prevention, protective services, health, law enforcement, and juvenile justice to create child- and family-focused systems.

### **\$32,000 - Skill Building Conference**

#### Statement of Purpose

NJTFCAN, in collaboration with DCF, hosted a statewide multidisciplinary skill building conference on Friday, September 9, 2016 for 300 child protection professionals entitled, *“The Digital Realm of Child Abuse.”* This day-long skill building event allowed for a comprehensive examination of child abuse images, also referred to as sexually exploitive images or child pornography. Speakers covered what child abuse images encompass, the victims and their families, roles of law enforcement, the perpetrators, the trauma inflicted,

and how to respond. Sextortion, sexting, cyber bullying and revenge pornography were also part of the presentations. (See Appendix D – Conference Materials)

### Project Objectives

- To enhance the knowledge of approximately 300 child protection professionals.

### Target Population

- Professionals in child welfare, law enforcement, social work, educators and daycare providers, mental health, medicine, juvenile justice, domestic violence, law guardians and CASA volunteers.

### Approach

- Selected experts will present on a topic of relevance in child abuse and neglect.

### Impact on the Child Protection System

- Provided an overview of child abuse images and the law.
- Described “the path” of child abuse images, from victimization to restitution.
- Outlined what child welfare professionals need to know about child abuse images and what to do if the situation is encountered.
- Discussed information about what needs to be done to safeguard children in the future.

### Outcome

- Professionals from various disciplines will improve their knowledge concerning the latest research and emerging child welfare issues.
- Enhanced knowledge and professional development of multidisciplinary teams and CASA volunteers.

## **\$229,321 - CJA New Initiatives via Community Request for Information**

### Statement of Purpose

NJTFCAN and DCF distributed a request for information/plan to solicit projects and ideas to improve the State’s child protection system in accordance with CJA criteria. Listed below the objectives, target population, approach, results expected and expectations proposed are the projects and new initiatives conducted in FFY 2016.

### Project Objectives

- To solicit innovative projects to improve the state’s response to child maltreatment and prevent additional trauma to child victims involved in the court process.
- To support best-practice standards in the identification, investigation, prosecution, and treatment of child maltreatment.

- To implement the goals and recommendations in the NJTFCAN CJA Three-Year Assessment.

#### Target Population

- Prosecutors, Human Service Advisory Councils, the Administrative Office of the Courts, caseworkers, educators and daycare providers, mental health providers, public/private agencies, regional diagnostic treatment centers and child advocacy centers.

#### Approach

- The request for information/plan was sent out to the public/target audience via DCF's statewide e-mail list.
- The request for information was advertised on the DCF website.
- Proposals were reviewed by a selection committee.

#### Results Expected

- Partnerships were developed with County and State entities as well as private, nonprofit agencies to implement the goals and recommendations of the NJTFCAN CJA Three-Year Assessment.
- Effective programs will grow in order to improve child protection systems.

#### Impact on the Child Protection System

- Partnerships will be developed to implement improvements in the child protection system and respond more effectively to child maltreatment.
- The child protection system will adopt improved strategies for handling civil and criminal cases of abuse and neglect.
- Professionals will receive specialized training to work with children and families involved in the investigation and prosecution process and child victims will experience less trauma.
- Families and children involved in the prosecution process will be informed about the services of child advocacy centers, multidisciplinary teams and RDTC's.
- Understanding the co-occurrence of child abuse and domestic violence.

#### ***Additional and Unique Professional Development – Trauma Informed Care***

##### **\$79,000 - Taming Trauma Training**

##### Statement of Purpose

The goal of this project is to provide training and consultation services to DCF administration, supervisors, staff, and stakeholders regarding trauma and secondary trauma experiences and its effects on the individual.

Taming Trauma uses the Adverse Childhood Experiences (ACES) study by Kaiser Permanente and the Center for Disease Control (CDC) to illustrate that the population the DCF worker serves is highly traumatized, having likely endured at least one, and too often many, traumatic experiences. Participants explore how such trauma can be acute and trigger a persistent stress response that is unable to be regulated by the individual(s) experiencing it. In turn, participants will gain an understanding how this causes physiological, cognitive and behavioral adaptations, and later maladaptation for survival.

Current research shows that child welfare workers have the highest rate of secondary traumatization in their workplace. In a circular fashion, the family experiences a traumatic event, then the worker experiences secondary trauma in their work with the family (which may also activate their own traumatic experiences) and this in turn affects the families with whom they work. This continuous exposure to traumatic events has been shown to have a significant effect on worker turnover, absenteeism, and medical leave.

The training shows the DCF employee how to recognize their own stress response and that of the youth and family members with whom they are working. The training focuses on defining secondary trauma and its effects to help DCF system partners to develop techniques to regulate and physically respond to stress. Participants will understand how their own stress response is triggered and it can then lead to their own secondary traumatization if not self-regulated. The training ends with interactive exercises to allow them to work with other participants to use the newly taught set of tools called Mutually Therapeutic Dyadic Attunement (MTDA) tools to bring together all the concepts around hierarchical brain shutdown due to chronic stressors and how to utilize breath, posture, breathing, “paralleling” and other interventions to down regulate oneself and the other in dyadic work.

#### Target Population

- The target population served by this program is DCF administrators, supervisors, staff, and stakeholders who are working with youth and their families. The trainee population is diverse: education ranges from some high school to doctoral level; various learning styles (including learning challenges) are represented; and of course, many cultures are reflected. Several professional disciplines are represented as well.

#### Approach

- Intensive classroom curriculum provided by Eric Arauz, President of the Trauma Institute of New Jersey.
- Lecture and group discussion.
- Role play activities in the use of Mutually Therapeutic Dyadic Attunement (MTDA) tools.
- Experiential learning activities include activation and management of the sympathetic and parasympathetic nervous system, Bee breath, Proximal abandonment test, and Yes/No experiment.
- Video presentations on Validation Therapy and the Still Face Experiment.
- Participants evaluate the training and make suggestions for improvement.

Outcome

In FFY 2016, the following trainings were conducted throughout the State:

- April 2016 – The training was first delivered jointly to Division of Child Protection and Permanency (CP&P) and Children’s System of Care (CSOC) leadership and was attended by 45 staff members.
- July 2016 – Three trainings were offered for Casework Supervisors and Local Office Managers of CP&P as well as Division Staff and Executive and Supervisory Level of Care Management Organizations of CSOC.
- October 2016 - March 2017 – Twenty trainings were offered for CP&P line staff and CSOC Care Managers.
- To date, 544 CP&P staff and 692 CSOC staff have successfully completed this training.

Impact on the Child Protection System

- A top down process was developed to offer this program first to the highest level of management, then the supervisory level, and finally the front line staff. CP&P and CSOC staffs were trained together, fostering common understanding and collaboration between youth and family serving staff in New Jersey.
- Attendees demonstrated increased ability to recognize their own stress responses and ways to regulate and reduce it.
- On evaluations, staff reports a better understanding of trauma and its effects on the individual.
- Data (non-identifying) has been collected on participant’s ACE test scores and meetings are underway to develop strategies to analyze this data.

***Additional and Unique Professional Development – Human Trafficking*****\$8,000 - Media Literacy and Internet Safety Training**Statement of Purpose

In alignment with the three year assessment identified priority of Internet Related Child Abuse Issues, in 2015 - 2016 DCF hosted the Child Welfare League of America’s, entitled, “Media Literacy and Internet Safety: A Comprehensive Seminar on the Impact of Social Media and Technology on Today’s Society and Youth.” This seminar provides information on the areas where children, particularly those in foster care, are increasingly vulnerable and, thus, need proper education and supervision. These topics include, but are not limited to: internet safety, cyber bullying, media marketing and advertisement, music’s impact on values and behavior and the desensitization of violence via video games. (See Appendix E – Training Information)

Target Population

- Professionals in child welfare and child behavioral health.

Approach

Workshops are conducted by Marcus Stallworth, expert in media literacy and internet safety in child welfare.

Impact on the Child Protection System

- Professionals will be better informed about the dangers of the internet and other social media and learn new strategies for working with children and families as well as in their response to child maltreatment.
- The Media Literacy Project aligns with CJA's focus on the front-end of child welfare by providing critical information about online tools to navigate human trafficking websites (for instance, the human trafficking website, Backpage).

Outcome

- CWLA provided DCF a two-day seminar training on media literacy and internet safety conducted by Marcus Stallworth. These training were held on February 25-26, 2016 and August 18-19, 2016 at DCF's Professional Center in New Brunswick, New Jersey for 59 attendees across two trainings.

**\$14,000 Shared Hope International (JuST Conference and JuST First Response)**Statement of Purpose

In FFY 2016, CJA funds were used to support multidisciplinary professionals in child protection in the participation of a nationally renowned training conference featuring today's most pressing issues facing professionals and advocates in the anti-trafficking field.

Target Population

- Professional staff members of DCF, the States' Juvenile Justice Commission and the Administrative Office of the Courts

Approach

- JuST Conference featured workshops focused on skill-building, survivor experiences, cross-discipline collaboration, case studies and lessons learned in the areas of investigation, prosecution and therapeutic services. This collaborative community training conference was open to any and all individuals, understanding that each person has a role to play in the prevention, disruption and eradication of sex trafficking.

(See Appendix F – Conference Materials)

- The JuST First Response is a unique training conference for anti-trafficking professionals working in victim services, legal representation, law enforcement, prosecution, judiciary and court services, child welfare or other child serving agencies, and healthcare professionals who work directly with juvenile victims of trafficking. This event is intended for those individuals seeking to establish, connect and strengthen collaborative multi-disciplinary teams within their jurisdictional systems of response.

(See Appendix G – First Response Conference Materials))

Outcome

- Five DCF staff, two staff members from the Juvenile Justice Commission and one staff member from the attended the JuST Conference from November 9-11, 2016 in National Harbor, Maryland.
- DCF's Statewide Administrator for Human Trafficking, Domestic Violence and Missing Youth and DCF's Human Trafficking Liaison for the Children's System of Care attended the JuST First Response Conference from June 28-29, 2016 in Phoenix, Arizona.

#### Impact on Child Protection System

- These conferences focus on working with victims of human trafficking thereby building the attending professionals knowledge and foster collaborative partnerships to improve the effectiveness of the strategies and supports provided for these victims.

#### *Child and Family Maltreatment*

##### **\$187,000 - Domestic Violence Liaison (DVL) Evaluation Project**

##### Statement of Purpose

Starting in July 2015, the Center on Violence Against Women & Children (VAWC) at Rutgers School of Social Work has been evaluating the statewide Domestic Violence Liaison (DVL) program in order to identify whether interagency collaboration between child welfare agencies and domestic violence service organizations can positively impact the lives of families experiencing co-occurring domestic violence and child maltreatment.

##### Target Population

- VAWC facilitated eight focus groups with key stakeholders across the state of New Jersey, including: CP&P staff (5), DVLs (2), and DVL supervisors (1).
- Focus groups discussed the current processes for screening and referring clients to the DVL program as well as the successes and challenges with the DVL program with specific attention given to determining successful collaboration and barriers to collaboration.

##### Approach

- The research team at VAWC reviewed academic literature and reports to learn how child welfare and domestic violence agencies across the U.S. have and are currently addressing the co-occurrence of domestic violence and child maltreatment.
- Focus groups discussed the current processes for screening and referring clients to the DVL program as well as the successes and challenges with the DVL program with specific attention given to determining successful collaboration and barriers to collaboration.  
VAWC distributed a confidential online survey to every local CP&P office and domestic violence program in each county. The survey included questions on perceptions and experiences with the DVL Program as well as their knowledge and attitude of domestic violence, child abuse, and the intersection of the two.

Additionally, questions were asked regarding staff's confidence in their abilities to identify domestic violence and refer to the DVL program. Every county participated in the survey. VAWC received 1190 responses, a 22% response rate.

- Throughout the project, an Advisory Committee held meetings to strategize the project. The Advisory Committee is comprised of VAWC, NJCEDV, DCF and DOW.

#### Impact on the Child Protection System

- Identification of impact the interagency collaboration between child welfare agencies and domestic violence service organizations has on the lives of families experiencing co-occurring domestic violence and child maltreatment.

#### Outcome

- From literature review, a research-to-practice brief was developed outlining the best practices and policies on addressing domestic violence in child welfare systems. This brief was disseminated to the Department of Children and Families (DCF) and to the New Jersey Coalition to End Domestic Violence (NJCEDV).
- A preliminary report has been received regarding progress in the evaluation. Further updates will be supplied once the report is finalized.

### **State Court Improvement Program 2017 Annual Self-Assessment Report**

This self-assessment is intended as an opportunity for Court Improvement Programs (CIPs) to review progress on required CIP projects, joint program planning and improvement efforts with the child welfare agency, and ability to integrate CQI successfully into practice. Questions are designed to solicit candid responses that help CIPs apply CQI and identify support that may be helpful.

#### **I. CQI Analyses of Required CIP Projects** (Joint Project with Agency and Hearing Quality Project)

##### Joint Project with the Child Welfare Agency:

Provide a concise description of the joint project selected in your jurisdiction. [This project will examine race and ethnicity data in order to have a full understanding of the factors influencing over-representation and delays to permanency for minority children in our state. This will ensure that, to the greatest extent possible, the court process does not contribute to delays in permanency and that minority children are ensured equity in reunification and permanency. The data will initially derive from the court's decision points and case file reviews.](#)

Identify the specific safety, permanency, or well-being outcome this project is intended to address. [Where such policies exist which disadvantage minority children, this project would work towards systems change which would improve time to permanency for Black and Hispanic children.](#)

Approximate date that the project began: [Spring 2016](#).

Which stage of the CQI process best describes the current status of project work? [“Phase I: Identify and Assess Needs – gather data, explore the problem in depth and identify who is most affected.” We have been collecting as much data as possible, in order to look at racial and ethnic disparities along the decision points in regards to permanency. We have developed a strategic plan, which addresses collecting further data on a local level.](#)

How was the need for this project identified? [Both anecdotal experience and AFCARS data suggested that there are disparities for minority children in achieving permanency at the same rate as white children.](#)

What is the theory of change for the project? [By gathering all available data and conducting case file reviews, we expect that various patterns will emerge which will highlight the causes and constraints contributing to delays in permanency for minority children. From this, we will be able to develop solutions aimed to affect change.](#)

If you do not yet have a theory of change and/or would like assistance, please indicate such in the space below. [n/a](#)

Have you identified a solution/intervention that you will implement? If yes, what is it? [Not yet.](#)

What has been done to implement the project? [1. Initial data collection \(notice of placement, exits to permanency, youth who have aged out\); 2. Agreement with the Department of Children and Families \(DCF\) on joint project 3. Consultation with the CBCC on project plan; 4. Review of DCF’s Portal Data; 5. Interim report and project plan drafted; 6. Disproportionality Subcommittee meetings to discuss plan and progress.](#)

What is being done or how do you intend to monitor the progress of the project? [Setting timeframes and monitoring through the Disproportionality Subcommittee and the Children in Court Improvement Committee \(CICIC\).](#)

What assistance or support would be helpful from the CBCC or Children’s Bureau to help move the project forward? [Continued consultation on both methodology and analysis of the data.](#)

#### Hearing Quality Project:

Provide a concise description of the ~~joint~~ project selected in your jurisdiction. [A comprehensive statewide stakeholder survey on quality hearings was designed and administered in order to establish a baseline of data. We will use the results of this survey to develop a theory of change and solutions to implement and measure.](#)

Approximate date that the project began: [September 2016](#).

Which stage of the CQI process best describes the current status of project work? **Phase I: Identify and Assess Needs. We have administered the survey and have begun to analyze the results.**

How was the need for this project identified? **As part of the grant application, and one of the requirements of the grant, the CICIC realized that it first needed to establish a baseline of data from all stakeholder perspectives, in regards to quality hearings. The CICIC therefore designed an online statewide survey.**

What is the theory of change for the project? **Theory of change will be developed upon review of the survey results.**

If you do not yet have a theory of change and/or would like assistance, please indicate such in the space below. **n/a**

Have you identified a solution/intervention that you will implement? If yes, what is it? **To be developed in the summer/fall of 2017.**

What has been done to implement the project? **1. Creation of survey, approval by full CICIC and Judiciary leadership; 2. Administration of the survey; 3. Collection and analysis of the data.**

What is being done or how do you intend to monitor the progress of the project? **Monitoring through the CICIC's monthly meetings.**

What assistance or support would be helpful from the CBCC or Children's Bureau to help move the project forward? **None at this time.**

**II. Trainings, Projects, and Activities** For questions 1-9, provide a *concise* description of work completed or underway to date in FY 2017 (October 2016-June 2017) in the below topical subcategories.

For question 1, focus on significant training events or initiatives held or developed in FY 2017 and answer the corresponding questions.

**1. Trainings**

<i>Topical Area</i>	<i>Did you hold or develop a training on this topic?</i>	<i>Who was the target audience?</i>	<i>What were the intended training outcomes?</i>	<i>How did you evaluate this training?</i>
Data	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

<i>Topical Area</i>	<i>Did you hold or develop a training on this topic?</i>	<i>Who was the target audience?</i>	<i>What were the intended training outcomes?</i>	<i>How did you evaluate this training?</i>
Hearing quality	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Judges and attorneys	Increasing civility in child welfare law	Online evaluation; and a six-month follow up evaluation will be administered.
Improving timeliness/permanency	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Judges and court staff	Review ASFA regulations to increase compliance/eliminate errors on court orders; also “Partnering to achieve permanency through visitation” and “Reinstatement of parental rights – an important step toward solving the problem of legal orphans”	Online evaluation; and a six-month follow up evaluation will be administered.
Quality legal representation	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Judges and attorneys	Better assistance of undocumented children and families	Online evaluation; and a six-month follow up evaluation will be administered.
Engagement & participation of parties	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	All stakeholders (Judges, attorneys, CASAs, court staff, DCF)	How and when Family Team Meetings and mediation are used and why these programs may help develop plans that will benefit families.	Online evaluation following the program; and a six-month follow up survey will be administered.

<i>Topical Area</i>	<i>Did you hold or develop a training on this topic?</i>	<i>Who was the target audience?</i>	<i>What were the intended training outcomes?</i>	<i>How did you evaluate this training?</i>
Well-being	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	All stakeholders	A number of workshops to address well-being: Housing, mental health, substance abuse treatment, trauma – collaborative approach and evidence-based treatment, child safety guide, independent living policy changes	Online evaluation following the program; and a six-month follow up survey will be administered.
ICWA	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Judges and court staff	Ensure court orders address ICWA findings	Will monitor through annual internal court order reviews.
Sex Trafficking	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No			

On average, with ordinary funding levels, how many training events do you hold per year?

Three.

What is your best prediction for the number of attorneys and judges that attend a training annually? 400.

- 2. Data Projects.** Data projects include any work with administrative data sets (e.g, AFCARS, SACWIS), data dashboards, data reports, fostering court improvement data, case management systems, and data sharing efforts.

Do you have a data project/activity?  Yes  No (skip to #3)

<b>Project Description</b>	<b>How would you categorize this project?</b>	<b>Work Stage (if applicable)</b>
FACTS (Family Automated Case Tracking System) Re-engineering Project.	Case management systems	Implementation

Project Description	How would you categorize this project?	Work Stage (if applicable)
	Choose an item.	Choose an item.
	Choose an item.	Choose an item.

(a) Do you have data reports that you consistently view?  Yes  No We have begun using AFCARS, DCF Data Portal and court data regularly as part of our Joint Data Project on Disproportionality.

(b) How are these reports used to support your work? [See above.](#)

**3. Hearing Quality.** Hearing quality projects include any efforts you have made to improve the quality of dependency hearings, including court observation/assessment projects, process improvements, specialty/pilot court projects, projects related to court orders or title IV-E determinations, mediation, or appeals.

Do you have a hearing quality project/activity?  Yes  No (skip to #4)

Project Description	How would you categorize this project?	Work Stage (if applicable)
Quality Hearings Survey: A statewide survey for all child welfare stakeholders was developed in order to establish a baseline of data.	Process Improvements	Identifying/Assessing Needs
	Choose an item.	Choose an item.
	Choose an item.	Choose an item.

**4. Improving Timeliness of Hearings or Permanency Outcomes.** Timeliness and permanency projects include any activities or projects meant to improve the timeliness of case processing or achievement of timely permanency. This could include general timeliness, focus on continuances or appeals, working on permanency goals other than APPLA, or focus on APPLA and older youth.

Do you have a Timeliness or permanency project/activity?  Yes  No (skip to #5)

Project Description	How would you categorize this project?	Work Stage (if applicable)
Assessing impact on timeliness and permanency of new policies regarding appeal time, implemented in 2012.	Appeals	Evaluation/Assessment
	Choose an item.	Choose an item.
	Choose an item.	Choose an item.

**5. Quality of Legal Representation.** Quality of legal representation projects may include any activities/efforts related to improvement of representation for parents, youth, or the agency. This might include assessments or analyzing current practice, implementing new practice models, working with law school clinics, or other activities in this area.

Do you have a quality legal representation project/activity?  Yes  No (skip to #6)

Project Description	How would you categorize this project?	Work Stage (if applicable)
Quality Hearings Survey as starting point for Quality Legal Representation project.	Other	Identifying/Assessing Needs
	Choose an item.	Choose an item.
	Choose an item.	Choose an item.

**6. Engagement & Participation of Parties.** Engagement and participation of parties includes any efforts centered around youth, parent, foster family, or caregiver engagement, as well as projects related to notice to relatives, limited English proficiency, or other efforts to increase presence and engagement at the hearing.

Do you have an engagement or participation of parties project/activity?  Yes  No

Project Description	How would you categorize this project?	Work Stage (if applicable)

Project Description	How would you categorize this project?	Work Stage (if applicable)
<b>Youth Participation in Court:</b> This project began with a “Youth in Court Protocol,” training of stakeholders, and multi-year survey of youth and stakeholders to collect data regarding youth participation in court hearings.	Youth Engagement	Evaluation/Assessment
	Choose an item.	Choose an item.
	Choose an item.	Choose an item.

7. **Well-Being.** Well-being projects include any efforts related to improving the well-being of youth. Projects could focus on education, early childhood development, psychotropic medication, LGBTQ youth, trauma, racial disproportionality/disparity, immigration, or other well-being related topics.

Do you have any projects/activities focused on well-being?  Yes  No (skip to #8)

Project Description	How would you categorize this project?	Work Stage (if applicable)
Joint Data Project on Disproportionality in Child Welfare	Racial Disproportionality	Identifying/Assessing Needs
	Choose an item.	Choose an item.
	Choose an item.	Choose an item.

8. **ICWA.** ICWA projects could include any efforts to enhance state and tribal collaboration, state and tribal court agreements, data collection and analysis of ICWA compliance, or ICWA notice projects.

Do you have any projects/activities focused on ICWA?  Yes  No (skip to #9)

Project Description	How would you categorize this project?	Work Stage (if applicable)
	Choose an item.	Choose an item.
	Choose an item.	Choose an item.

Project Description	How would you categorize this project?	Work Stage (if applicable)
	Choose an item.	Choose an item.

- 9. Preventing Sex Trafficking and Strengthening Families Act (PSTFSA).** PSTFSA projects could include any work around domestic child sex trafficking, the reasonable and prudent parent standard, a focus on runaway youth, focus on normalcy, collaboration with other agencies around this topic, data collection and analysis, data sharing, or other efforts to fully implement the act into practice.

Do you have any projects/activities focused on PSTSFA?  Yes  No

Project Description	How would you categorize this project?	Work Stage (if applicable)
Atlantic County Pilot: This project will focus on identifying court involved youth who are victims of child sex trafficking, and connecting them to appropriate services.	Sex Trafficking	Implementation
	Choose an item.	Choose an item.
	Choose an item.	Choose an item.

**III. CIP Collaboration in Child Welfare Program Planning and Improvement Efforts**

Please describe how the CIP has been involved with the state’s CFSP due June 30, 2017.

The CIP provides DCF with information on activities and projects that have been completed over the last year.

Please describe how the CIP was or will be involved in the most recent/upcoming title IV-E Foster Care Eligibility Review in your state.

CIP and Judiciary staff will be present when title IV-E Foster Care Eligibility Review results are shared with stakeholders. CIP and Judiciary staff also participated in an internal audit of court orders to prepare for the federal review.

Please describe how the CIP is or was involved in preparing and completing round 3 of the CFSR and PIP, if required, in your state.

The CIP has been involved in the CFSR at all phases of the review. CIP and Judiciary staff attended the kick-off meeting last year and has been involved in planning. Judiciary staff will be participating as reviewers, as well.

Are there any strategies or processes in place in your state that you feel are particularly effective in supporting joint child welfare program planning and improvement?

The CIP in NJ enjoys a close and collaborative relationship with DCF. This is due to DCF's participation on the CICIC as well as constant communication and common goals. CIP representatives are also involved in DCF's Task Force on Child Abuse and Neglect.

Does the state child welfare agency currently offer professional partner training to judges, attorneys, and court personnel as part of its title IV-E Training Plan?

Yes.

If yes, please provide a brief description of what is provided and how.

CIP and Judiciary staff has participated in the CFSR kickoff and various skill building trainings. Judges and Judiciary staff are invited to participate in the debriefs from quality assurance and case reviews. They are also invited to DCF's biannual conference.

If no, have you met with child welfare agency leadership to discuss and explore utilizing professional partner training for judges, attorneys and court personnel?

Which category or categories of activity best describe current CIP data efforts with the child welfare agency?

- Contributing data                       Receiving data                       Jointly using data
- Collaborative meetings                       Collaborative systems change project(s)
- Other: \_\_\_\_\_

**IV. CQI Current Capacity Assessment**

1. Has your ability to integrate CQI into practice changed this year? If yes, what do you attribute the increase in ability to? *Yes, there is more focus on incorporating CQI into our CIP activities. This is attributable to the increased focused on CQI at last year's grantee meeting and strategic planning process.*
  
2. Which of the following CBCC Events/Services have you/your staff engaged in in the 2017 Fiscal Year?
  - Annual CIP Meeting                       CQI Consult (*Topic: Joint Data and Quality Hearings*)
  - Constituency Group – ICWA                       Constituency Group – Anti-Trafficking
  - Constituency Group – New Directors                       Constituency Group – APPLA/Older Youth
  - CIP All Call — *What % of All Calls does your CIP participate in? 100%*

3. Do you have any of the following resources to help you integrate CQI into practice?  
 CIP staff with CQI (e.g., data, evaluation) expertise     Consultants with CQI expertise  
 a University partnership                       Contracts with external agencies to assist with CQI efforts  
 Other resources: \_\_\_\_\_
3. Describe the largest challenges your CIP faces with implementing CQI into your work. The greatest challenge is [having the staffing resources to gather data through court observation and/or case file reviews](#).
4. Is there a topic or practice area that you would find useful from the Capacity Building Center for Courts? Be as specific as possible (e.g., data analysis, how to evaluate trainings, more information on research about quality legal representation, how to facilitate group meetings, etc.) [Data analysis](#).

## APPENDIX A: DEFINITIONS

### Definitions of Evidence

**Evidence-based practice** – evidence-based practices are practice that have been empirically tested in a rigorous way (involving random assignment to groups), have demonstrated effectiveness related to specific outcomes, have been replicated in practice at least one, and have findings published in peer reviewed journal articles.

**Empirically-supported-** less rigorous than evidence-based practices are empirically-supported practices. To be empirically supported, a program must have been evaluated in some way and have demonstrated some relationship to a positive outcome. This may not meet the rigor of evidence-base, but still has some support for effectiveness.

**Best-practices** – best practices are often those widely accepted in the field as good practice. They may or may not have empirical support as to effectiveness, but are often derived from teams of experts in the field.

### Definitions for Work Stages

**Identifying and Assessing Needs** – This phase is the earliest phase in the process, where you are identifying a need to be addressed. The assessing needs phase includes identifying the need, determining if there is available data demonstrating that this a problem, forming teams to address the issue.

**Develop theory of change**—This phase focuses on the theorizing the causes of a problem. In this phase you would identify what you think might be causing the problem and develop a “theory of change”. The theory of change is essentially how you think your activities (or intervention) will improve outcomes.

**Develop/select solution**—This phase includes developing or selecting a solution. In this phase, you might be exploring potential best-practices or evidence-based practices that you may want to

implement as a solution to the identified need. You might also be developing a specific training, program, or practice that you want to implement.

**Implementation** – the implementation phase of work is when an intervention is being piloted or tested. This includes adapting programs or practices to meet your needs, and developing implementation supports.

**Evaluation/assessment** – the evaluation and assessment phase includes any efforts to collect data about the fidelity (process measures: was it implemented as planned?) or effectiveness (outcome measures: is the intervention making a difference?) of the project. The evaluation assessment phase also includes post-evaluation efforts to apply findings, such as making changes to the program/practice and using the data to inform next steps.

<b>2017 CAPTA CPSAI Update Report</b>	
<b>Section 1 – Identifying Information</b>	
<b>1a</b>	<b>Provider:</b> Catholic Charities, Diocese of Metuchen
	<b>1b Program Name:</b> Child Protection Substance Abuse Initiative
<b>1c</b>	<b>Relevant CAPTA Program:</b> <input checked="" type="checkbox"/> CPSAI, <input type="checkbox"/> CBCAP, <input type="checkbox"/> CTC
<b>1d</b>	<b>Program Address:</b> 26 Safran Avenue, Edison, NJ 08837
<b>1e</b>	<p><b>Objective:</b> To provide substance abuse assessments, extended assessments, treatment referrals, case management and counselor aide services to caregivers and families, referred to us by DCP&amp;P. Individuals are referred to CPSAI to rule out or determine if there is a substance use disorder.</p> <p>Once the assessment or extended assessment is complete, when treatment is the recommendation, CPSAI informs the original referral source, DCP&amp;P, to assist with motivating/transition those involved individuals to engage in treatment. This aids in reducing barriers that may allow the customers to refuse to comply; or work to reduce any issues that may arise within the early treatment phase. To provide education and a better understanding of substance use disorder to DCP&amp;P family service workers through; trainings surrounding topics related to working with substance using families.</p>
<b>1f</b>	<b>Outcome(s) Addressed:</b> X Safety <input type="checkbox"/> Permanency <input type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<b>Overview of Service:</b> The Catholic Charities CPSAI Program outposts Substance Abuse Counselors, counselor

	<p>aides in the local DCP&amp;P offices. This program provides consultation services with DCP&amp;P workers as needed, to identify appropriate cases to be assessed for substance use, to assess DCP&amp;P clients for substance use disorder, per referral, and to manage those cases referred to treatment. CPSAI provides early identification and assessment of the severity of the addictive disorder. Catholic Charities CPSAI Program provides referral to the appropriate level of care for treatment, at a facility best suited or available to the client's individual need/unique situation. Catholic Charities CPSAI Program provides collaboration with treatment agencies for treatment coordination, intake appointments, and transportation when needed. CPSAI provides monitoring of treatment compliance in keeping with the current case closing protocols. Catholic Charities CPSAI Program provides transportation services within all three counties, and system coordination between Essex and Union County DCP&amp;P and the Local County Welfare Agencies. Catholic Charities provides Extended Assessment services to customers where it is clinically indicated such as having risk factors that appear to be related to substance use, or self-reported substance use differs from collateral information provided by DCP&amp;P. The CPSAI Program also offers an immediate response to workers needing their customers assessed via our immediate assessment process. Workers can have their customers seen that day or the first working day after, if the case is deemed an emergency, and the client meets the criteria for emergency assessments, through the DCP&amp;P office. Urine drug screen testing is included in the assessment, whether it is an initial or an extended assessment.</p> <p>The CPSAI Program provides trainings throughout the year for the DCP&amp;P family service workers surrounding substance use disorder, and the impact substance use can have on families.</p>
<b>2b</b>	<p><b>Population Served:</b>                  Caregivers of children that are involved with DCP&amp;P; adults that live in the household with the child(ren) who are involved with DCP&amp;P and adults who are being considered as Adoptive or Resource Families. In addition there are adults who are referred from Family Court and / or Family Drug Court that are customers of DCP&amp;P.</p>
<b>2c</b>	<p><b>Geographical Area of Services:</b>                  DCP&amp;P cases are served within the counties of Middlesex, Union and Essex.</p>
<b>2d</b>	<p><b>Referral Sources:</b>                  DCF, DCP&amp;P's Case Workers, Supervisors and Gatekeepers.</p>
<p><b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b></p>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b>  <b>Include data where available:</b>                  Out of 3688 referrals received, 2369 were assessed; 1445 customers were given a diagnostic impression; 1114 customers were referred to treatment; 613 customers were reported to have enrolled in the treatment process; Customers that were referred to extended assessment from the initial assessment equaled 60. There were 26 SAI eligible customers referred. We continue to improve the data collection and statistics for more precise information. We are able to produce reports which are more accurate, and faster than in the past. Using this information has allowed our program to locate and improve services, in our local offices. Using this information has increased our outreach to clients and DCP&amp;P Caseworkers, and</p>

	<p>has improved engaging, hard to reach clients in the assessment process. Catholic Charities continues to collaborate with the Division of Mental Health and Addiction Services (DMHAS), working together, improving data collection, for the future, without access to information through the New Jersey Substance Abuse Monitoring System (NJSAMS).</p> <p>There were also four DCP&amp;P trainings completed.</p> <p>Program improvements have resulted in increased reporting time, and improved communications with DCP&amp;P workers.</p>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b></p> <ol style="list-style-type: none"> <li>1) Determining the severity of substance use disorder in the home, and customers following through and enrollment in treatment, reduces the potential for continued substance use including alcohol and/or neglect of the children, thereby allowing the families to remain intact and increases the safety of children.</li> <li>2) We provided in house and outside trainings, to educate the family service workers on engagement and identifying potential life areas where clients are at risk for substance use disorders as well as current trends of drugs of abuse in communities.</li> </ol>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b></p> <ol style="list-style-type: none"> <li>1) Customers identified with substance use disorders that engaged in the treatment process and began to get well, allowed their families to remain intact, get healthy, and the environment became safer for the children.</li> <li>2) Customers that did not follow recommendations, since identified, were able to be discussed by DCP&amp;P, and then decisions could be made, by them, as to the safety of the children.</li> </ol>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b></p> <ol style="list-style-type: none"> <li>1) The inconsistency of dedicated interview space creates a barrier to conducting more than one assessment which would reduce the scheduling time. We have discussed this in meetings and here in this report previously.</li> <li>2) The complexity of working with a large system like DCP&amp;P, often results in communication problems. Those communication issues can result in the customers not following through with treatment recommendations, which can create a barrier for us accomplishing our goal of clients getting into treatment, as well as scheduling the client for the assessment on the front end. We are working to increase communication with DCP&amp;P via email, to all parties involved, voice mail and speaking with the worker and or supervisor in person.</li> <li>3) Lack of understanding of the disease of addiction within the DCP&amp;P worker population creates a lack of awareness on how a parent or caregiver using substances, including alcohol, in the household can impact children, on an emotional and behavioral level.</li> </ol> <p>We are providing substance use disorder trainings to the DCP&amp;P employees that will enhance their understanding of clients with substance use disorders, and general overall information on Drug and Alcohol and their effects.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b></p> <p>Assessments, Extended Assessments, Immediate Assessments, Counselor Aide Services, and DCP&amp;P Trainings</p>
<b>3f</b>	<p><b>Enter your contracted Level of Service portion that is Title IV-B funded for the period</b></p>

	<p><b>of 10/1/15 – 9/30/16:</b> 4800 comprehensive LOCI-2R, NJSAMS assessments with treatment recommendations, 75% who did not receive a diagnostic impression with the initial assessment, excluding those where a no diagnostic impression was applied, will complete extended assessments with written reports, and 60% of customers with treatment recommendations will be enrolled in an appropriate treatment program.</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b> 3688 Referrals were received. Out of those referrals, 2369 assessments were completed. 1445 customers were diagnosed and out of that number, 1114 customers were provided with a referral to treatment. 613 of the customers referred to treatment, were enrolled.</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b> # of unduplicated individuals: 3566 unduplicated individuals referred and 2270 unduplicated individuals were assessed. # of unduplicated families: 2916 unduplicated families referred and 2019 unduplicated families were assessed.</p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b> Feedback from the RDS/Gatekeepers is positive. The RDS/Gatekeepers feel the counselors are an important part of their team. Stakeholder feedback has also been presented as positive with the communication between all parties increasing, and improving.</p>
<b>Section 4 – The Year Ahead FFY '16 (10/1/16– 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <ol style="list-style-type: none"> <li>1) Continue to provide case management services to help ensure admission to treatment programs for clients, when treatment is recommended.</li> <li>2) CPSAI will provide ongoing training to assist Counselors on new assessment tool the CAAPE 5 and the full roll out and implementation.</li> <li>3) CPSAI to continue to improve communications with DCP&amp;P at staff and supervisor meetings.</li> <li>4) CPSAI will continue to work with the DCP&amp;P training departments to have all 4 trainings offered to DCP&amp;P workers count towards their yearly required credits.</li> </ol>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <ul style="list-style-type: none"> <li>• Providing more detailed reports due to a more comprehensive assessment, while increasing communication, and updates during the CPSAI process.</li> <li>• CPSAI will also make efforts to use the DCP&amp;P organizational chain of command to engage clients before closing cases especially for the intake unit.</li> </ul>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p>

	<ul style="list-style-type: none"> <li>• 4800 assessments with treatment recommendations and 60% of customers with treatment recommendations will be enrolled in an appropriate treatment program.</li> </ul>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b>          # of unduplicated individuals: 4800          # of unduplicated families: 4500</p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b></p> <ol style="list-style-type: none"> <li>1) Evaluate program level of service</li> <li>2) # of assessments completed (Initial, Extended, Immediate)</li> <li>3) # of customers diagnosed</li> <li>4) # of customers referred to treatment</li> <li>5) # of clients enrolled in treatment</li> <li>6) Track time frame of assessment / recommendation / engaging client / case closure</li> </ol>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <ol style="list-style-type: none"> <li>1) Supervisor Case Record Review</li> <li>2) Consistent training with staff on all facets of the contracted services.</li> <li>3) Continued participation at DCP&amp;P supervisor and Staff meetings</li> <li>4) RDS/Gatekeeper meetings on a frequent basis</li> <li>5) All staff will continue to attend staff and clinical meetings.             <ul style="list-style-type: none"> <li>• Data comparison will be utilized to track areas of improvement or in need of improvement such as; reducing number of those who remain non-compliant with CPSAI recommendations along with, reduced numbers of returned referrals.</li> </ul> </li> </ol>
<b>5c</b>	<p><b>How do you collaborate with community partners?</b></p> <ol style="list-style-type: none"> <li>1) Ongoing communication with DCP&amp;P</li> <li>2) Coordination with other service providers i.e.: Substance Abuse Initiative (SAI)</li> <li>3) Participation in the County Consortium Meetings</li> <li>4) Attendance to DCP&amp;P Improving outcomes, Focus on supervision and if requested Family Team meetings</li> <li>5) Treatment Program Open Houses and treatment program information sessions at CPSAI staff meetings presented by the treatment programs</li> <li>6) Professional substance use disorder trainings for up to date knowledge on current drug trends.</li> <li>7) Brainstorming / group meetings with the team to discuss concerns and ideas for improvement.</li> <li>8) Various public engagements to inform public and private institutions of substance use issues, increasing awareness regarding signs and symptoms of substance use disorder and what resources are available for the CPSAI program and other programs that could prove to be</li> </ol>

	beneficial to the families we serve.

**Section 1 – Identifying Information**

<b>1a</b>	<b>Provider:</b> Center for Family Services	<b>1b Program Name:</b> Child Protection Substance Abuse Initiative
<b>1c</b>	<b>Relevant CAPTA Program:</b> <input checked="" type="checkbox"/> CPSAI, <input type="checkbox"/> CBCAP, <input type="checkbox"/> CTC	
<b>1d</b>	<b>Program Address:</b> 594 Benson Street Camden, NJ 08103	
<b>1e</b>	<b>Objective:</b> To provide substance abuse assessments, urine drug screens, referral to treatment, referral to extended assessments, case management and supportive services for parents/caregivers who are referred due to current or suspected substance abuse. This supports the achievement of family safety, permanency and well-being.	
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input type="checkbox"/> Permanency <input type="checkbox"/> Well-Being	

**Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)**

<b>2a</b>	<p><b>Overview of Service:</b> The Center for Family Services CPSAI Program provides:</p> <ul style="list-style-type: none"> <li>a. Consultation with DCP&amp;P workers as needed to identify appropriate cases to be assessed.</li> <li>b. Standardized substance abuse assessments, including urine drug screens, referral and case management to, and advocacy for, appropriate levels of treatment.</li> <li>c. Substance abuse training to DCP&amp;P staff to facilitate the early identification of potential substance abuse issues.</li> <li>d. Identification of cases appropriate for Work First New Jersey Substance Abuse Initiative (SAI) and coordination of treatment placement.</li> <li>e. Collaboration with provider agencies for treatment coordination, follow up and monitoring of treatment compliance in keeping with current case closing protocols.</li> <li>f. Transportation and support services.</li> <li>g. Ongoing written and verbal case conferencing with DCP&amp;P Staff</li> </ul> <p>Systems coordination facilitating communication between DCP&amp;P (Camden County) and local county welfare agency.</p>	
<b>2b</b>	<p><b>Population Served:</b> The population served consists of adult caregivers who are under investigation or supervision to rule out substance abuse or dependence as a precipitating or coexisting factor to child abuse/ neglect. Adult caregivers who received a DSM V diagnosis were referred to the appropriate level of treatment.</p>	
<b>2c</b>	<p><b>Geographical Area of Services:</b> Services are provided on site at DCP&amp;P offices throughout the Southern Region. This</p>	

	includes Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester and Salem.
<b>2d</b>	<b>Referral Sources:</b> Department of Children and Families/Division of Child Protection and Permanency
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals. Include data where available:</b></p> <p>Out of the <u>6681</u> referrals received, <u>4412</u> clients were assessed. <u>2185</u> clients were referred to treatment and 1110 enrolled in treatment. There were 125 clients referred to extended assessment. <u>90</u> clients completed extended assessment. <u>247</u> were referred for a 2<sup>nd</sup> Urine Drug Screen. There were <u>53</u> clients SAI eligible and transferred to SAI for services.</p> <p>There were 3 joint trainings given for CP-SAI and DCP&amp;P staff covering topics of: Vicarious Traumatization and Self Care DSM and ASAM Criteria Refusal Skills in a Relapse Prespective</p> <p>There were also on-going in-service trainings on the process of assessment, staff meetings, new hire meetings and ethics training.</p>
<b>3b</b>	<p><b>How did this improve outcomes for children and families?</b></p> <p>By determining the severity of substance abuse in the home and assisting clients in entering the treatment process, the risk of harm to the children was reduced thereby promoting the safety, reunification and preservation of the family. It also provided an opportunity for joint trainings and discussions</p>
<b>3c</b>	<p><b>Identify specific factors that contributed to this improvement:</b></p> <p>1) Improvements were accomplished through ongoing communication/engagement with the clients, DCP&amp;P caseworkers and substance abuse treatment agencies.</p> <p>2) The services provided include: case management, counselor aide contact, home visits to deliver appointment letters as well as phone contact and transportation to the assessment and treatment intake appointment.</p>
<b>3d</b>	<p><b>Identify significant barriers to goal accomplishment:</b></p> <ol style="list-style-type: none"> <li>1) Increase in number of referrals in some DCP&amp;P local offices</li> <li>2) Staff vacancies</li> <li>3) Lack of available treatment within the Southern Region</li> <li>4) Inability to contact clients i.e. no phone, homeless</li> <li>5) Lack of treatment for male clients</li> <li>6) Lack of transportation</li> <li>7) Long waiting lists for treatment slots</li> <li>8) Financial difficulty</li> <li>9) Client refusal and/or non-compliance</li> <li>10) Lack of treatment options for Spanish speaking clients</li> <li>11) Lack of space within certain DCP&amp;P offices for conducting assessments</li> <li>12) Loss of beds in due to residential agencies going private</li> </ol>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b></p> <p>A service unit is the substance abuse assessment which includes a urine drug screen, referral to treatment when clinically indicated, and referral to extended assessment. It also includes</p>

	Case Management Cases, Counselor Aide Services, and DCP&P Trainings.
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b></p> <p>Level of service expected 5100 assessments to be completed, 3,825 clients will be placed in treatment, 25 families per Counselor Aide per month will be receive case management services from the Counselor Aides.</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b></p> <p>Our contract states that each CADC should assess 25 clients a month and each CA should provide case management to 25 families.</p> <p>Level of Service expected is 5100 assessments to be completed. 85% of clients assessed and diagnosed, will be placed in treatment.</p> <p>We received 6681 referrals and did 4412 assessments</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b></p> <p># of unduplicated individuals: 3187</p> <p># of unduplicated families: 3187</p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b></p> <p>Feedback information is provided through several sources. Through participation at the Child Welfare DCP&amp;P Consortium Meetings, regularly scheduled Resource Development Specialist Meetings as well as ongoing communication with local and State representatives of the CP-SAI project, positive feedback was reported in support of the ongoing services provided by CP-SAI.</p>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b></p> <ul style="list-style-type: none"> <li>• CPSAI will continue to provide case management services to enhance client outreach thereby supporting a continuum of care.</li> <li>• Substance abuse training to DCP&amp;P staff to facilitate the early identification of potential substance abuse issues at local DCP&amp;P offices.</li> <li>• Combined Substance Abuse Educational workshop series are presented at offsite location to DCP&amp;P/CP-SAI staff throughout the year.</li> <li>• Providing additional resources to the RDS’ to share with their staff at the RDS meeting held every three months</li> <li>• The use of a new assessment tool, CAAPE 5</li> </ul>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b></p> <ol style="list-style-type: none"> <li>1. During the year FFY 2017 we will increase the number of assessments scheduled per CADC to increase the number of assessments being completed and number of</li> </ol>

	<p>clients entering treatment. We have also changed how soon appointments are offered as a result of the new referral form</p> <ol style="list-style-type: none"> <li>2. Assign and move staff to other offices with the greatest need, where there is a higher number of referrals, to improve our levels of service including splitting staff between more than one office if needed.</li> <li>3. Continue to utilize CADC call out policy to provide backup services when CADC's are out of the office so as not to interrupt services.</li> <li>4. We filled the spots of those staff out on medical leave with temporary staff so as not disturb the flow of services.</li> <li>5. We will look for effective ways to communicate with clients that don't have access to a phone or don't have minutes on their phones.</li> </ol>
<p><b>4c</b></p>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b></p> <p>5100 assessments 25 hours of case management per counselor aide</p>
<p><b>4d</b></p>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b></p> <p># of unduplicated individuals: 5100 # of unduplicated families: 5100</p>
<p><b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b></p>	
<p><b>5a</b></p>	<p><b>How will you measure progress?</b></p> <ol style="list-style-type: none"> <li>1. Monitoring state mandated spreadsheets for contracted goals</li> <li>2. Reviewing monthly CADC assessment logs</li> <li>3. Clinical supervisors reviewing each assessment completed by CADC, office referrals and CA progress notes to assess case management hours</li> <li>4. Doing a monthly report that is sent to central office</li> <li>5. Instituting a Quality review staff member that reviews charts in each office monthly</li> </ol>
<p><b>5b</b></p>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b></p> <ol style="list-style-type: none"> <li>1. Continue to work closely with DCP&amp;P staff on a case by case basis to support families and provide child protection.</li> <li>2. Continue to attend and participate in monthly county consortium meetings</li> <li>3. Ongoing CPSAI staff trainings/staff development on all aspects of the contracted services as well as substance abuse education/training for the clinical staff.</li> <li>4. Weekly review of all records by Clinical Supervisor.</li> <li>5. Continued participation @ DCP&amp;P staff meetings and RDS/Gatekeeper meetings on a regular basis.</li> <li>6. Stakeholder satisfaction surveys.</li> <li>7. Attend focus on supervision and Family Team meetings when needed</li> <li>8. Attend Child Stat meetings</li> </ol>

	<p>Meetings with Contract Administrator and Statewide Manager of Substance Abuse Services at DCP&amp;P Central Office.</p> <p>Continue to meet with DCP&amp;P Resource Development Specialists to address areas needing improvement as well as reviewing monthly data and contract obligations. Meetings scheduled approximately every 2 months.</p>
<p><b>5c</b></p>	<p><b>How do you collaborate with community partners?</b></p> <ol style="list-style-type: none"> <li>1. Attend and participate in Consortium meeting with DCP&amp;P staff, treatment providers and staff from SAI to address specific issues that create treatment barrier for clients.</li> <li>2. Attend and participate in Resource Fairs for DCP&amp;P</li> <li>3. Continue to build relationships with treatment providers by contacting them weekly for follow-ups on clients who have entered treatment.</li> <li>4. Continue to provide Substance Abuse specific training that will be open to DCP&amp;P staff from all 7 counties.</li> </ol> <p>Participated in Women’s Steering Committee Meeting, CP-SAI providers meeting and CP-SAI statewide meetings.</p>

<p align="center"><b>Section 1 – Identifying Information</b></p>	
<p><b>1a</b></p>	<p><b>Provider:</b> Preferred Behavioral Health</p> <p><b>1b Program Name:</b> Child Protection Substance Abuse Initiative</p>
<p><b>1c</b></p>	<p><b>Relevant CAPTA Program:</b> <input checked="" type="checkbox"/> CPSAI, <input type="checkbox"/> CBCAP, <input type="checkbox"/> CTC</p>
<p><b>1d</b></p>	<p><b>Program Address:</b> P.O. box 2036, Lakewood, New Jersey 08701</p>
<p><b>1e</b></p>	<p><b>Objective:</b> The result expected by the Department of Children and Families is protection of the child through:</p> <ul style="list-style-type: none"> <li>• Comprehensive Substance Use Assessment (DCP&amp;P Offices and the Community)</li> <li>• Identification of Substance Use Related Disorders</li> <li>• Extended Assessment</li> <li>• Collaboration with DCP&amp;P about case recommendations</li> <li>• Referral to Substance Use Treatment Program with appropriate Level of Care</li> <li>• Transportation to/from Evaluation or Substance Use Treatment</li> <li>• Transportation to/from Extended Assessment</li> <li>• Drug Screens – Chain of Custody, GC/MS</li> <li>• Presentation of difficult cases at Consortiums monthly to collaborate with Child Welfare</li> </ul>

	<p>Providers, DCP&amp;P and Social Services, bi-monthly attendance at Passaic Early Childhood Conference</p> <ul style="list-style-type: none"> <li>• Participation in Family Team Meetings and Focus on Supervision (where applicable)</li> <li>• Follow-up with treatment providers once client admitted into treatment facility</li> </ul>
<b>1f</b>	<b>Outcome(s) Addressed:</b> <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Permanency <input checked="" type="checkbox"/> Well-Being
<b>Section 2 – Service Description Basics FFY (10/1/15 – 9/30/16)</b>	
<b>2a</b>	<p><b>Overview of Service:</b> Preferred Behavioral Health’s Child Protection Substance Abuse Initiative (CPSAI) program provides substance use assessments, extended assessments, referral, case management, motivational interviewing, transportation, and chain of custody drug screenings for families associated with the Department of Children and Families, Division of Child Protection and Permanency. CPSAI offers expertise in the area of Substance Use Disorders by offering trainings, consultation, participation in the CW Consortium, participation in Family Team Meetings, Passaic Early Childhood Conference and Focus on Supervision (where applicable). The goal of CPSAI is to ensure child safety by assisting DCP&amp;P with the identification of a parent/guardians involvement with Substance use by providing a complete comprehensive substance use assessment to ascertain the appropriate level of care for the parent/guardian involved with the Department of Children and Families.</p>
<b>2b</b>	<p><b>Population Served:</b> The target population served are parents/guardians involved with the Department of Children &amp; Families due to allegations of substance use. Preferred has demonstrated experience with the target population since the year 2000.</p>
<b>2c</b>	<p><b>Geographical Area of Services:</b> We currently operate the CPSAI Program in eleven counties: Bergen, Hudson, Hunterdon, Mercer, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex and Warren, located in 20 Local DCP&amp;P Offices.</p>
<b>2d</b>	<p><b>Referral Sources:</b> Division of Child Protection and Permanency.</p>
<b>Section 3 – The Year in Review FFY (10/1/15 – 9/30/16)</b>	
<b>3a</b>	<p><b>Provide a summary of program accomplishments on goals.</b>  <b>Include data where available:</b>            CPSAI has met the multifaceted needs of our clients through seamless and prompt referrals, as well as, other services whenever possible.</p> <ul style="list-style-type: none"> <li>• We received 10,902 referrals.</li> <li>• We completed 8,029 substance use assessments.</li> <li>• Of the 8,029 clients assessed, 5,111 clients were given a substance use/dependence diagnosis.</li> <li>• We referred 2,335 clients to Extended Assessment for further evaluation.</li> <li>• There were 5,111 referred to treatment and 2,499 clients enrolled in treatment.</li> <li>• There were 8,029 clients who received Case Management Services.</li> <li>• There were 138 clients who were eligible for and referred to services with the SAI.</li> </ul> <p>Additionally,</p> <ul style="list-style-type: none"> <li>• All clients identified as needing additional services were referred for Mental Health Treatment, Medical Evaluations and Social Services.</li> <li>• CPSAI participates in five Consortium meeting per month (Ocean Monmouth, Mercer, Passaic and Hudson).</li> <li>• CPSAI attends the Professional Advisory Committee on Alcoholism and Drug Abuse</li> </ul>

	<p>(PACADA) as scheduled in various counties where we provide DCP&amp;P services.</p> <ul style="list-style-type: none"> <li>• CPSAI attends all supervisor and staff meetings regarding the CAAPE 5.</li> <li>• CPSAI staff attends the Statewide CPSAI Providers Meetings as scheduled.</li> <li>• CPSAI staff attends Gatekeepers meetings as scheduled.</li> <li>• CPSAI staff attends the DCP&amp;P/CW, Women’s and Father Steering Committee Meetings as scheduled.</li> <li>• CPSAI has been enhanced through training and education; many staff members are pursuing their Licensure and Certification towards Mental Health and Addictions; such as LCADC, LCSW, LSW, LAC, LPC, CADC.</li> <li>• CPSAI has been involved in the Treatment Engagement Improvement Project to motivated more clients to enter into treatment and identify client needs.</li> </ul> <p>PBH/CPSAI provided 15 trainings to DCP&amp;P and CPSAI staff, 25 in-service workshops to DCP&amp;P Caseworkers and Supervisors and 27 in-service workshops for CPSAI staff.</p>
<p><b>3b</b></p>	<p><b>How did this improve outcomes for children and families?</b> Providing substance use assessments to determine if there is a substantiated substance use problem, allows DCP&amp;P to become actively involved with the family. This results in the safety of the child/children. The CPSAI Staff removed barriers for assessments and treatment admissions by providing transportation and using culturally sensitive staff from the local communities to motivate clients that are hard to engage.</p>
<p><b>3c</b></p>	<p><b>Identify specific factors that contributed to this improvement:</b></p> <ul style="list-style-type: none"> <li>• Monthly Consortium Meetings</li> <li>• Relationships with providers to be able to initiate immediate access to treatment</li> <li>• CPSAI Assessment Counselors are able to utilize the Division of Mental Health &amp; Addiction Services, DCP&amp;P treatment slots designed specifically to meet the needs of DCP&amp;P clients.</li> <li>• Participation in Family Team Meetings and ongoing communication with Caseworkers, Supervisors, Gatekeepers, Local Office Managers and Community Providers.</li> <li>• CPSAI stays current with best practices in all areas of addiction, including continually updating our drug screening capabilities</li> <li>• CPSAI Staff participates in internal and external Cultural Competency Trainings</li> <li>• CPSAI Staff attends the Passaic Early Childhood Conference two times a month.</li> </ul>
<p><b>3d</b></p>	<p><b>Identify significant barriers to goal accomplishment:</b></p> <ol style="list-style-type: none"> <li><b>1. Limited treatment slots in many geographical areas</b> CPSAI continues to address this through our Extended Assessment Programs and Case Management strategies.</li> <li><b>2. Limited bi-lingual services in all regions</b> CPSAI addresses this utilizing our bi-lingual staff who have relationships with programs throughout the State</li> <li><b>3. Due to the complicated nature of many of the DCP&amp;P clients evaluated, many of them fall short of admission criteria, for example those clients on pain medication and/or medication assisted therapy</b> CPSAI utilizes ASAM Criteria to refer client to appropriate services</li> <li><b>4. Lack of residential services, especially when related to co-occurring clients without</b></li> </ol>

	<p><b>insurance</b>  CPSAI has dually licensed staff and supervisors to identify and expedite all admissions, especially relating to the Co-Occurring clients needing services.</p>
<b>3e</b>	<p><b>Definition of Level of Service as per contract:</b>  A Level of Service is as follows:</p> <ul style="list-style-type: none"> <li>• Substance Use Assessment (Adult/Adolescent)</li> <li>• Drug Screen (Chain of Custody, GC/MS Screening)</li> <li>• In-home substance use assessments and drug screening</li> <li>• Transportation</li> <li>• Extended Assessment</li> <li>• Case Management</li> <li>• Family Meetings</li> <li>• Consortiums</li> <li>• Trainings</li> </ul>
<b>3f</b>	<p><b>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/15 – 9/30/16:</b>  CPSAI is contracted to complete 7,800 Substance Use Assessments  CPSAI is contracted to complete approximately 1,800 Extended Assessments</p>
<b>3g</b>	<p><b>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/15 – 9/30/16:</b>  CPSAI received 10,902 referrals for the contract year from the Division of Child Protection and Permanency  CPSAI completed 8,029 assessments, of the 8,029 assessments completed 5,111 clients were diagnosed and referred to the appropriate Level of Care. CPSAI referred 2, 335 clients to Extended Assessment.</p>
<b>3h</b>	<p><b>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.</b>  <b># of unduplicated individuals:</b> 8,029 clients and families were served  <b># of unduplicated families:</b> 8,029 clients and families were served  Of the above 8,029 clients assessed 5,111 clients were diagnosed and referred to treatment</p>
<b>3i</b>	<p><b>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.</b>  CPSAI Supervisors attend the Women’s and Father’s Steering Committee Meetings, Monthly Consortiums, DCP&amp;P Staff Meetings and Gatekeeper meetings as scheduled, Communication with Local Office Manager and Gatekeepers, Contract Administrators and Statewide Meetings to discuss programmatic changes, issues, etc.</p>
<b>Section 4 – The Year Ahead FFY (10/1/16 – 9/30/17)</b>	
<b>4a</b>	<p><b>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.</b>  CPSAI continues to recruit certified and licensed bi-lingual staff and dually licensed</p>

	<p>clinicians to complete assessments. Recognizing a wide range of cultural and ethnic differences, we continue to recruit and hire staff who live in the communities we serve. The CAAPE-5 was initiated and the CPSAI Project through a comprehensive substance use assessment intends to establish the appropriate level of care recommendation using the CAAPE-5, the Level of Care Index-3 (LOCI-3), Diagnostic Statistical Manual Criteria (DSM-5) and applying ASAM Third Edition Criteria to determine the severity of the substance use disorder and the potential risk to the child(ren). The results of the substance use assessment will enable the CPSAI Assessment/Extended Assessment Counselor to make an appropriate referral to treatment. Additionally, it is an opportunity to determine if the client requires further services, including medical and/or psychiatric evaluation. We will continue to provide in-service workshops to DCP&amp;P Staff for the next contract year, as participation in the workshops provide increased knowledge of addiction disorders.</p>
<b>4b</b>	<p><b>Identify changes you will make that stem from stakeholder feedback.</b> N/A</p>
<b>4c</b>	<p><b>How many IV-B units of service are you expecting to deliver for the period of 10/1/16 – 9/30/17?</b> 7,800 Substance Use Assessments and 1,800 Extended Assessments</p>
<b>4d</b>	<p><b>Indicate how many unduplicated individuals and unduplicated families you expect to serve.</b> # of unduplicated individuals: 7,800 # of unduplicated families: 7,800</p>
<b>Section 5 – Evaluating Progress FFY (10/1/16 – 9/30/17)</b>	
<b>5a</b>	<p><b>How will you measure progress?</b> CPSAI will measure progress through the data collected utilizing the tracking reports submitted monthly. CPSAI will measure progress through ongoing feedback from DCP&amp;P at Gatekeepers meetings, Statewide Provider Meetings, Women’s and Father’s Steering Committee Meetings, DCP&amp;P Staff Meetings, meetings with Gatekeepers, Local Office Managers and Consortiums. CPSAI will also measure progress through completing the required level of care in our Annex A.</p>
<b>5b</b>	<p><b>Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.</b> Our Quality Improvement process starts at the initial referral. The professionalism and quality care that CPSAI provides to our DCP&amp;P clients, evaluation, assessments and any other service units CPSAI delivers. Also ongoing communication with DCP&amp;P until the client has completed the evaluation process and / or referred and engaged in treatment. CPSAI uses best practices when completing assessments. Preferred uses a high standard drug screening, all tests are Chain of Custody and GC/MS confirmed which gives validity in testimony in Court, CPSAI has a Toxicologist available to testify if called. Staff has the ability to perform assessments and drug screening in the field. CPSAI stays current with the trends of various drug use in the different geographic areas throughout the State. We continue to experience a heroin epidemic in many of the counties we serve. The increase in prescription medication use continues to increase and we are working with medical</p>

	<p>professionals to collaborate effectively and continue to motivate medical professionals to use the Prescription Monitoring program to effectively determine compliance with regards to narcotic pain medication.</p>
<p><b>5c</b></p>	<p><b>How do you collaborate with community partners?</b>                  CPSAI will collaborate with community partners and/or providers through in-service workshops, open houses, case conference with outside providers, consortiums, Professional Advisory Committee on Alcoholism and Drug Use, and Women’s and Father’s Steering Committee Meetings and trainings, as scheduled. CPSAI attends the Statewide Meetings with Contract Administrators and the Monitoring Body of this grant.</p>

## **NJ Citizen Review Panel Reports**

NJ has three statutorily required Citizen Review Panels:

1. New Jersey Task Force on Child Abuse and Neglect (NJTFCAN)
2. New Jersey Staffing and Oversight Review Subcommittee (SORS)
3. New Jersey Child Fatality and Near Fatality Review Board (CFNFRB)

Each panel submits and publishes an annual report that can be reviewed publically at the DCF Public Website. The following links represent the latest Citizen Review Panel Reports:

NJTFCAN: Sixth Annual Report July 1, 2015-June 30, 2016

<http://www.nj.gov/dcf/news/reportsnewsletters/taskforce/NJTFCAN.Report.2016.pdf>

SORS: Tenth Annual Report July 1, 2015- June 30, 2016

<http://www.nj.gov/dcf/news/reportsnewsletters/taskforce/SORS.Report.2016.pdf>

CFNFRB: 2015 Annual Report- Issued December, 2015

[http://www.nj.gov/dcf/documents/about/commissions/fatality/CFNFRB.Report\\_2015.pdf](http://www.nj.gov/dcf/documents/about/commissions/fatality/CFNFRB.Report_2015.pdf)

DCF is committed to the partnerships with the Citizen Review panels and continues to work in collaboration with them. Each year the three primary Citizen Review panels submit an annual report and DCF is given the opportunity to respond. The following represents the DCF responses to the previous year's annual reports:



*State of New Jersey*

DEPARTMENT OF CHILDREN AND FAMILIES  
P.O. Box 729  
TRENTON, NJ 08625-0729

CHRIS CHRISTIE  
*Governor*

KIM GUADAGNO  
*Lt. Governor*

ALLISON BLAKE, Ph.D., L.S.W.  
*Commissioner*

May 31, 2017

Martin A. Finkel, DO, FACOP, FAAP  
Co-Chair, NJ Task Force on Child Abuse and Neglect  
Professor of Pediatrics  
Medical Director  
c/o Child Abuse Research Education Services (CARES) Institute  
UMDNJ, School of Osteopathic Medicine  
42 E. Laurel Road, Suite 1100  
Stratford, NJ 08084

Dear Dr. Finkel:

The Department of Children and Families (DCF) values the feedback and recommendation of the New Jersey Task Force on Child Abuse and Neglect in its 2015-2016 Sixth Annual Report. DCF is committed to expanding our use of evidence-supported services and data throughout the Department. We strive for the incorporation of measurable outcomes and strategies in our programs and services.

To that end, I want to formally thank you and the Task Force for your continued commitment to New Jersey's children and families. I look forward to continuing our work with the Task Force as you continue to provide the opportunity to build on our successes and address areas for continued improvement in our work. Together, we can shape the future of New Jersey's child welfare system to ensure a better today and even a greater tomorrow for every individual we serve.

Thank you for your leadership, service and commitment.

Sincerely,

A handwritten signature in cursive script that reads "Allison Blake".

Allison Blake, Ph.D., L.S.W.  
Commissioner

AB:dy



State of New Jersey

DEPARTMENT OF CHILDREN AND FAMILIES  
P.O. BOX 729  
TRENTON, NJ 08625-0729

CHRIS CHRISTIE  
*Governor*

KIM GUADAGNO  
*Lt. Governor*

ALLISON BLAKE, PH.D., L.S.W.  
*Commissioner*

May 18, 2017

Marygrace Billek, L.C.S.W., L.C.A.D.C., Chairwoman  
Human Services Director  
Mercer County Department of Human Services  
PO Box 8068  
Trenton, NJ 08650-0068

Dear Ms. Billek:

This letter is to formally thank you and the members of the Staffing and Oversight Review Subcommittee (SORS) for the SORS 10th Annual Report as well as your volunteerism and continued commitment to New Jersey's children, youth and families. DCF strives to build collaborative partnerships with stakeholders and community partners to improve outcomes for New Jersey's children, youth and families.

The identified SORS priorities and areas for follow-up align with the DCF mission. As a result, we look forward to continuing our work with SORS as you continue to provide the opportunity to build on our successes and address areas for improvement in our work. Together, we can shape the future of New Jersey's child welfare system to ensure a better today and even a greater tomorrow for every individual we serve.

Thank you for your leadership, service and commitment.

Sincerely,

A handwritten signature in cursive script that reads "Allison Blake".

Allison Blake, Ph.D., L.S.W.  
Commissioner

AB:DM

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*State of New Jersey*

DEPARTMENT OF CHILDREN AND FAMILIES

P.O. Box 729

TRENTON, NJ 08625-0729

August 8, 2016

CHRIS CHRISTIE  
*Governor*

KIM GUADAGNO  
*Lt. Governor*

ALLISON BLAKE, PH.D., L.S.W.  
*Commissioner*

Kathryn M. McCans, M.D.  
Chairwoman  
Judy L. Postmus, Ph.D.  
Chairwoman  
New Jersey Child Fatality and Near Fatality Review Board  
P.O. Box 717  
Trenton, NJ 08627-0717

Dear Dr. McCans and Dr. Postmus:

Thank you for forwarding the Child Fatality and Near Fatality Review Board's report of 2013 fatalities. This letter is the New Jersey Department of Children and Families' response to the report's recommendations.

Response to Recommendation #1:

Thank you for recognizing the Children's System of Care's (CSOC) previous and ongoing work to enhance trauma-informed care through assessment, documentation, and service provision. We are pleased CSOC continues to make meaningful and impressive advances serving New Jersey's children and youth.

CSOC has updated its assessment tool, the Child Adolescent Needs and Strength, to more comprehensively assess trauma.

Recognized as a national model, CSOC was selected by the Substance Abuse Mental Health Services Administration for a grant to advance trauma treatment services. Thanks to the grant, CSOC will implement:

- the Six Core Strategies, an evidence-based practice to reduce out-of-home treatment providers' reliance on restraint and seclusion and increase their trauma informed care capacity; and
- the Nurtured Heart Approach in all out-of-home programs, Care Management Organizations, Family Support Organizations, and with communities through Children's Interagency Coordinating Councils.

The grant also permits CSOC to ensure youth have a greater voice through Youth Partnerships and complete return-on-investment research.

Dr. McCans and Dr. Postmus  
 August 8, 2016  
 Page 2

CSOC has been addressing continuity of care since 2013:

- CSOC has unified care management organization (CMO) services, allowing CMOs to work with children, youth, and young adults with moderate and complex needs. Such needs include behavioral health, substance use, and developmental/intellectual challenges. CSOC unified CMOs so youth and families can have the same care manager for the duration of care, eliminating unwelcome and unproductive disruptions from switching to a new care manager.
- CSOC has increased the provider capacity for Intensive in Community (IIC) Providers through an open public request for provider's process. Increasing capacity helps residential providers continue in-home services, which is critical to stabilizing a child upon returning home from residential care.
- Since implementing a new Request for Qualification process, CSOC has developed a deep provider pool. CSOC's pool of Intensive In-home Services providers have expertise in applied behavioral analysis for youth with developmental/intellectual disabilities.
- CSOC expanded its substance use assessment capacity, better enabling it to connect with appropriate treatment as identified.
- Since services for youth with substance use disorders was transferred to CSOC in July 2013, CSOC has worked to increase rates and expertise among its substance use disorder treatment providers, and has successfully integrated care for youth with co-occurring disorders.

Response to Recommendation #2:

CP&P policy affirms the need to keep cases open for parents with substance use disorder who have been referred for assessment, scheduled for treatment, are in any active treatment, or for whom there is a protective services or child welfare concern.

The policy ensures parents receive support that helps them transition from formal treatment to recovery supports, have a recovery and relapse prevention plan, are positively engaged in recovery, and demonstrate recovery stability before their case is closed or an alternative permanency plan is developed. The policy is available at [http://www.nj.gov/dcf/policy\\_manuals/PPP-III-C-8-300\\_issuance.shtml](http://www.nj.gov/dcf/policy_manuals/PPP-III-C-8-300_issuance.shtml).

CP&P is currently updating its policies to clarify expectations regarding child protective investigations in matters involving legally prescribed medications. The policy is expected to be released later this year.

Dr. McCans and Dr. Postmus  
August 8, 2016  
Page 3

Response to Recommendation #3:

The Division of Family and Community Partnerships' Office of School-Linked Services contracts with private non-profit organizations and school districts to provide prevention and support services for youth in public elementary, middle, and high schools. School Based Youth Services Program (SBYSP) services are located in host schools and coordinated with existing community resources. All youth are eligible to participate and services are provided before, during, and after school and during summer months.

SBYSP helps youth navigate their adolescent years, acquire skills to find work or continue their education, and graduate healthy and drug-free. SBYSP services include mental health counseling, employment counseling, substance abuse education and prevention, preventive health awareness, primary medical linkages, learning support, healthy youth development, recreation, and information and referral.

All SBYSPs are encouraged to use evidence-based/informed curricula, assessments, and best practice strategies. This year SBYSP will phase-in an enhanced program design that aligns with the research-based Youth Thrive protective and promotive factors framework created by the Center for the Study of Social Policy. Outcomes will focus on personal resilience, social connections, knowledge of adolescent development (including brain development and the impact of trauma), concrete support in times of need, and social, emotional, and cognitive competencies. More information about the Youth Thrive Framework is available at: <http://www.cssp.org/reform/child-welfare/youththrive>.

We have identified a need to reach youth at an earlier age, and consequently are directing the development of new School Based Youth Services Programs toward middle school aged youth. DCF has recently posted a Request for Proposals to develop a middle school program in Essex County.

Response to Recommendation #4:

The New Jersey Youth Suicide Prevention Project partnered with Rutgers University Behavioral Health Care, the DCF Office of Professional Development, and CSOC to provide the CONNECT suicide awareness training to CP&P staff, clinical providers, school personnel, and other gatekeepers. The Garrett Lee Smith Suicide Prevention Grant funding ended in 2015; however, Rutgers UBHC continues to make the training available. More information about CONNECT is available at [theconnectprogram.org](http://theconnectprogram.org).

We welcome the opportunity to discuss the recommendations and responses with the Board.

Thank you for your leadership and for the continued interest of the Board in the well-being of New Jersey's children and families.

Sincerely,



Allison Blake, Ph.D., L.S.W.  
Commissioner

Section K  
Chafee Foster Care  
Independence Program  
&  
Education and Training  
Voucher Program

### **CHAFEE Services Annual Update: Accomplishments and Plans**

During the federal fiscal year of **October 1, 2015 to September 30, 2016**, Chafee funded services have been utilized to meet the intended purposes of the funds as described below. In addition to the accomplishments and planned activities, information regarding collaboration, program support, and service description are included. Organizationally the primary responsibility for administering, coordinating and assessing the delivery of Chafee funded services as well as the Education and Training Vouchers was organized by the Department of Children and Families, Office of Adolescent Services (OAS).

The Office of Adolescent Services collaborated with a variety of internal and external stakeholders and partners to provide services to adolescents who are involved with child welfare. These include:

- DCF continues to fund (10/1/15-6/30/16 only) and use 25 slots in the New Jersey Youth Corps through the New Jersey Department of Labor for CP&P involved adolescents. New Jersey Youth Corps engages young adults in full-time community service, training and educational activities. Staff who serve as mentors guide the youth. The youth receive education development, employability skills instruction, personal and career counseling, and transition services.
- DCF contracts with community agencies to provide transitional housing for older youth. DCF currently funds 370 beds throughout the state.
- DCF partners with Montclair State University to provide the Post BA in Adolescent Advocacy Certificate Program for DCF staff who primarily work with adolescents.
- DCF continues to collaborate with stakeholders, service providers and youth across the state through the Task Force on Helping Youth Thrive in Placement (HYTIP). HYTIP is tasked with ensuring that children and youth involved in out of home placements have the right to live the most normal childhood and adolescence possible.
- DCF continues to partner with an organization, EverFi that provides a computer based financial literacy program.
- DCF continues to collaborate with Foster and Adoptive Family Services to provide ETV to eligible youth who have aged out of foster care or left care for kinship legal guardianship or adoption through the New Jersey Foster Care (NJFC) Scholars program.
- DCF collaborated with the National Resource Center for Youth Services, the Center for the Study of Social Policy, and Rutgers University School of Social Work to have training developed utilizing the Youth Thrive Framework.
- OAS provides several different mentoring opportunities/services for adolescents and young adults through Rutgers, The State University of NJ, Project Myself and through faith-based organizations and private non-profits. The Summer Housing and Internship Program (SHIP) and Summer Internship Program (SIP) is an additional support to NJ Foster Care Scholars.

- DCF continues to partner with the John J. Heldrich Center at Rutgers University to provide training on the New Jersey Career Assistance Navigator (NJCAN). NJCAN is an online career guidance website.
- DCF collaborated with the NJ Department of Education on the development of school district guidelines for the implementation of the Every Student Succeeds Act (ESSA).
- DCF collaborated with LGBTQI community partners to provide safe space liaisons with information on coaching peers, locating resources, changing culture in the office and understanding sexual orientation and gender identity.
- DCF continues to partner with national experts on the Phase II Youth At-Risk of Homelessness (YARH) funding to support initial implementation and testing of the most promising intervention strategies developed during Phase I of this grant process.
- DCF continues to work with the New Jersey Department of Labor and Workforce Development and the State Employment and Training Commission to identify, evaluate and expand access to employment programs models and partnerships.
- DCF contracts with community providers to provide rescue intervention for cases of human trafficking of youth, prevention of human trafficking, providing stabilization, resources and supported services youth need, and prepare youth for independence.
- DCF continues to collaborate with First Star Academy and Rowan University to provide a year round college bridge program for youth in foster care, beginning at 8<sup>th</sup> grade and going through 12<sup>th</sup> grade.
- DCF partnered with Xerox and Rutgers School of Social Work on a two year contract through the Department of Treasury to create an electronic distribution process of the independent living stipend through debit card or direct deposit as well as provide youth with access to a mobile application to assist with budgeting and financial literacy.
- DCF is working with the NJ Department of Community Affairs who has provided DCF with 100 project based Section-8 Housing Vouchers to provide long term, stable and supportive housing opportunities for young people aging out of care.
- DCF continues to partner with Prevent Child Abuse New Jersey to offer prevention of Human Trafficking training to providers and youth.

The Office of Adolescent Services provided the following program support to DCF staff as well as community partners:

- Through the Adolescent Practice Forums which includes CP&P, Children's System of Care, Care Management Organizations, Child Health Nurses, and the DCF Office of Education staff, several informational presentations and mini trainings were held on a variety of topics including Medicaid Extension, educational initiatives, youth engagement, trauma informed care, employment resources, expectant and parenting youth and permanency initiatives.
- OAS provided the Got Adolescents? Training to CP&P staff. The training covers adolescent policy, practice and resources.

- The Post BA Certificate in Adolescent Advocacy was offered to 40 DCF staff. The program at Montclair State University is a fifteen credit certificate focused on adolescent advocacy and case practice. It is designed to provide students with a multidisciplinary understanding of the role of the adolescent advocate seen through the disciplines of law, sociology, and psychology.
- DCF provided human trafficking prevention trainings to community contracted providers and youth through a contracted provider.
- OAS provided in-service training to the Safe Space Liaisons on a variety of topics including New Jersey's anti-bullying bill of rights, holistic LGBTQI services for youth, and working with LGBTQI families.
- DCF provided the Value of Permanency training in conjunction with the Permanency Roundtables which included information on the importance of legal permanency for older youth.
- DCF partnered with Rutgers to hold an Adolescent Networking Conference to provide training on various topics to CP&P staff and service providers.
- OAS provided training on the Transitional Plan for YOUth Success and the Casey Life Skills Assessment for adolescent serving CP&P staff.
- OAS provided training on the NJ Career Assistance Navigator web based resource to CP&P staff as well as contracted providers.
- OAS provided training to CP&P staff on the new debit card/direct deposit process (Q Card) and financial literacy module mobile application (Pay Perks).
- OAS administered 2 one-day trainings titled "Understanding the Importance of Permanency" for CIC Judges, Deputy Attorneys General (DAGs), Law Guardians, the Office of the Public Defender and CASA Advocates to complement NJDCF's efforts towards permanency for older adolescents.

OAS would like the following technical/capacity building assistance:

- Talk to and learn from other jurisdictions who provide services to youth 18-21
- NYTD data collection
- Supervisory level transfer of learning
- Savings accounts for youth in care (including minors)
- Serving expectant and parenting youth

**Purpose 1: Assist Youth in Making the Transition to Self-Sufficiency**  
Accomplishments:

- LGBTQI training and support continued to be provided to the DCF Safe Space Liaisons and staff throughout the state.
- The “Got Adolescents?” training, covering adolescent policy, practice and resources, continued to be offered to CP&P staff as well as other interested DCF staff.
- Community based contracted life skills programs continued to provide services to youth ages 14-21.
- The 15 Youth Advisory Boards (YAB) continue to provide leadership opportunities for youth through meetings twice a month.
- Ensured provider community delivered life skills in line with specific elements of the independent living skills as defined by the National Youth in Transitions Database (NYTD).
- DCF continued to partner with an organization that provides a computer based financial literacy program, Everfi, to youth and expanded access to additional contracted providers as well as staff within DCF.
- DCF continued to work with Xerox and Rutgers to prepare for and switch from the independent living stipend being a paper check to debit card or direct deposit.
- DCF continues to promote rescue, intervention and prevention of human/sex trafficking of youth, provide youth linkages to stabilization and needed resources as well as prepare youth for independence.
- DCF continued to work with Rutgers to tailor the Youth Thrive curriculum to New Jersey’s needs. This training was offered to DCF staff, contracted agencies, and resource parents.
- The Post BA in Adolescent Advocacy Certificate Program continued to be offered primarily to CP&P staff who work with adolescents to provide staff with a multidisciplinary understanding of the role of the adolescent advocate as seen through the disciplines of law, sociology, and psychology.
- Adolescent Practice Forums were held across the state for CP&P, CMO, Child Health Nurse, and DCF Office of Education staff to share information on a variety of topics that are pertinent to assisting youth who are involved with child welfare.
- OAS participated in Aging Out events that are designed to provide information to youth who are aging out of care to help with their transition.
- For the 2015-2016 academic year, there were 24 confirmed graduates from the New Jersey Foster Care Scholars program.
- Continue to provide technical assistance to school district staff and DCF staff to ensure educational stability for children in out of home placement.
- An annual statewide Safe Space Liaison/LGBTQI Youth Committee training day was developed to include workshops and panel discussions for the Safe Space Liaisons and the LGBTQI Youth Committee members.
- A LGBTQI policy was published to provide and ensure a safe, healthy, and inclusive environment for all the children, youth, and families we serve.

- Through the YARH Federal Implementation grant piloted new life skills services to CP&P involved youth in three counties to promote self-sufficiency.

Planned Activities:

- CP&P staff will continue to work with youth on life skills training and/or refer them to the appropriate services to assist them in their transition to self-sufficiency.
- Continue to reinforce independent living skills development and service delivery by focusing on and tracking the delivery of specific elements of independent living skills as defined by the National Youth in Transitions Database (NYTD).
- Continue to provide training on Adolescent policy, practice and resources for caseworkers who have adolescents on their caseload.
- Create a new NYTD data collection process to ensure accurate documentation of independent living services youth are receiving.
- Expand the financial literacy program to more DCF providers and offices.
- Continue to assess services that are available for pregnant or parenting youth including fatherhood programs.
- Review and update the Youth Advisory Board program model.
- Continue to implement YARH pilot programming and evaluate initial impact.

**Purpose 2: Assist Youth in Obtaining Education, Training and Services Necessary to Obtain Employment**

Accomplishments:

- Training on the NJ Career Assistance Navigator (NJCAN) was provided to DCF staff as well as contracted providers to assist youth in exploring career and post-secondary options.
- OAS continues to provide coaching services (Rutgers, The State University of NJ, Project MYSELF) to youth who are scholarship recipients. The goal of this mentoring is to help youth stay in school and navigate the challenges of college life. Special attention is being given to first year students enrolled in remedial courses and students on academic probation.
- Continued to provide the Summer Housing Internship Program (SHIP) for 40 NJ Foster Scholars. The SHIP program, located on four college campuses, provides youth with coaching, mentoring, a paid internship, a 3-credit elective course, housing and enrichment activities for 12 weeks during summer break.
- The Summer Internship Program (SIP) was launched in May 2013 and offers 20 NJ Foster Scholars the same opportunities offered by the SHIP program but who do not need the housing component.
- Employment resources were added to the New Jersey Youth Resource Spot [www.njyrs.org](http://www.njyrs.org) website.
- Convened the 1<sup>st</sup> annual statewide Safe Space Liaison/LGBTQI Youth Committee training day on December 11, 2015 that included workshops and panel discussions for the Safe Space Liaisons, the LGBTQI Youth Committee members and young people.

Planned Activities:

- Continue to collaborate and partner with the NJ Labor and Workforce Development and the State Employment and Training Commission (SETC).
- Work with the SETC 's Shared Youth Vision Council (SYVC) to support planning and implementation of the State's strategic plan for the Workforce Innovation Opportunity Act (WIOA).
- 
- Review and update the academic and career readiness programming to ensure that are prepared for and informed of post-secondary education and employment options.
- Adjust the NJCAN training and deliver to staff, stakeholders, and providers.
- Incorporate Employment Boot Camps for New Jersey Foster Care Scholars through Project MYSELF to enhance resume critiques, interview skills and career planning.

Purpose 3: Assist Youth to Prepare for and Enter Post-Secondary Training and Educational Institutions

Accomplishments:

- Foster and Adoptive Family Services (FAFS) continues to administer the New Jersey Foster Care (NJFC) Scholars program, which provides financial assistance to eligible youth to pursue post-secondary education programs.
- FAFS hosted or participated in multiple outreach events, webinars, meetings and presentations to inform various stakeholders, including youth, about the NJFC Scholars program.
- In addition to the above outreach, FAFS presented at conferences throughout the state and met with Financial Aid Offices or Educational Opportunity Fund (EOF) Staff at New Jersey post-secondary institutions to familiarize the staff about the NJFC Scholars program. OESP and OAS continued to raise awareness of the NJFC Scholars program and discussed the importance of planning for youth's post-secondary education during regional education stability liaison meetings and during meetings with CP&P local office management including supervisors, casework supervisors, and case practice specialists.
- OESP and OAS provided technical assistance to CP&P adolescent workers and supervisors regarding the importance of educational planning, choosing a post-secondary program, and the availability of Education Training Vouchers (ETV) through the NJFC Scholars program.
- OESP and OAS provided technical assistance to CP&P case managers and supervisors to ensure youth have access to flex funds to enable them to receive academic supports such as tutoring and college preparatory courses, books, extracurricular activities, and college fees.
- The Director of Client Services at the Higher Education Student Assistance Authority (HESAA) agreed to streamline the process for independent student verifications, homeless student documentation to ensure NJ Foster Care Scholars with financial assistance in a timely manner . HESSA also posted information about the NJ Foster Care Scholars Program on their website.

- OESP presented the NJ Foster Care Scholars Program at the Essex and Morris-Passaic Counties' School Counselor Association.
- OESP and OAS provided approximately 167 Ward of the Court letters to verify adolescents as an independent when filing for the Free Application for Federal Student Aid, assisting them in being eligible for the maximum amount of federal and state to be offered Meetings were held with the following EOF programs discuss New Jersey Foster Care Scholars eligibility, collaborative services partnership opportunities for adolescent's success in postsecondary education: Rutgers University, School of Health Related Professions, Rutgers University- Newark, Middlesex County College, Brookdale College, Rutgers University, School of Sciences and Arts, Warren County Community College, and Bergen County College.
- Monitored retention via weekly reports prepared by Foster and Adoptive Family Services (FAFS) in regards to Project MYSELF information. The report contains: student contact info, post-secondary contact info, academic info (GPA, # of credits, registration status), student's academic standing (highlighting first year NJFC Scholars, probation/remedial instruction/students readmitted on appeal, students who are pending removal, students who have been removed and students who have graduated) and semester notes.
- Through the YARH Federal Implementation grant piloted new Educational Champion services with CP&P involved youth in three counties to promote academic success and engage in post-secondary planning.
- Focused outreach efforts using a monthly report run by DCF's Office of Evaluation, Research and Reporting, providing the number of eligible youth based on CP&P placement history and those who exited care for KLG or Adoption. This outreach will help streamline specific reports, resources and outreach for the NJFC Scholars program.

#### Planned Activities:

- Use NJFC Scholars retention rates for post-secondary institutions posted on the US Department of Education as a baseline for NJ Foster Care Scholars' year to year retention.
- Increase collaboration efforts with post-secondary support programs for high school-to-college transitions, specifically the Educational Opportunity Fund (EOF) programs in New Jersey institutions.
- Explore collaboration with high school to college "bridge" programs, such as TRIO programs like Upward Bound, and NJ GEAR UP program.
- DCF continues to provide Ward of the Court letters to young adults pursuing post-secondary education who experienced foster care at age 13 and after. These letters provide verification of the students' independent status on the Free Application for Federal Student Aid (FAFSA).
- Continue to work with legal, IT and Communications to develop an online campaign for donations to replenish the DCF Scholarship Fund for youth in their pursuit of higher education.

- Continue to provide training and technical support to CP&P staff on the Federal and State Education laws and regulations.
- Review and update the academic and career readiness programming to ensure that are prepared for and informed of post-secondary education and employment options.

**Purpose 4: Provide Personal and Emotional Support to Youth through Mentors and Interactions with Dedicated Adults**

Accomplishments:

- Continue to provide permanency services to assist older adolescents in achieving relational or legal permanency.
- OAS continues to support CP&P staff and community partners by providing on-going training on the importance of life long connections and working with youth to ensure they do not age out of care without connections to caring adults.
- A workgroup continues to meet to look at the current permanency support services that exist for youth and work to increase knowledge about these services and the number of youth in need of permanency that are referred.
- The Permanency Roundtables were held for older youth in care who have not achieved legal permanency.
- A video was created to highlight the importance of permanency for older adolescents to be used in trainings throughout DCF and that will be available on the DCF public website as well as the NJ Youth Resource Spot website.
- Two, one-day trainings titled “Understanding the Importance of Permanency “for CIC Judges, Deputy Attorneys General (DAGs), Law Guardians, the Office of the Public Defender and CASA Advocates to complement NJDCF’s efforts towards permanency for older adolescents was offered.
- Through the YARH Federal Implementation grant piloted new permanency and mentoring with CP&P involved youth in three counties to promote legal permanency and life-long connections.

Planned Activities:

- Work with community providers to create resource, respite and holiday homes for older adolescents who are in care, including those in college.
- Permanency workgroup will continue to meet to redefine the existing permanency programs for better utilization.
- Review the existing adolescent mentoring programs to assess their effectiveness.

**Purpose 5: Provide Financial, Housing, Counseling, Employment, Education, and Other Appropriate Support and Services to Former Foster Care Recipients between 18 and 21 years of age**

Accomplishments:

- The Medicaid Extension for Young Adults (MEYA) continues to be available to the age of 26 for eligible youth. Information was shared with internal and external stakeholders in an effort to offer this resource to as many eligible youth as possible.
- OAS continues to partner with the Mercer Homeless Youth Subcommittee to look at options for housing that may exist or that can be established.
- The Adolescent Housing Hub, an online reservation system, continues to provide access to housing programs for DCF involved and homeless youth.
- CP&P continues to allow youth to remain in foster care until age 21; as such, they are eligible to receive financial, housing, counseling, employment, education and other appropriate services.
- DCF continues to provide Ward of the Court letters to young adults pursuing post-secondary education who experienced foster care at age 13 and after. These letters provide verification of the students' independent status on the Free Application for Federal Student Aid (FAFSA).
- Beginning in June 2012, OESP provided a flyer regarding eligibility and contact information for the NJFC Scholars program to the Office of Adoption Operations to include in the Adoption and KLG Subsidy Letters for Children Turning 18 and in the Annual Verification of Child's School Attendance letters.
- DCF continues to provide new and updated information on resources and services for DCF involved and non-involved youth on the new NJ Youth Resource Spot website.
- Continue to share information about the Adolescent Housing Hub to share with staff and community providers. CF continues to provide case management as well as financial assistance to youth who have aged out of care between the ages of 18-22.
- A new form and policy was developed for young adults, 18-21, who continue to receive voluntary services from CP&P that outlines the expectations/responsibilities as well as what supports/services they can receive.
- Provided supportive housing through newly acquired Section 8 Housing vouchers targeting expectant and parenting youth and high need youth.

Planned Activities:

- OAS will create a Statewide Homeless Youth Committee to identify strategies to prevent and address youth homelessness.
- Review existing transitional living programs to assess their effectiveness and to ensure that they are able to provide the necessary supports to youth.

**Purpose 6: Make Available Vouchers for Education and Training (ETV), Including Post-Secondary Education, To Youth Who Have Aged Out of Foster Care**

Accomplishments:

DCF continues to provide ETV to eligible youth who have aged out of foster care or left care for kinship legal guardianship or adoption through the New Jersey Foster Care (NJFC) Scholars program. The program is overseen by the Office of Educational Support and Programs (OESP) within the Office of Adolescent Services (OAS), and administered by the community provider, Foster and Adoptive Family Services (FAFS).

- The number of youth who received ETV awards for the 2015-2016 academic year is as follows:
  - 414 unduplicated youth participated in the NJFC Scholars Program
    - 222 unduplicated youth utilized ETV funding, 100 of those were new youth.
    - The remaining students did not utilize NJFC Scholars program funding because financial aid packages provided by their post-secondary institutions covered their expenses during the academic year, they did not request educational supports, or they were not registered for classes.
- Transitions for Youth at the Rutgers University School of Social Work continued to provide coaching and support in the areas of academic, social and physical and mental well-being to all NJFC Scholars through Project MYSELF and beyond.
- Collaboration between OESP, OAS, FAFS, and Project MYSELF is central to the program's operation. OESP communicates regularly with FAFS and Project MYSELF staff to provide program support and resolve any issues surrounding a student's academic performance, social well-being, or financial status at a post-secondary institution.
  - During the Fall 2015 semester, Project MYSELF coaches and FAFS Scholarship Associates conducted monthly check-in calls to discuss case management concerns, Scholar updates and team strategy.
- Mentoring and educational services are provided through the contracted Project Myself program, coordinated by Rutgers, The State University of NJ, to youth who are scholarship recipients in the NJFC Scholars program. The goal of this mentoring is to support youth in college, and to assist in their transition into college life. Specific outreach and program support is given to first year students enrolled in remedial courses and students on academic probation (Tier 1 Students)
  - "Tier One" students are all first-year NJFC Scholars, students with a below a 2.0 GPA for the previous semester, students enrolled in remedial courses, and students who have had appeals granted to re-enter the program. All Tier One students receive a minimum of bi-weekly contact with at least one face-to-face meeting per month with their Project Myself coach. If face-to-face contact is not possible for out of state students, Skype or another video conferencing method is used for the contact.
  - "Tier Two" students are all returning scholars who are in good academic standing with a semester GPA of a 2.0 or above. Scholars receive a minimum of monthly contact from their support coach via telephone or email. Face-to-face visits and Skype meetings will be arranged as needed or if the student requests this type of contact. If a Tier Two student requires crisis intervention, a needs assessment and referral to the appropriate campus or community resource is provided.

- OAS continues to provide the Summer Housing Internship Program (SHIP) for 40 NJ Foster Care Scholars. The SHIP program, located on the four college campuses of Rutgers University-Camden, Newark and New Brunswick, and Montclair State University, provides youth with coaching, mentoring, a paid internship, a 3-credit elective course, housing and enrichment activities for 12 weeks during summer break. This program serves this population during a time where housing is most beneficial to college students in transition to their next academic year.
- The Summer Internship Program (SIP) was launched in May 2013 and offers 20 NJ Foster Care Scholars the same opportunities offered by the SHIP program, but who do not need the housing component. SIP is a 12-week program that includes academic and support coaching, mentoring, a paid internship, a 3-credit elective course and enrichment activities. Transportation, bus passes and resources from the SIP program and provided to assist youth in attending their internship and specific activities and class.
- FAFS continued to hold year-round workshops throughout the state for current and former foster youth, their caregivers and caring adults to assist them in applying for ETV and provide assistance with completing the Free Application for Federal Student Aid (FAFSA).

#### Planned Activities:

- FAFS will continue to hold year-round workshops throughout the state for current and former foster youth, their caregivers and caring adults to assist them in applying for ETV and will provide assistance with completing the Free Application for Federal Student Aid (FAFSA). More direct support and information will be presented at local offices and high schools where there is a larger population of youth in out of home care.
- Continue to promote the NJFC Scholars program and Project MYSELF as a unified programmatic experience for eligible adolescents
- Begin research on developing additional mentoring, training, informational opportunities, support services and networks within NJFC Scholars to create positive youth identity within the program, such as YAB partnerships and other avenues focusing on resilience, self-sufficiency and positive youth development.
- Increase collaboration efforts with post-secondary support programs for high school-to-college transitions, specifically the Educational Opportunity Fund (EOF) programs in New Jersey institutions.
- Continue collaboration with the Higher Education Student Assistance Authority to streamline independent verification and Tuition Aid Grant eligibility for New Jersey Foster Care Scholars
- Continue outreach to middle-school and high school guidance counselors for NJFC Scholars eligibility, housing resources and other services available to adolescents in need.
- DCF policy has been updated and is now available to the public via the DCF website.

Purpose 7: Provide Services to Youth Who Attained Kinship Guardianship or Adoption at age 16 and Older.

#### Accomplishments:

- Youth who exit foster care at 16 or older and attain Kinship Legal Guardianship or Adoption continue to be eligible for services including but not limited to life skills, aftercare,

wraparound funds and housing. These services continue to be provided through contracted agencies.

Planned Activities:

- DCF is working to expand knowledge and information regarding service availability for youth who exit foster care at 16 or older and attain KLG or Adoption.
- OAS will share information on available services to adoptive and kinship legal guardianship families.

**Purpose 8: Ensure children who are likely to remain in foster care until 18 years of age have regular, on-going opportunities to engage in age or developmentally-appropriate activities as defined in section 475(11) of the Act.**

DCF has policy, practice, resources, and initiatives in place to ensure that youth have opportunities to engage in developmentally-appropriate activities. In 2016, a policy that addresses normalcy for youth in out of home placement was published. The Children and Youth Bill of Rights was published in the policy manual. In addition, DCF's flex fund policy (400) outlines how funds can be used towards "enrichment" activities such as camp, entertainment, games, driving lessons, bicycle gear, activity and membership fees, sports, fees, vacation, and classes. Additionally, in 2012 DCF created the Task Force on Helping Youth Thrive in Placement (HYTIP) to identify areas of practice where more strategies were needed to help promote "normalcy" for youth in care. A recommendations report was created and DCF has been following up to achieve these recommendations. The updated Transitional Plan for Youth Success (TPYS), which deployed in September of 2014 was enhanced to highlight a youth's hobbies, activities, and interests at the beginning of the plan. DCF also received a train the trainer on the Youth Thrive framework with the goal to design a 3 day intensive training for staff and providers. The Youth Thrive training will provide guidance on how to engage, assess, and plan with and for a young person through a protective and promotive factor lens ultimately supporting developmentally appropriate and realistic goal setting and activities for and with youth. In addition, through the Youth Advisory Board restructure and enhancement in 2013-2014 the program model was designed to provide youth with opportunities to develop peer networks, engage in community service events, and cultural/recreational activities.

Accomplishments:

- Launched the Youth Thrive training to staff, stakeholders, and providers, including resource parents.

Planned Activities:

- Provide training and support to resource parents to help promote these activities.
- Update contracts and program models for adolescent community based programs to ensure they are promoting developmentally appropriate activities.
- Update other policy regarding providing opportunities for young people to engage in age or developmentally-appropriate activities.
- Implement the Youth At Risk of Homelessness service intervention strategies to promote youth to engage in developmentally appropriate activities.

### National Youth in Transitions Database (NYTD)

- One of the partners DCF is working with for the Connecting YOUTH Federal planning grant is Child Trends who will be reviewing NJ data (including NYTD) in Phase II of the project to get an understanding of the youth we serve. In addition to that, DCF has collected data via the 2013 Rutgers needs assessment and is currently figuring out how to use this information to inform service delivery as well as any changes/restructuring of services. Since 2010, DCF has been collecting NYTD data from contracted agencies that provide independent living services as well as data from the outcomes survey. DCF is working towards reviewing and analyzing the NYTD data to help inform the work.
- DCF is currently examining and updating existing databases to streamline NYTD data collection. We are looking at possibly providing an interface for providers to enter the independent living services that are provided to youth/young adults. In addition, DCF has contracted with a community agency to administer the NYTD survey to youth ages 19 and 21 who are no longer involved with DCF to ensure better continuity and engagement with youth.

OAS holds quarterly meetings with contracted community agencies who provide services for youth who are or were involved with CP&P. These meetings provide an opportunity for networking, as well as a forum to provide updates on adolescent policy, practice and resources. In addition, through the Youth at Risk of Homelessness (YARH) federal project, a cross section of internal and external stakeholders were brought together via a systems mapping and charrette to provide feedback and input that was used in planning for the proposed intervention. DCF partners with and coordinates services with several community agencies in NJ that are funded under the Part B title III of the Juvenile Justice Delinquency Prevention Act of 1974. The agencies provide the basic center programs, transitional living programs and street outreach for youth who are homeless. OAS collaborates with these agencies when there are current or former CP&P involved adolescents who are in need of housing or who have runaway or are missing. We do not currently coordinate services with abstinence programs. In addition, DCF life skills providers are required to provide pregnancy prevention inclusive of education and information regarding abstinence. DCF endeavors to involve youth/young adults in all aspects of our work including, but not limited to, reviewing and providing comments on adolescent policy, getting feedback on services/supports that are offered to adolescents as well as providing internship opportunities within the Office of Adolescent Services. Through the Youth Advisory Boards we also receive feedback on CP&P practice and policies.

### **Indian Tribe Consultation:**

New Jersey does not have any federally recognized Indian Tribes.

# Section L

## Statistical and Supporting Information

<b>Workforce Information</b>
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DCF is committed to hiring an educated, diversified workforce and providing them with the necessary training and tools to fulfill the Department's mission to ensure and promote the safety, well-being and success of New Jersey's children and families. Social workers seeking employment with DCF must meet stringent requirements in order to be hired. Extensive training for all new caseworkers is mandatory as is 40 hours of continuing education per year for all other caseload carrying workers and supervisors. DCF also has established caseload standards so that workers have the ability to effectively meet the needs of the children and families they serve.

**Summary of Recruitment Plan for Family Service Specialist Trainee (FSST)**

The Department of Children and Families takes a proactive approach to hiring by maintaining a pool of pre-screened, pre-qualified candidates to fill vacancies for our entry level case manager position, Family Service Specialist Trainee. Since our Department receives more than 11,000 resumes for this position each year, candidates are prioritized based on their education and experience in order to select those candidates most likely to succeed in public social work. Our recruitment efforts are centered on a massive interviewing process known as a Job Fest. A Job Fest generally includes 25 to 35 candidates interviewed in the AM session and the same number for a PM session and consists of:

**A. Introduction**

1. Overview of the Department of Children and Families, Division of Child Protection and Permanency, and DCP&P and the role of the Family Service Specialist
2. Instructions for completing the pre-employment forms/paperwork
3. Overview of the Hiring Process
4. Video presentation-the realities of the job

**B. Initial Interview**

1. Each candidate is interviewed individually by a panel of two interviewers.
2. Each fest has eight to twelve interview panels
3. Interview questions for the most part are scenario-based and designed to assess the following skills:
  - a. Judgment/Decision Making
  - b. Oral Communication
  - c. Problem Analysis
  - d. Interpersonal Responsiveness
  - e. Organization
  - f. Time Management

**C. Writing Sample**

1. Each candidate participates in preparing a writing sample in ten minutes
2. The writing sample is evaluated to determine if it is relevant, coherent, in a narrative format, and reflects proper spelling/grammar/punctuation

**D. Credential/Paperwork Checkout**

1. Each candidate meets with an HR representative to:
  - a. Review employment application for completeness
  - b. Review and verify documents (valid driver's license, social security card, college transcript, list of references)
  - c. Ensure candidate signs necessary releases, consents, and affidavits

- d. Advise candidate of any outstanding documentation needed to complete the application process

Candidates successfully completing the Job Fest and background check processes are added to a hiring matrix which is distributed each week to the 46 Local Offices throughout the State. Managers and supervisors in the Local Offices use the hiring matrix to select candidates to fill positions as vacancies occur. This proactive process allows our agency to fill caseload carrying positions as soon as vacancies become available. By doing so, we are better able to maintain mandated caseload standards.

**Degree and certifications required for case workers and professionals responsible for the management of cases and child protective services staff**

**Family Service Specialist Trainee:**

- Graduation from an accredited college or university with a Bachelor's degree. Preference is given to those with a Bachelor's or Master's degree in Social work or a related degree with six months of social work experience.

**Family Service Specialist 2**

- Graduation from an accredited college or university with a Bachelor's degree. One (1) year of experience in professional social work, direct support counseling, guidance, or case management involving high risk child abuse and neglect or other problematic situations involving counseling services to clients with social, emotional, psychological, or behavioral problems including gathering and analyzing information, determining needs, and planning and supporting and/or carrying out treatment plans.
- A supervised social work field placement of three hundred (300) hours serviced through an accredited college or university or performed in a social service agency may be substituted for the indicated experience.
- A Master's degree in Social Work, Psychology, Guidance and Counseling, Divinity, Marriage and Family Therapy, or other related behavioral science area may be substituted for the indicated experience.
- Applicants who do not possess the required degree may substitute additional professional support work experience related to case management on a year for year basis with one (1) year of experience being equal to thirty (30) semester hour credits.

**Family Service Specialist 1**

- Graduation from an accredited college or university with a Bachelor's degree.
- Two (2) years of experience in professional social work, direct support counseling, guidance, or case management involving high risk child abuse and neglect or other problematic situations involving counseling services to clients with social, emotional, psychological, or behavioral problems including gathering and analyzing information, determining needs, and planning and/or carrying out treatment plans.
- A maximum of one year of non-caseload carrying experience may be credited toward the experience requirement listed above.

- A supervised social work field placement of three hundred (300) hours serviced through an accredited college or university or performed in a social service agency may be substituted for one (1) year of indicated experience.
- A Master's degree in Social Work, Psychology, Guidance and Counseling, Divinity, Marriage and Family Therapy, or other related behavioral science area may be substituted for one (1) year of indicated experience.
- Applicants who do not possess the required degree may substitute additional professional case management experience on a year for year basis with one (1) year of experience being equal to thirty (30) semester hour credits.

### **Supervising Family Services Specialist 2**

- Three (3) years of experience in professional social work, direct support counseling, guidance, or case management involving high risk child abuse and neglect or other problematic situations involving counseling services to clients with social, emotional, psychological, or behavioral problems, including gathering and analyzing information, determining needs, and planning and/or carrying out treatment plans.
- A maximum of one year of non-caseload carrying experience may be credited toward the experience requirement listed above.
- A supervised social work field placement of three hundred (300) hours serviced through an accredited college or university or performed in a social service agency may be substituted for one (1) year of indicated experience.
- A Master's degree in Social Work, Psychology, Guidance and Counseling, Divinity, Marriage and Family Therapy, or other related behavioral science area may be substituted for one (1) year of indicated experience.
- Applicants who do not possess the required degree may substitute additional experience as indicated on a year-for-year basis with one (1) year of experience being equal to thirty (30) semester hour credits.

### **Supervising Family Service Specialist 1 (Casework Supervisor)**

- Four (4) years of experience in professional social work, direct support counseling, guidance, or case management involving high risk child abuse and neglect or other problematic situations involving counseling services to clients with social, emotional, psychological, or behavioral problems including gathering and analyzing information, determining needs, and planning and/or carrying out treatment plans, one (1) year of which shall have been a supervisory capacity.
- A maximum of one year of non-caseload carrying experience may be credited toward the non-supervisory experience requirement listed above.
- A supervised social work field placement of three hundred (300) hours serviced through an accredited college or university or performed in a social service agency may be substituted for one (1) year of non-supervisory experience.
- Applicants who do not possess the required degree may substitute additional experience as indicated on a year-for-year basis with thirty (30) semester hour credits being equal to one (1) year of non-supervisory experience.

- A Master's degree in Social Work, Psychology, Guidance and Counseling, Divinity, Marriage and Family Therapy, or other related behavioral science area may be substituted for one (1) year of non-supervisory experience.

### **Training Requirements for staff**

See Attachment D: Training Plan Updates

### **Caseload Requirements**

DCF is committed to maintaining caseload standards that will allow workers to effectively address the needs of the families on their caseloads. The standards to which we work to adhere are:

- Intake workers (Investigators) have no more than 12 families at a time and no more than 8 new intakes per month.
- Permanency workers have no more than 15 families with ten children in placement.
- Adoption workers have no more than 15 children.
- No more than 5 workers assigned to a supervisor

Figures 1 through 5 represent data gleaned from NJS to demonstrate caseload requirement compliance. Adoption caseloads fluctuate statewide on a quarterly basis and additional supports are given to those areas by the Office Adoption Operations, Resource and Interstate Services. Figures 6 through 11 represent workforce data gleaned from DCF Human Resources.

Figure 1

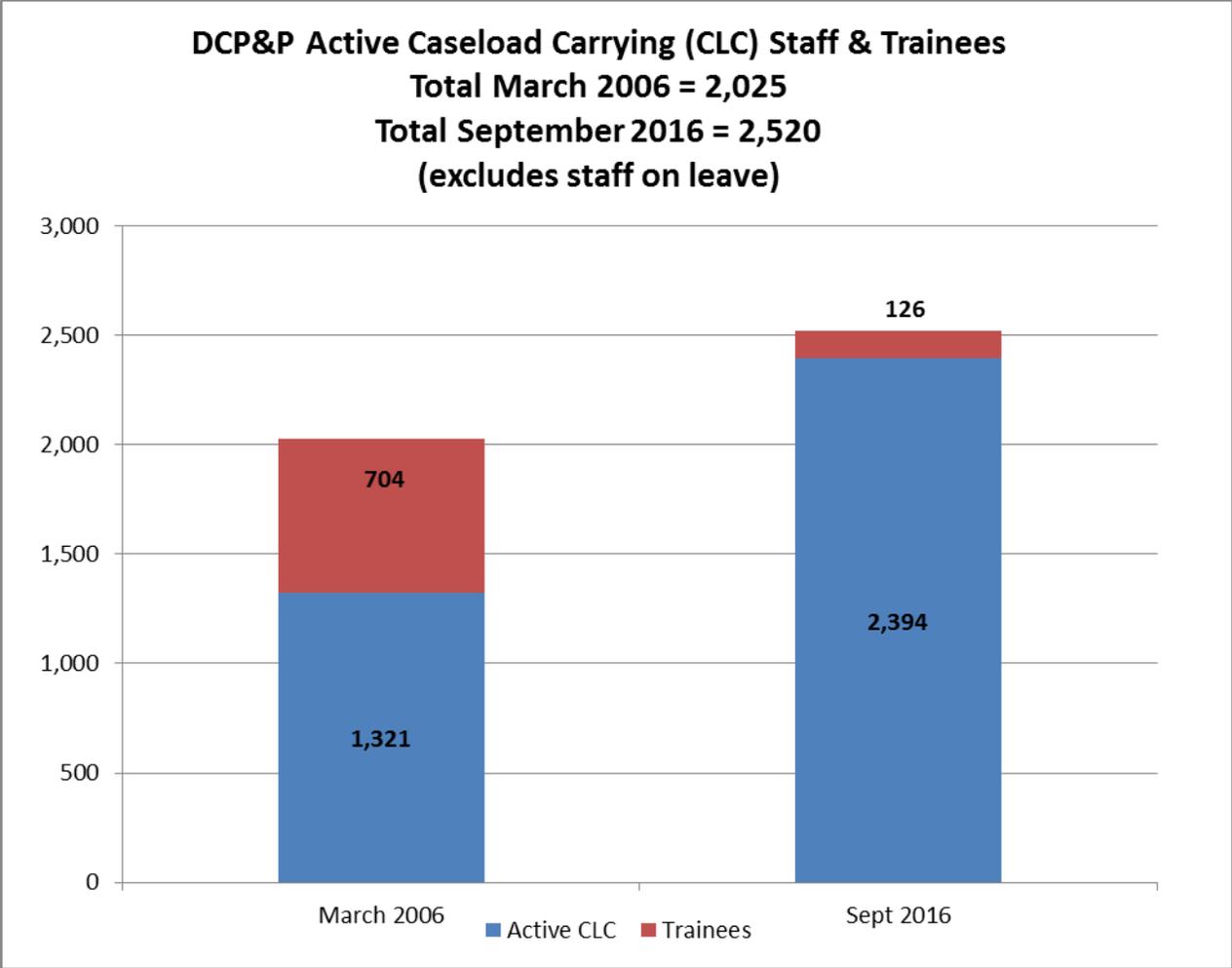


Figure 2

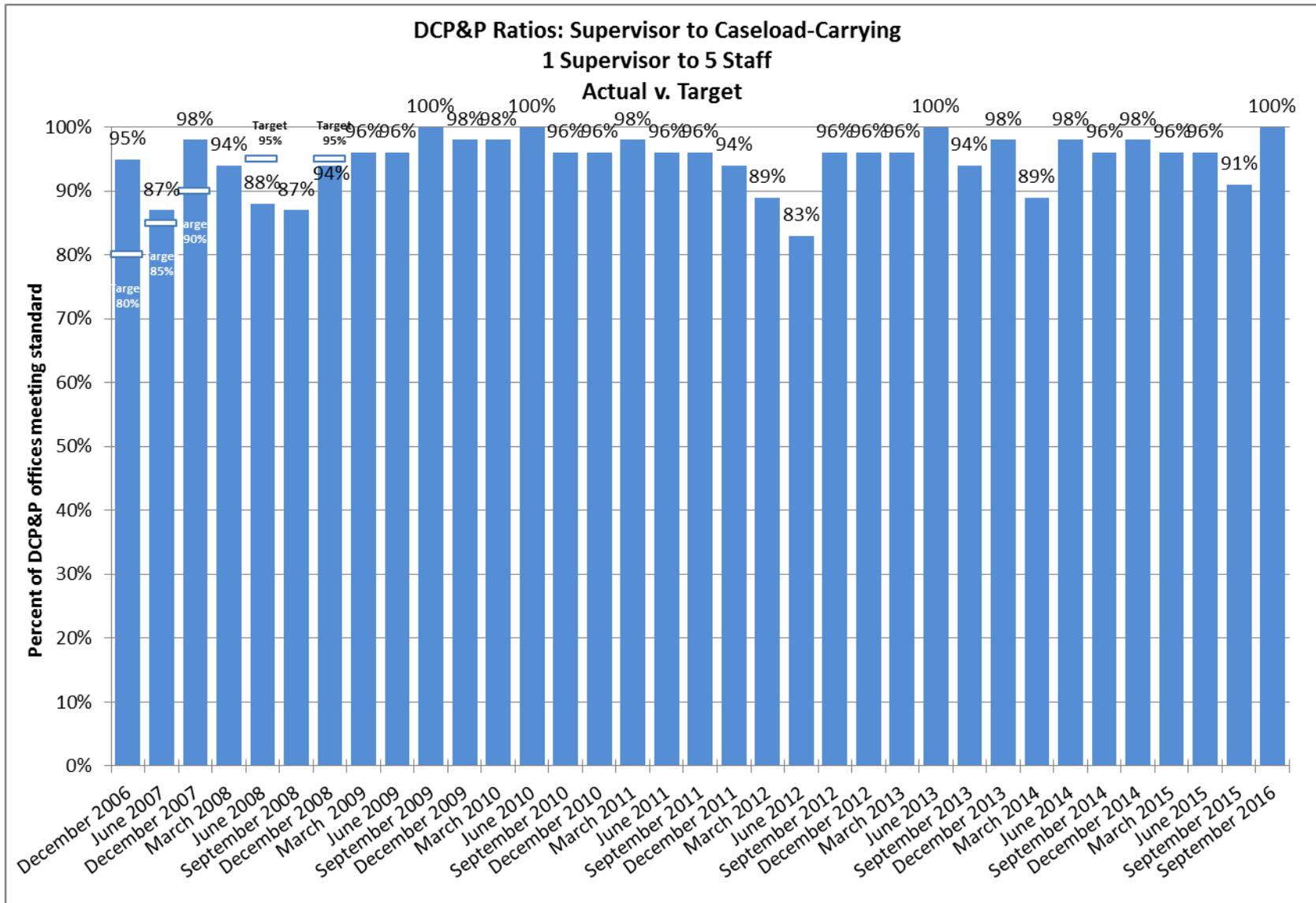


Figure 3

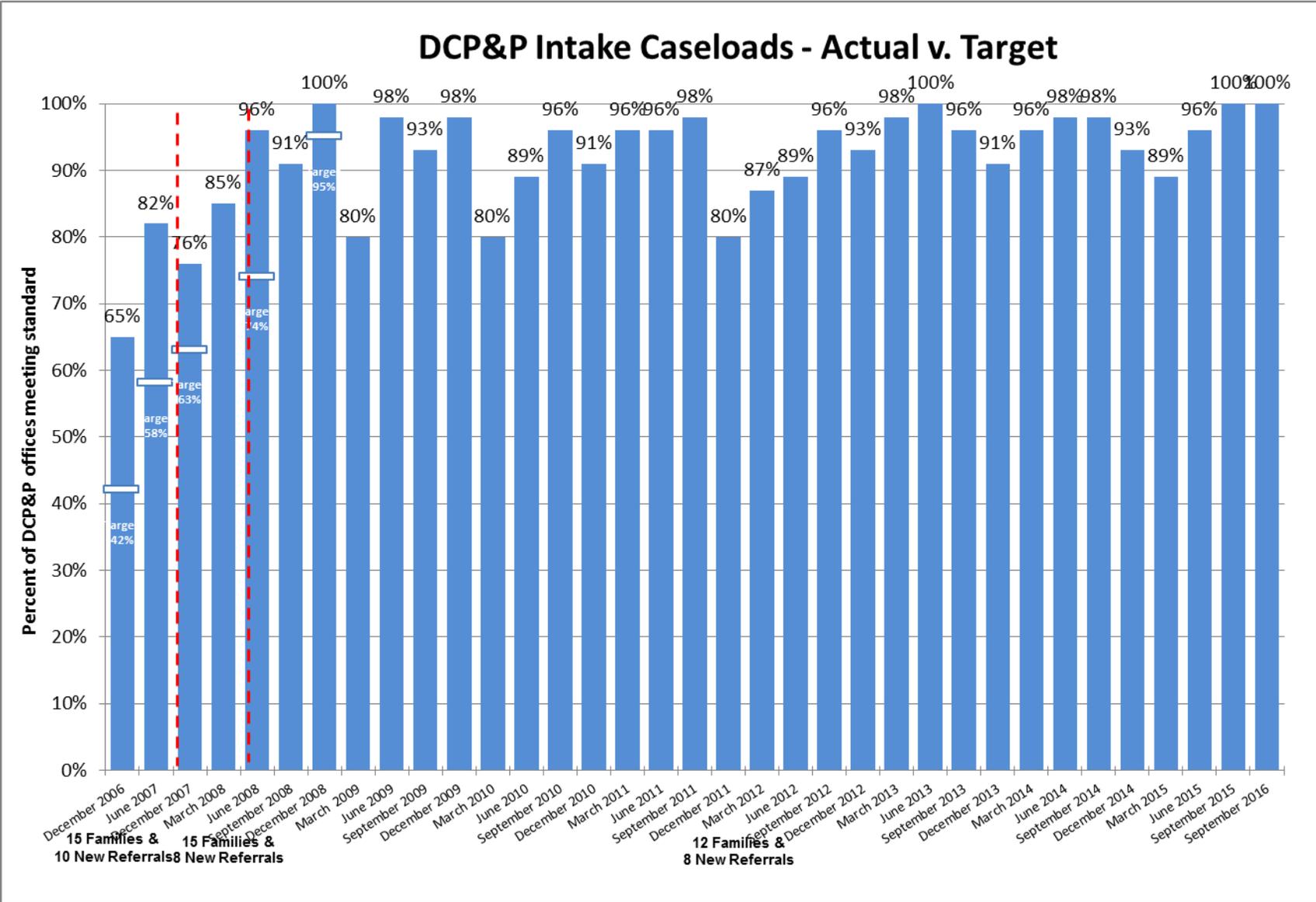
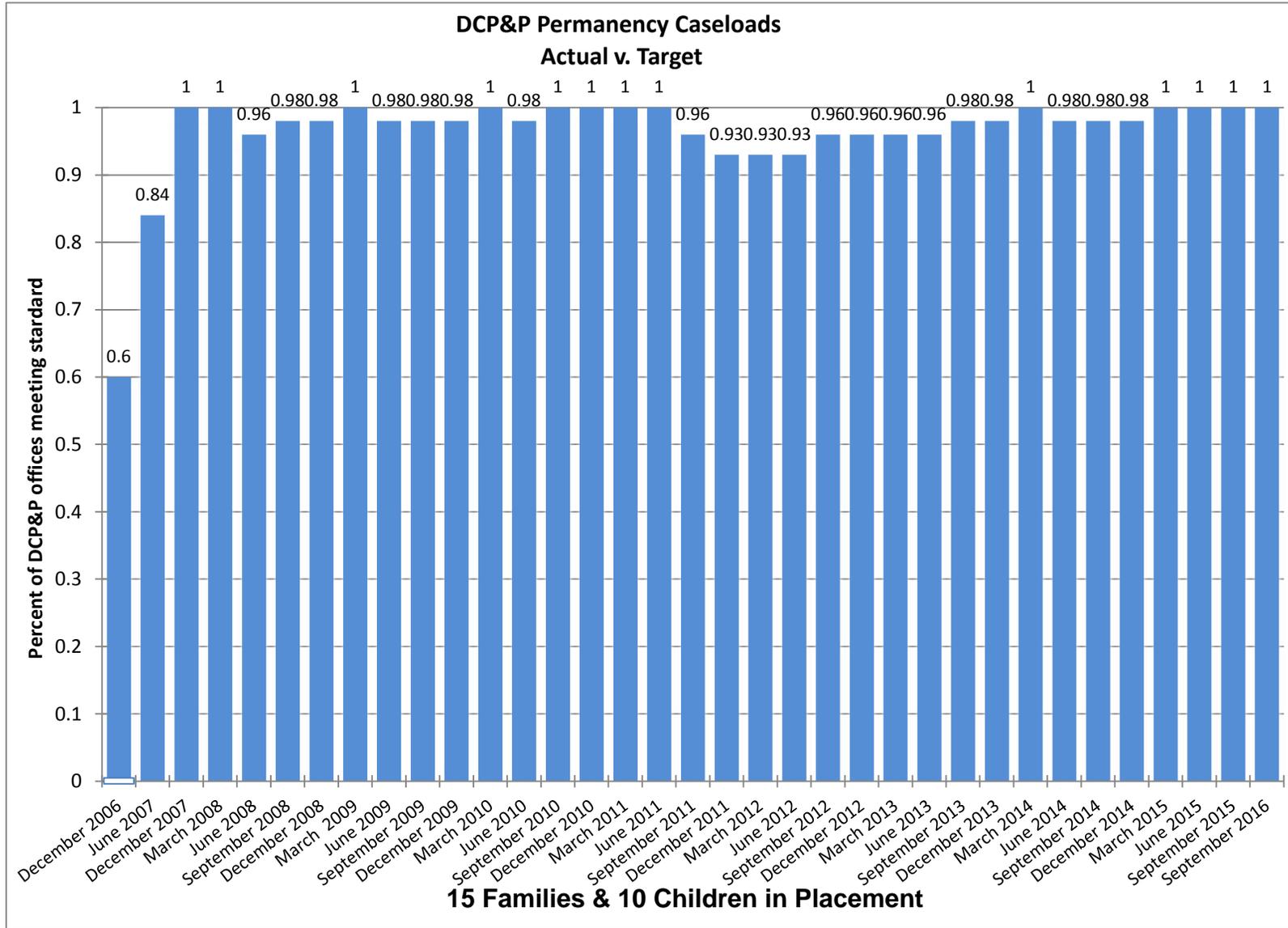


Figure 4





**Figure 6  
Educational Degrees by Job Title**

<b>All Child Welfare Staff by Job Title as of September 30, 2016</b>	<b>MSW</b>	<b>Other Masters</b>	<b>BSW</b>	<b>Other Bachelors</b>	<b>Law Degree</b>	<b>PhD</b>	<b>No 4- year Degree</b>	<b>Staff Totals</b>
Family Service Specialist Trainee	30	43	46	218			2	339
Family Service Specialist 2	139	160	357	1393	1	2	17	2069
Family Service Specialist 1	56	52	85	547	1		9	750
Front Line Supervisor (SFSS 2)	88	46	71	435	2		10	652
Case Practice Specialist (CSS)	18	10	11	45				84
Case Work Supervisor (SFSS 1)	43	21	18	119	1		4	206
Local Office Manager	15	7	5	14				41
Area Office Support Staff	3	3	4	9			2	21
Area Office Manager	8	1	1	7				17
<b>Degree Totals</b>	<b>400</b>	<b>343</b>	<b>598</b>	<b>2787</b>	<b>5</b>	<b>2</b>	<b>44</b>	<b>4179</b>
<b>New Hires by Job Title for October 1, 2015 through September 30, 2016</b>	<b>MSW</b>	<b>Other Masters</b>	<b>BSW</b>	<b>Other Bachelors</b>	<b>Law Degree</b>	<b>PhD</b>	<b>No 4- year Degree</b>	<b>Staff Totals</b>
Family Service Specialist Trainee	26	42	43	198				309
Family Service Specialist 1								0
Family Service Specialist 2	2	1		4				7
Local Office Manager		1		1				2
<b>Degree Totals</b>	<b>28</b>	<b>44</b>	<b>43</b>	<b>203</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>318</b>

**Figure 7  
Educational Degrees by Job Function**

<b>All Child Welfare Staff by Job Function as of September 30, 2016</b>	<b>MSW</b>	<b>Other Masters</b>	<b>BSW</b>	<b>Other Bachelors</b>	<b>Law Degree</b>	<b>PhD</b>	<b>No 4-year Degree</b>	<b>Staff Totals</b>
<b>Adoption Worker</b>	22	15	49	154			1	<b>241</b>
<b>Adoption Supervisor</b>	7	6	7	33			1	<b>54</b>
<b>Intake Worker</b>	75	70	168	684		1	6	<b>1004</b>
<b>Intake Supervisor</b>	24	16	27	150	1		2	<b>220</b>
<b>Permanency Worker</b>	95	135	227	991	1	1	12	<b>1462</b>
<b>Permanency Supervisor</b>	49	18	29	194			4	<b>294</b>
<b>Resource Family Worker</b>	20	22	27	171			4	<b>244</b>
<b>Resource Family Supervisor</b>	5	2	5	34			1	<b>47</b>
<b>Local Office Support Staff</b>	13	12	16	142			6	<b>189</b>
<b>Local Office Support Supervisor</b>	2	4	3	22	1		1	<b>33</b>
<b>Case Practice Specialist</b>	16	10	10	41				<b>77</b>
<b>Case Work Supervisor</b>	42	21	18	117	1		4	<b>203</b>
<b>Local Office Manager</b>	15	7	5	14				<b>41</b>
<b>Area Office Support Staff</b>	7	4	6	33	1		2	<b>53</b>
<b>Area Office Manager</b>	8	1	1	7				<b>17</b>
<b>Degree Totals</b>	<b>400</b>	<b>343</b>	<b>598</b>	<b>2787</b>	<b>5</b>	<b>2</b>	<b>44</b>	<b>4179</b>

<b>New Hires by Job Function for October 1, 2015 through September 30, 2016</b>	<b>MSW</b>	<b>Other Masters</b>	<b>BSW</b>	<b>Other Bachelors</b>	<b>Law Degre e</b>	<b>PhD</b>	<b>No 4- year Degree</b>	<b>Staff Totals</b>
<b>Adoption Worker</b>				1				<b>1</b>
<b>Intake Worker</b>	3	3	6	13				<b>25</b>
<b>Permanency Worker</b>	25	40	37	187				<b>289</b>
<b>Resource Family Worker</b>				1				<b>1</b>
<b>Local Office Manager</b>		1		1				<b>2</b>
<b>Area Office Support Staff</b>								<b>0</b>
<b>Degree Totals</b>	<b>28</b>	<b>44</b>	<b>43</b>	<b>203</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>318</b>

**Figure 8  
Race/Ethnicity/Gender by Job Title**

All Child Welfare Staff by Job Title as of September 30, 2016	Asian	Black	Hispanic	Native American	White	Total Female	Asian	Black	Hispanic	Native American	White	Total Male	Staff Totals
	Family Service Specialist Trainee	4	100	17	11	166	298	1	19			21	41
Family Service Specialist 2	18	790	74	3	780	1665	7	202	18	2	175	404	2069
Family Service Specialist 1	9	274	33	3	313	632	3	53	7	1	54	118	750
Front Line Supervisor (SFSS2)	7	218	28	1	298	552	2	38	1		59	100	652
Case Practice Specialist (CSS)		23	1		48	72		4	1		7	12	84
Case Work Supervisor (SFSS1)	5	69	8		101	183		12	2		9	23	206
Local Office Manager		16	1		16	33		3	1		4	8	41
Area Office Support Staff		5	1		10	16	1				4	5	21
Area Office Manager		4			12	16		1				1	17
<b>Totals</b>	<b>43</b>	<b>1499</b>	<b>163</b>	<b>18</b>	<b>1744</b>	<b>3467</b>	<b>14</b>	<b>332</b>	<b>30</b>	<b>3</b>	<b>333</b>	<b>712</b>	<b>4179</b>
New Hires by Job Title for October 1, 2015 through September 30, 2016	Asian	Black	Hispanic	Native American	White	Total Female	Asian	Black	Hispanic	Native American	White	Total Male	Staff Totals
Family Service Specialist Trainee	2	93	16	9	152	272	1	18			18	37	309
Family Service Specialist 1						0						0	0
Family Service Specialist 2		2			5	7						0	7
Local Office Manager		2				2						0	2
<b>Totals</b>	<b>2</b>	<b>97</b>	<b>16</b>	<b>9</b>	<b>157</b>	<b>281</b>	<b>1</b>	<b>18</b>	<b>0</b>	<b>0</b>	<b>18</b>	<b>37</b>	<b>318</b>

**Figure 9  
Race/Ethnicity/Gender by Job Function**

Child Welfare Staff by Job Function as of September 30, 2016	Asian	Black	Hispanic	Native American	White	Total Female	Asian	Black	Hispanic	Native American	White	Total Male	Staff Totals
	Adoption Worker	4	79	12	1	120	216		12			13	25
Adoption Supervisor		16			30	46		2			6	8	54
Intake Worker	10	332	59	2	412	815	2	80	16	1	90	189	1004
Intake Supervisor	3	60	22	1	107	193		10	1		16	27	220
Permanency Worker	13	570	46	11	543	1183	8	157	8	2	104	279	1462
Permanency Supervisor	3	106	4		127	240	2	21			31	54	294
Resource Family Worker	1	115	3		88	207	1	12			24	37	244
Resource Family Supervisor		22	2		18	42		2			3	5	47
Local Office Support Staff	3	60	4	3	90	160		13	1		15	29	189
Local Office Support Supervisor	1	12			14	27		3			3	6	33
Case Practice Specialist		22	1		43	66		4	1		6	11	77
Case Work Supervisor	5	68	8		99	180		12	2		9	23	203
Local Office Manager		16	1		16	33		3	1		4	8	41
Area Office Support Staff		17	1		25	43	1				9	10	53
Area Office Manager		4			12	16		1				1	17
<b>Totals</b>	<b>43</b>	<b>1499</b>	<b>163</b>	<b>18</b>	<b>1744</b>	<b>3467</b>	<b>14</b>	<b>332</b>	<b>30</b>	<b>3</b>	<b>333</b>	<b>712</b>	<b>4179</b>
New Hires by Job Function for October 1, 2015 through September 30, 2016	Asian	Black	Hispanic	Native American	White	Total Female	Asian	Black	Hispanic	Native American	White	Total Male	Staff Totals
	Adoption Worker				1	1						0	1
Intake Worker		3			16	19		1			4	5	24
Permanency Worker	2	92	15	9	139	257	1	17		1	14	33	290
Resource Family Worker		2			1	3						0	3
Local Office Manager						0						0	0
Area Office Support Staff						0						0	0
<b>Totals</b>	<b>2</b>	<b>97</b>	<b>15</b>	<b>9</b>	<b>157</b>	<b>280</b>	<b>1</b>	<b>18</b>	<b>0</b>	<b>1</b>	<b>18</b>	<b>38</b>	<b>318</b>

**Figure 10  
Separations from DCF by Job Title**

All Child Welfare Staff Separations by Job Title from October 1, 2015 through September 30, 2016	Retirement	Resignation in Good Standing	Resignation Not in Good Standing	Resignation Pending Disciplinary Action	Removal	Appointment Discontinued	Transfer to another Department	Death	Title Totals
	Family Service Specialist Trainee		27				11		
Family Service Specialist 2	13	114	3	13	3	1	12		159
Family Service Specialist 1	19	8							27
Front Line Supervisor (SFSS 2)	12	7						1	20
Case Practice Specialist (CSS)	3	1							4
Case Work Supervisor (SFSS 1)	6	1							7
Local Office Manager	2							1	3
Area Office Support Staff									0
Area Office Manager	1								1
<b>Separation Totals</b>	<b>56</b>	<b>158</b>	<b>3</b>	<b>13</b>	<b>3</b>	<b>12</b>	<b>12</b>	<b>2</b>	<b>259</b>

**Figure 11**  
**Years of Service & Salary Ranges by Job Title**

<b>All Child Welfare Staff by Job Title as of September 30, 2016</b>	<b>Average Years of Service</b>	<b>Minimun Annual Salary</b>	<b>Maximun Annual Salary</b>
<b>Family Service Specialist Trainee</b>	0.70	\$49,263.43	\$51,529.95
<b>Family Service Specialist 2</b>	7.35	\$53,910.34	\$76,393.06
<b>Family Service Specialist 1</b>	13.68	\$59,031.79	\$83,803.57
<b>Front Line Supervisor (SFSS 2)</b>	15.46	\$64,677.09	\$92,011.89
<b>Case Practice Specialist (CSS)</b>	17.45	\$67,714.29	\$96,415.56
<b>Case Work Supervisor (SFSS 1)</b>	20.50	\$70,903.32	\$101,039.55
<b>Local Office Manager</b>	22.96	No official salary range	
<b>Area Office Support Staff</b>	22.85	\$53,910.34	\$105,891.38
<b>Area Office Manager</b>	25.26	No official salary range	

### **Juvenile Justice Transfer**

#### **Juvenile Justice Transfer**

There were 15 children in placement under the legal authority of the Division of Child Protection & Permanency (DCP&P), during this reporting period that were transferred from DCP&P to the Juvenile Justice Commission (JJC). The Office of Research, Evaluation & Reporting generated a report that listed all children in placement, with a placement ending reason of "Custody and Care Transferred to Another Agency". All children listed on the report were reviewed through SACWIS, and the DCP&P Area and Local office staff identified the children who were transferred to the JJC.

### **Sources of Data on Child Maltreatment Deaths**

Child fatalities are reported to the NJ Department of Children and Families Child Death Review Unit by many different sources including, law enforcement agencies, medical personnel, family members, schools, medical examiners offices and occasionally child death review teams. In addition the Bureau of Vital Statistics confirms all child fatalities and supplies the birth as well as death certificates when available. The DCP&P Assistant Commissioner makes the determination as to whether the child fatality was a result of child maltreatment.

The State NCANDS liaison consults with the Child Death Review Unit Coordinator to insure that all child maltreatment fatalities are reported in the State NCANDS files.

The New Jersey State SACWIS system (NJS) is the primary source of reporting child fatalities in the NCANDS Child File. Specifically, child maltreatment deaths are reported in the NCANDS Child File in data element 34, Maltreatment Death, from data collected and recorded by Investigators in the Investigation and Person Management screens in the NJS.

Other child maltreatment fatalities not reported in the Child File due to data anomalies, but which are designated child maltreatment fatalities by the Child Death Review Unit under the Child Abuse Prevention and Treatment Act (CAPTA), are reported in the NCANDS Agency File in data element 4.1, Child Maltreatment Fatalities not reported in the Child File.

### **Education and Training Vouchers**

The total number of ETV awards granted for the 2015-2016 School Year was 222 with 100 new ETV awards.

The total number of ETV awards estimated for the 2016-2017 School Year is 207 with an estimated number of 102 new ETVs- see Section Financial Information.

### **Inter-Country Adoptions**

See Section: Services for Children Adopted from Other Countries.

### **Monthly Caseworker Visit Data**

See Section: Monthly Caseworker Visit Formula Grant provides preliminary data. Final Data will be submitted By December 15, 2017 as required.

# Section M

## Financial Information

CFS-101, Part I  
 U. S. Department of Health and Human Services  
 Administration for Children and Families

Attachment B  
 OMB Approval #0970-0426  
 Approved through September 30, 2017

**CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CFCIP, and ETV**  
**For Fiscal Year 2018: October 1, 2017 through September 30, 2018**

<b>1. State or Indian Tribal Organization (ITO):</b>	New Jersey	<b>2. EIN:</b> 216 000 928
<b>3. Address:</b> 50 East State Street, 2nd Floor, Trenton, NJ 08625		<b>4. Submission Type:</b> <input checked="" type="checkbox"/> NEW <input type="checkbox"/> REVISION
<b>5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) funds</b>		\$5,371,985
a) Total administrative costs (not to exceed 10% of title IV-B Subpart 1 estimated allotment)		\$537,198
<b>6. Total estimated title IV-B Subpart 2, Promoting Safe and Stable Families (PSSF) funds</b> This line contains a formula to display the sum of lines 6a - 6f.		\$5,492,099
a) Total Family Preservation Services		\$1,241,148
b) Total Family Support Services		\$1,235,403
c) Total Time-Limited Family Reunification Services		\$1,266,535
d) Total Adoption Promotion and Support Services		\$1,749,013
e) Total Other Service Related Activities (e.g. planning)		\$0
f) Total administrative costs (FOR STATES ONLY: not to exceed 10% of title IV-B subpart 2 estimated allotment)		\$0
<b>7. Total estimated Monthly Caseworker Visit (MCV) funds (FOR STATES ONLY)</b>		\$345,949
a) Total administrative costs (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)		\$34,594
<b>8. Re-allotment of title IV-B subparts 1 &amp; 2 funds for States and Indian Tribal Organizations:</b>		
a) Indicate the amount of the State's/Tribe's allotment that will not be required to carry out the following programs: CWS \$0 PSSF \$0 MCV (States only) 0		
b) If additional funds become available to States and ITOs, specify the amount of additional funds the States or Tribes requesting: CWS \$537,198 PSSF \$549,209 MCV (States only) \$34,594		
<b>9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (FOR STATES ONLY)</b> Estimated amount plus additional allocation, as available.		\$657,136
<b>10. Estimated Chafee Foster Care Independence Program (CFCIP) funds</b>		\$2,297,848
a) Indicate the amount of State's or Tribe's allotment to be spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment).		\$410,227
<b>11. Estimated Education and Training Voucher (ETV) funds</b>		\$732,632
<b>12. Re-allotment of CFCIP and ETV Program funds:</b>		
a) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out the CFCIP Program.		\$0
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out the ETV Program.		\$0
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for the CFCIP Program.		\$229,784
d) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for the ETV Program.		\$73,263
<b>13. Certification by State Agency and/or Indian Tribal Organization:</b> The State agency or Indian Tribal Organization submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA State Grant, CFCIP and ETV programs, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.		
<i>Signature of State/Tribal Agency Official</i>	<i>Signature of Central Office Official</i>	
<i>Title Chief Financial Officer, Department of Children and Families</i>	<i>Title</i>	
<i>Date</i> 6/15/17	<i>Date</i>	

2018 APSR

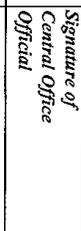
**CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CFCIP, and ETV**  
**Fiscal Year 2017, October 1, 2016 through September 30, 2017**

<b>1. State or Indian Tribal Organization (ITO): New Jersey</b>		<b>2. EIN: 216000928</b>	
<b>3. Address: 50 East State Street, 2nd Floor, Trenton NJ 08625</b>		<b>4. Submission:</b> <input type="checkbox"/> New <input checked="" type="checkbox"/> Revision	
<b>5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) Funds</b>		\$5,337,180	
a) Total administration (not to exceed 10% of title IV-B Subpart 1 estimated allotment)		\$533,718	
<b>6. Total estimated title IV-B Subpart 2, Provides Safe and Stable Families (PSSF) Funds. This amount should equal the sum of lines a - f.</b>		\$5,683,958	
a) Total Family Preservation Services		\$1,289,048	
b) Total Family Support Services		\$1,283,303	
c) Total Time-Limited Family Reunification Services		\$1,314,435	
d) Total Adoption Promotion and Support Services		\$1,797,172	
e) Total for Other Service Related Activities (e.g. planning)		\$0	
f) Total administration (FOR STATES ONLY: not to exceed 10% of title IV-Bsubpart 2 estimated allotment)		\$0	
<b>7. Total estimated Monthly Caseworker Visit (MCV) Funds (FOR STATES ONLY)</b>		\$357,967	
a) Total administration (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)		\$35,796	
<b>8. Re-allotment of title IV-B subparts 1 &amp; 2 funds for States and Indian Tribal Organizations:</b>			
a) Indicate the amount of the State's/Tribe's allotment that will not be required to carry out the following programs: CWS \$0, PSSF \$0, and/or MCV(States only) \$0.			
b) If additional funds become available to States and ITOs, specify the amount of additional funds the States or Tribes requesting: CWS \$533,718, PSSF \$568,395, and/or MCV(States only) 0.			
<b>9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (no State match required): Estimated Amount plus additional allocation, as available. (FOR STATES ONLY)</b>		\$653,919	
<b>10. Estimated Chafee Foster Care Independence Program (CFCIP) funds</b>		\$2,297,848	
a) Indicate the amount of State's or Tribe's allotment to be spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)		\$438,116	
<b>11. Estimated Education and Training Voucher (ETV) funds</b>		\$684,463	
<b>12. Re-allotment of CFCIP and ETV Program Funds:</b>			
a) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out CFCIP Program		\$0	
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out ETV Program		\$0	
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for CFCIP Program		\$229,785	
d) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for ETV Program		\$68,446	
<b>13. Certification by State Agency and/or Indian Tribal Organization.</b>			
The State agency or Indian Tribe submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA State Grant, CFCIP and ETV programs, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.			
Signature and Title of State/Tribal Agency Official Chief Financial Officer, Department of Children and Families		Signature and Title of Central Office Official	
			

CFS-101, Part III  
U. S. Department of Health and Human Services  
Administration for Children and Families

Attachment B  
OMB Approval #6970-0426  
Approved through September 30, 2017

**CFS-101, PART III: Annual Expenditures for Title IV-B, Subparts 1 and 2, Chafee Foster Care Independence (CFCIP) and Education And Training Voucher (ETV):  
Reporting For Fiscal Year 2015 Grants: October 1, 2014 through September 30, 2016**

1. State or Indian Tribal Organization (IT/O): New Jersey		2. EIN: 216 000 928	3. Address: 50 East State Street, 2nd Floor, Trenton, NJ 08625			
4. Submission Type: <input checked="" type="checkbox"/> NEW <input type="checkbox"/> REVISION						
Description of Funds	Estimated Expenditures for FY15 Grants	Actual Expenditures for FY15 Grants	Number Individuals served	Number Families served	Population served	Geographic area served
5. Total title IV-B, subpart 1 funds	\$ 5,253,870	\$ 5,253,870	7228	3433	N A	Statewide
a) Administrative Costs (not to exceed 10% of title IV-B, subpart 1 total allotment)	\$ 525,684	\$ 524,583				
6. Total title IV-B, subpart 2 funds (This line contains a formula that will display the sum of lines a-f)	\$ 5,253,870	\$ 5,253,870				
a) Family Preservation Services	\$ 1,241,148	\$ 1,241,148				
b) Family Support Services	\$ 1,131,619	\$ 1,131,619				
c) Time-Limited Family Reunification Services	\$ 1,266,535	\$ 1,266,535				
d) Adoption Promotion and Support Services	\$ 1,614,568	\$ 1,614,568				
e) Other Service Related Activities (e.g. planning)	\$ -	\$ -				
f) Administrative Costs (FOR STATES; not to exceed 10% of total title IV-B, subpart 2 allotment)	\$ -	\$ -				
7. Total Monthly Caseworker Visit funds (STATES ONLY)	\$ 330,616	\$ 132,230				
a) Administrative Costs (not to exceed 10% of MCV allotment)	\$ -	\$ -				
8. Total Chafee Foster Care Independence Program (CFCIP) funds	\$ 2,297,848	\$ 2,297,848				
a) Indicate the amount of allotment spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)	\$ 613,916	\$ 424,900	92	N A	N A	Statewide
9. Total Education and Training Voucher (ETV) funds	\$ 735,895	\$ 735,895	222	N A	N A	Statewide
10. Certification by State Agency or Indian Tribal Organization: The State agency or Indian Tribal Organization agrees that expenditures were made in accordance with the Child and Family Services Plan, which was jointly developed with, and approved by, the Children's Bureau.						
Signature of State/Tribal Agency Official	Date	Signature of Central Office Official	Date			
	6/15/17					
Title Chief Financial Officer, Department of Children and Families		Title				

<b>CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 &amp; 2 Funds, CAPTA, CFCIP, and ETV</b>	
<b>For Fiscal Year 2018: October 1, 2017 through September 30, 2018</b>	
<b>1. State or Indian Tribal Organization (ITO):</b>	New Jersey
<b>2. EIN:</b>	216 000 928
<b>3. Address:</b> 50 East State Street, 2nd Floor, Trenton, NJ 08625	<b>4. Submission Type:</b>
	<input checked="" type="checkbox"/> NEW
	<input type="checkbox"/> REVISION
<b>5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) funds</b>	\$5,371,985
a) Total administrative costs (not to exceed 10% of title IV-B Subpart 1 estimated allotment)	\$537,198
<b>6. Total estimated title IV-B Subpart 2, Promoting Safe and Stable Families (PSSF) funds</b>	
This line contains a formula to display the sum of lines 6a - 6f.	\$5,492,099
a) Total Family Preservation Services	\$1,241,148
b) Total Family Support Services	\$1,235,403
c) Total Time-Limited Family Reunification Services	\$1,266,535
d) Total Adoption Promotion and Support Services	\$1,749,013
e) Total Other Service Related Activities (e.g. planning)	\$0
f) Total administrative costs (FOR STATES ONLY: not to exceed 10% of title IV-B subpart 2 estimated allotment)	\$0
<b>7. Total estimated Monthly Caseworker Visit (MCV) funds (FOR STATES ONLY)</b>	\$345,949
a) Total administrative costs (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)	\$34,594
<b>8. Re-allotment of title IV-B subparts 1 &amp; 2 funds for States and Indian Tribal Organizations:</b>	
a) Indicate the amount of the State's/Tribe's allotment that will not be required to carry out the following programs: CWS \$0 PSSF \$0 MCV (States only) 0	
b) If additional funds become available to States and ITOs, specify the amount of additional funds the States or Tribes requesting: CWS \$537,198 PSSF \$549,209 MCV (States only) \$34,594	
<b>9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (FOR STATES ONLY)</b>	
Estimated amount plus additional allocation, as available.	\$657,136
<b>10. Estimated Chafee Foster Care Independence Program (CFCIP) funds</b>	\$2,297,848
a) Indicate the amount of State's or Tribe's allotment to be spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment).	\$410,227
<b>11. Estimated Education and Training Voucher (ETV) funds</b>	\$732,632
<b>12. Re-allotment of CFCIP and ETV Program funds:</b>	
a) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out the CFCIP Program.	\$0
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out the ETV Program.	\$0
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for the CFCIP Program.	\$229,784
d) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for the ETV Program.	\$73,263
<b>13. Certification by State Agency and/or Indian Tribal Organization:</b>	
The State agency or Indian Tribal Organization submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA State Grant, CFCIP and ETV programs, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.	
<i>Signature of State/Tribal Agency Official</i>	<i>Signature of Central Office Official</i>
<b>Title</b> Chief Financial Officer, Department of Children and Families	<b>Title</b>
<b>Date</b>	<b>Date</b>

**CFS-101 Part II: Annual Estimated Expenditure Summary of Child and Family Services**  
**State or Indian Tribal Organization (ITO):** New Jersey **For FY 2018: OCTOBER 1, 2017 TO SEPTEMBER 30, 201**

SERVICES/ACTIVITIES	(A) IV-B Subpart I- CWS	(B) IV-B Subpart II- PSSF	(C) IV-B Subpart II- MCV *	(D) CAPTA*	(E) CFCIP	(F) ETV	(G) TITLE IV-E	(H) STATE, LOCAL & DONATED FUNDS	(I) Number Individuals To Be Served	(J) Number Families To Be Served	(K) Population To Be Served	(L) Geog. Area To Be Served
1.) PROTECTIVE SERVICES	\$ 2,328,893			\$ -			\$ -	\$ 84,633,000	6699	N A	Children in out of home care	Statewide
2.) CRISIS INTERVENTION (FAMILY PRESERVATION)	\$ -	\$ 1,241,148		\$ -			\$ -	\$ 1,746,072	410	366	Eligible Children & Families	Statewide
3.) PREVENTION & SUPPORT SERVICES (FAMILY SUPPORT)	\$ 2,328,894	\$ 1,235,403		\$ 657,136			\$ -	#####	158916	N A	Children & Families	Statewide
4.) TIME-LIMITED FAMILY REUNIFICATION SERVICES	\$ -	\$ 1,266,535		\$ -			\$ -	\$ 1,784,702	230	86	Eligible Children & Families	Statewide
5.) ADOPTION PROMOTION AND SUPPORT SERVICES	\$ -	\$ 1,749,013					\$ -	\$ 2,456,863	1665	308	Eligible Children & Families	Statewide
6.) OTHER SERVICE RELATED ACTIVITIES (e.g. planning)	\$ -	\$ -					\$ -	\$ -	N A	N A	N A	N A
7.) FOSTER CARE MAINTENANCE:												
(a) FOSTER FAMILY & RELATIVE FOSTER CARE	\$ -						\$ 20,902,345	\$ 41,615,000	5961	N A	All Children in Foster Care	Statewide
(b) GROUP/INST CARE	\$ -						\$ 5,501,102	\$ 11,410,898	178	N A	All Eligible Children Adopted	Statewide
8.) ADOPTION SUBSIDY PYMIS.	\$ 177,000						\$ 52,252,000	\$ 90,027,000	14001	N A	Children	Statewide
9.) GUARDIANSHIP ASSISTANCE PAYMENTS	\$ -						\$ 1,500,000	\$ 20,406,000	1905	N A	All Eligible Children	Statewide
10.) INDEPENDENT LIVING SERVICES	\$ -	\$ -			\$ 2,297,848		\$ 221,257	\$ 7,833,895	1577	N A	Eligible Children under age 21	Statewide
11.) EDUCATION AND TRAINING VOUCHERS	\$ -				\$ -	\$ 732,632	\$ -	\$ 887,672	207	N A	All Eligible Children	Statewide
12.) ADMINISTRATIVE COSTS	\$ 537,198	\$ -	\$ 34,594				\$ 81,529,666	#####				
13.) FOSTER PARENT RECRUITMENT & TRAINING	\$ -	\$ -		\$ -			\$ 1,640,817	\$ 2,775,323				
14.) ADOPTIVE PARENT RECRUITMENT & TRAINING	\$ -	\$ -		\$ -			\$ 1,990,617	\$ 1,977,324				
15.) CHILD CARE RELATED TO EMPLOYMENT/TRAINING	\$ -						\$ 375,296	\$ -	N A	N A	N A	Statewide
16.) STAFF & EXTERNAL PARTNERS TRAINING	\$ -	\$ -		\$ -	\$ -	\$ -	\$ 4,938,900	\$ 7,540,031				
17.) CASEWORKER RETENTION, RECRUITMENT & TRAINING	\$ -	\$ -	\$ 311,355				\$ -	\$ -				
18.) TOTAL	\$ 5,371,985	\$ 5,492,099	\$ 345,949	\$ 657,136	\$ 2,297,848	\$ 732,632	#####	#####	191749	760	0	
19.) TOTALS FROM PART I	\$ 5,371,985	\$ 5,492,099	\$ 345,949	\$ 657,136	\$ 2,297,848	\$ 732,632						<input type="checkbox"/> YES
20.) Difference (Part I - Part II)	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0						<input checked="" type="checkbox"/> NO
* These columns are for States only; Indian Tribes are not required to include information on these programs.												
** Only states or tribes operating an approved title IV-E waiver demonstration may enter information for rows 1-6 in column (g), indicating planned use of title IV-E funds for these purposes.												

**CFS-101, PART III: Annual Expenditures for Title IV-B, Subparts 1 and 2, Chafee Foster Care Independence (CFCIP) and Education And Training Voucher (ETV): Reporting For Fiscal Year 2015 Grants: October 1, 2014 through September 30, 2016**

<b>1. State or Indian Tribal Organization (ITO):</b> New Jersey		<b>2. EIN:</b> 216 000 928		<b>3. Address:</b> 50 East State Street, 2nd Floor, Trenton, NJ 08625			
<b>4. Submission Type:</b> <input checked="" type="checkbox"/> NEW <input type="checkbox"/> REVISION							
<i>Description of Funds</i>	<i>Estimated Expenditures for FY 15 Grants</i>	<i>Actual Expenditures for FY 15 Grants</i>	<i>Number Individuals served</i>	<i>Number Families served</i>	<i>Population served</i>	<i>Geographic area served</i>	
<b>5. Total title IV-B, subpart 1 funds</b>	\$ 5,256,844	\$ 5,245,851	1341	N A	N A	Statewide	
a) Administrative Costs (not to exceed 10% of title IV-B, subpart 1 total allotment)	\$ 525,684	\$ 524,585					
<b>6. Total title IV-B, subpart 2 funds</b> (This line contains a formula that will display the sum of lines a-f.)	\$ 5,253,870	\$ 5,253,870	7228	3433	N A	Statewide	
a) Family Preservation Services	\$ 1,241,148	\$ 1,241,148					
b) Family Support Services	\$ 1,131,619	\$ 1,131,619					
c) Time-Limited Family Reunification Services	\$ 1,266,535	\$ 1,266,535					
d) Adoption Promotion and Support Services	\$ 1,614,568	\$ 1,614,568					
e) Other Service Related Activities (e.g. planning)	\$ -	\$ -					
f) Administrative Costs (FOR STATES: not to exceed 10% of total title IV-B, subpart 2 allotment)	\$ -	\$ -					
<b>7. Total Monthly Caseworker Visit funds (STATES ONLY)</b>	\$ 330,616	\$ 152,230					
a) Administrative Costs (not to exceed 10% of MCV allotment)	\$ -	\$ -					
<b>8. Total Chafee Foster Care Independence Program (CFCIP) funds</b>	\$ 2,297,848	\$ 2,297,848					
a) Indicate the amount of allotment spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)	\$ 613,916	\$ 424,900	92	N A	N A	Statewide	
<b>9. Total Education and Training Voucher (ETV) funds</b>	\$ 735,895	\$ 735,895	222	N A	N A	Statewide	
<b>10. Certification by State Agency or Indian Tribal Organization:</b> The State agency or Indian Tribal Organization agrees that expenditures were made in accordance with the Child and Family Services Plan, which was jointly developed with, and approved by, the Children's Bureau.							
<i>Signature of State/Tribal Agency Official</i>		<i>Date</i>		<i>Signature of Central Office Official</i>		<i>Date</i>	
<i>Title Chief Financial Officer, Department of Children and Families</i>				<i>Title</i>			

<b>CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 &amp; 2 Funds, CAPTA, CFCIP, and ETV</b>	
<b>Fiscal Year 2017, October 1, 2016 through September 30, 2017</b>	
<b>1. State or Indian Tribal Organization (ITO):</b> New Jersey	<b>2. EIN:</b> 216000928
<b>3. Address:</b> 50 East State Street, 2nd Floor, Trenton NJ 08625	<b>4. Submission:</b> [ ] New [ X ] Revision
<b>5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) Funds</b>	\$5,337,180
a) Total administration (not to exceed 10% of title IV-B Subpart 1 estimated allotment)	\$533,718
<b>6. Total estimated title IV-B Subpart 2, Provides Safe and Stable Families (PSSF) Funds. This amount should equal the sum of lines a - f.</b>	\$5,683,958
a) Total Family Preservation Services	\$1,289,048
b) Total Family Support Services	\$1,283,303
c) Total Time-Limited Family Reunification Services	\$1,314,435
d) Total Adoption Promotion and Support Services	\$1,797,172
e) Total for Other Service Related Activities (e.g. planning)	\$0
f) Total administration (FOR STATES ONLY: not to exceed 10% of title IV-Bsubpart 2 estimated allotment)	\$0
<b>7. Total estimated Monthly Caseworker Visit (MCV) Funds (FOR STATES ONLY)</b>	\$357,967
a) Total administration (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)	\$35,796
<b>8. Re-allotment of title IV-B subparts 1 &amp; 2 funds for States and Indian Tribal Organizations:</b>	
a) Indicate the amount of the State's/Tribe's allotment that will not be required to carry out the following programs: CWS \$0, PSSF \$0, and/or MCV(States only) \$0.	
b) If additional funds become available to States and ITOs, specify the amount of additional funds the States or Tribes requesting: CWS \$533,718, PSSF \$568,395, and/or MCV(States only) 0.	
<b>9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (no State match required):</b> Estimated Amount plus additional allocation, as available. (FOR STATES ONLY)	\$653,919
<b>10. Estimated Chafee Foster Care Independence Program (CFCIP) funds</b>	\$2,297,848
a) Indicate the amount of State's or Tribe's allotment to be spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)	\$438,116
<b>11. Estimated Education and Training Voucher (ETV) funds</b>	\$684,463
<b>12. Re-allotment of CFCIP and ETV Program Funds:</b>	
a) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out CFCIP Program	\$0
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out ETV Program	\$0
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for CFCIP Program	\$229,785
d) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for ETV Program	\$68,446
<b>13. Certification by State Agency and/or Indian Tribal Organization.</b>	
The State agency or Indian Tribe submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA State Grant, CFCIP and ETV programs, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.	
<b>Signature and Title of State/Tribal Agency Official</b> Chief Financial Officer, Department of Children and Families	<b>Signature and Title of Central Office Official</b>

**CFS-101 ADDENDUM**

**Title IV-B Subpart 1 – Payment Limitations**

The amount of FY2005 Title IV-B, subpart 1, funds New Jersey expended for child care, foster care maintenance, and adoption assistance payments totaled \$724,011.

The amount of non-federal funds expended by New Jersey for foster care maintenance payments and used as part of the Title IV-B, subpart 1 state match for FY2005 was \$0.

**Title IV-B Subpart 2 – Non-supplantation Requirement**

The 1992 base year amount of state expenditures for the purposes of Title IV-B, subpart 2 totaled \$31,021,000.

The FY2015 amount of state expenditures for the purposes of Title IV-B, subpart 2 totaled \$83,888,000.

Attachment E

Annual Reporting of Education and Training Vouchers Awarded

Name of State: New Jersey

	Total ETVs Awarded	Number of New ETVs
<u>Final Number: 2015-2016 School Year</u> (July 1, 2015 to June 30, 2016)	222	100
<b>2016-2017 School Year*</b> (July 1, 2016 to June 30, 2017)	207	102

Comments:

\*in some cases this might be an estimated number since the APSR is due on June 30, the last day of the school year.