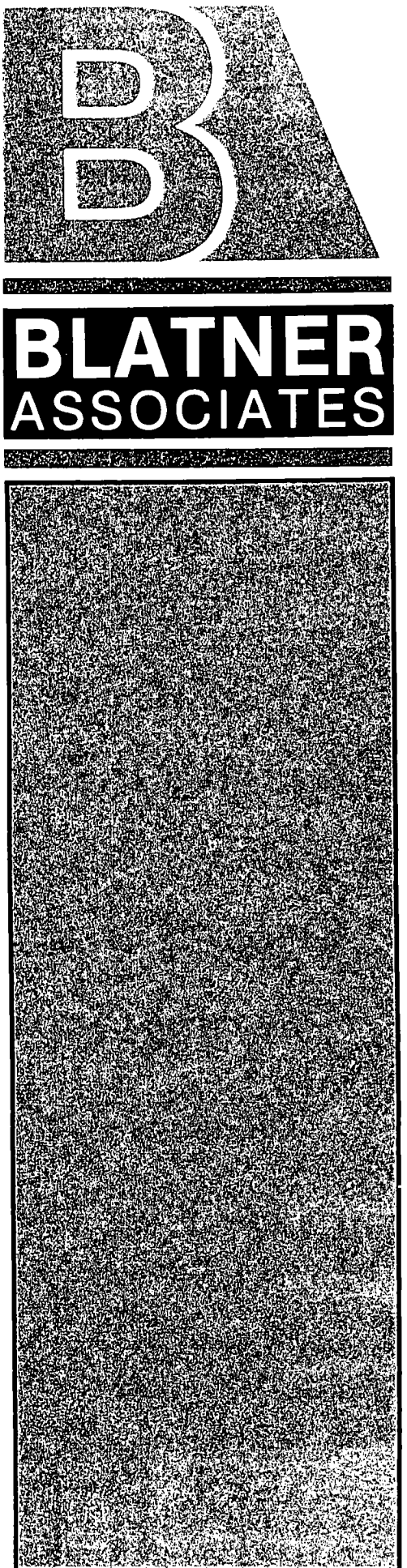


Draft Proposed Model

NJ. is considering. This is the "model" we adapt for discussions with other states including WI, NY, PA and SC.

Background

Background

My Presentation

- today on CWA Mgd. Care for a particular region.

THE FAMILY SUPERVISION NETWORK OF NEW JERSEY- AN OVERVIEW

- A ***Managed Service System*** for at-risk families that forges an ongoing partnership between families and their service managers as they matriculate through integrated provider networks.
- A system of care that stresses ***Prevention and Early Intervention.***
- A system that is ***Child/Family/Consumer Centered.***
- A system designed to ***Meet the Needs and Preferences*** and ***Draw Upon the Strengths and Opportunities of*** the ***Neighborhoods and Communities*** that it exists to serve.
- ***Management*** of the system ***by a Core Entity that Partners with Consumers, Government Agencies, Providers, Advocates, Educators, and Key Community Stakeholders.***
- A system whose services are contracted at a ***Negotiated Rate per Family.***
- A system that provides ***Intensive*** and ***Short - Term*** intervention with ***24 hour*** administrative ***Support*** to management and direct services.
- A model that cuts ***Across Systems.***
- A model that requires a ***Comprehensive Management Information System.***
- A system that requires a ***Comprehensive Research and Evaluation Component*** that addresses services, costs, outcomes, and impacts.
- A model that ***Aligns Policy and Program Objectives to Fiscal Incentives.***
- A model that requires a ***No Refusal Policy.***

POTENTIAL BENEFITS OF THE FAMILY SUPER-VISION NETWORK OF NEW JERSEY

- Enhancement of family self-sufficiency ***and*** child protection.
- Reduced risk of inappropriate, delayed or faulty decision-making regarding removal (or not) of children from their natural homes ***and*** maintenance of children in unnecessary out-of-home placement.
- Intensified, family-specific, "wrapped" services.
- A single entity acts as the primary care/service manager for children and families for accessibility, continuity, quality, accountability, and support throughout their "career" of public involvement.
- Accelerated family permanency for children.
- Development of neighborhood support systems and reduction in families' reliance on public social services and subsequent dependency and long term financial obligation for same.
- Comprehensive, demonstratable qualitative results of costs and effectiveness of services and impacts on families.
- Greater control and assessment of all costs associated with servicing protective services families.
- More efficient and accountable use of dollars allocated to service protective services families.
- Elimination or drastic reduction in duplication, fragmentation, gaps in services.

THE FAMILY SUPER-VISION NETWORK OF NEW JERSEY
A MODEL FOR MANAGED SERVICES

I. Introduction

For years, policy makers, program administrators, and child and family advocates have recognized that the state child welfare systems are in crisis - overwhelmed by reports of abuse and neglect, by the numbers of children needing protection and families needing services, and by the severity and complexity of families' problems. Several current factors are confronting New Jersey policy-makers who must make critical decisions regarding the future of services to children and families at-risk. Some of these factors include:

- time of tremendous change in both the definition and structure of families;
- debate over government responsibilities for social programs;
- the movement to redesign and restructure funding streams to make them more flexible and in a manner that promotes individualized services;
- the increase in the dependency on drugs and alcohol among family members/caregivers; the increase in the number of children who are poor in New Jersey; the increase in homelessness; the increase in severe mental illness within families;
- the increase in juvenile crime in New Jersey and the Whitman commitment to legislatively, administratively and programatically respond to this phenomenon;
- the Family Preservation and Support Services Plan; the debate over family preservation versus removal, the debate over DYFS versus "other agency" responsibilities, the DYFS interest in privatization;
- the Whitman interest in privatization and capitated models, etc;
- the diminishing resources within and outside of DYFS (Some District Offices are currently staffed as low as 51% of the CWLA Workload Standards);
- public cynicism towards Child Welfare organizations' sustained ability to impact family preservation and prevention of harm to children.

In the context of these influencing factors, there is general consensus both in New Jersey and across the nation that change is necessary. Further, there appears to be a growing recognition that any hope of improving the situation within child welfare depends on a fundamental reform of the nature and scope of services to children and families and the manner in which they are to be delivered.

The position of practitioners, advocates and consumers alike is that services to children and families need to be more ***preventative; more comprehensive; less fragmented; community based; and need to cut across-systems***. A model that advances a preventative, comprehensive, integrated and community based approach will ensure that:

- From the start, families have the skills and capacity to keep children safe and assure their healthy development.

- During a crisis, families have the assistance and support to resolve severe problems that might otherwise result in harm to children and placement outside the home.

- After a crisis, families have the assistance and support to achieve or restore healthy functioning.

II. Statement of Need

The "at-risk" population of children is typically defined in two ways: children whose general well - being and safety are in jeopardy or those children whose family circumstances are such that they are at risk of placement outside the home (placement can include all types of foster care, relative care, group home, residential, institutional, or shelter care).

Research has demonstrated that prompt and early intervention can successfully prevent abuse and neglect in at-risk populations, and therefore, prevent unnecessary and prolonged placement outside the family home. The recent Family Preservation Planning process in New Jersey identified the need for greater emphasis on prevention and early intervention and more intensive services earlier in the "life of a client in the system." The Association for Children in New Jersey's "Stolen Futures" report, concluded that a new service delivery system is needed that focuses on prevention and early intervention for at-risk families, rather than waiting to intervene until there is a serious risk to the child's safety and well-being.

There is a growing recognition and an imperative need to develop greater collaboration between State Departments in response to the vulnerable children and families for whom the respective Departments provide services. For example there are startling statistics that confirm the increase in the utilization and/or abuse of substances (drugs and alcohol). The use and abuse of substances impacts directly on the parents and caretakers ability to provide a safe and caring home for their children. DYFS has articulated that approximately 70% of their caseloads have drug/alcohol related issues. Currently the state offers little opportunity for meaningful substance abuse treatment for the poor.*

The need for prevention and early intervention is also essential to reducing the number of children presenting with intractable emotional problems as a result of family situations; abuse and neglect. "Stolen Futures" points out that by the time a placement is considered for children older than ten, half of them had six or more prior case openings and needed treatment for severe emotional problems.

The out-of-home placement system in New Jersey is challenged daily to meet the multiple needs of the population it serves. Issues from unnecessary placements to multiple placements; to excessive length of time in placement, coupled with limited and ever diminishing resources, as well as the inherent costs associated with placements, creates a major dilemma for child welfare officials and staff.

Perhaps, unlike any other year in recent history, 1995 represents a critical juncture in history. Congress is intent to dismantle the numerous federal programs in place which assist families in a variety of ways. There may no longer be a federal welfare program. The impending enactment of block grants could further eat away at the safety net originally created for children and families in need. Limitations of federal funding will further impact the state's current resources - fiscally and programatically that can avail themselves to family support and family preservation services.

There is an urgent need for more intense, expert and coordinated attention to families in need, at a time when resources are drying up. New Jersey, like its sister states, is therefore compelled to reexamine the structure, service delivery system and the available resources in the context of its legal mandate to ensure the safety and well being of its most vulnerable children and families. Some critical, and perhaps, painful decisions must be made.

III. Proposed Model

In response to both the dilemma and the opportunity that confronts New Jersey and the rest of the nation, a group of planners, advocates, providers, and academics, have joined together to form a partnership, a collaborative, that proposes a new approach to structuring and modeling services to high risk protective services children and families. "The Family Super-vision Network of New Jersey," is advanced for consideration. It is a comprehensive managed service model of service delivery to DYFS protective service families. The recommendation is for the establishment of this network statewide, with a lead entity in each of the four DYFS Regions. Its critical elements include:

- Governance/management by a collaborative as lead entity. This would include:
  - Consumer-dominated steering committee;
  - Family Systems approach to protective service families through training, supervision, and quality assurance;
  - A strong, integrated service management information system;
  - Collaborative policy and standard setting;
  - Strong administrative and financial management;

- Technology transfer among member sites;
- Utilization review and quality assurance/improvement functions;
- Education and training to consumers, case managers, providers, and the community;
- Research and evaluation of the effectiveness of the model, the services, and the costs;
- Consumer satisfaction, grievance and dispute resolution procedures

- Establishment of FOUR (4) CFSS'S (***Comprehensive Family Service Systems***) or managed service provider networks, one in each region of DYFS (Refer to attached graphic). The Statewide Network would serve as the policy making entity with each regional lead entity assuming direct responsibility for:
    - Intensive assessment;
    - Family service planning;
    - Family service management;
    - Family service supervision;
    - Family service tracking;
    - Family service oversight;
- The collaborative, with its partners, would establish standard service continuum requirements based on st of-the-art practice and community surveys of need and preferences.
    - full range of services available or developed in the community, that are flexible, customized, innovative service models (parent/child foster care; parent/child substance abuse treatment; parent/child "independent or transitional living"; "second chance homes for young parents"; school based support and treatment; community companions, mentors), etc.
    - full range of in and out-of-home options for children;
    - an administrative support system that provides 24 hour response at both the direct service and management level;
- Intensive short-term intervention.
    - intensive and expert front end risk and service/ resource assessment;

- formulation of a service plan;

- supervision and monitoring of the service plan;

- No refusal policy - each CFSS would have to provide assessment services and management of each and every family referred by DYFS. No family can be refused.

- Creative contracting. Rather than contracting for specific services, DYFS would contract with the collaborative on a negotiated per family rate.

- Establishment of a system that aligns policy and program objectives with financial incentives.

- Establishment of an extended Network with other State Departments - Health, Education, Criminal Justice, Consumer Affairs, Labor, etc.

- Full accountability system.

  - system to measure compliance with policy, standards, and protocol of the Collaborative;

  - system to measure outcome - length of time families must be reliant on the system; length of stay in out-of home care; types of services needed and effectiveness of same;

  - system to enhance the risk assessment and service need assessment tools;

  - system to measure costs - all related costs of servicing families;

- A Developmental Phase for Implementation - there will be a planful establishment of a provider network in each CFSS , as well as training on goals, objectives, guiding principles, and research mechanics ***PRIOR*** to start-up in any CFSS.

- Comprehensive Management Information System.

- Technology transfer.

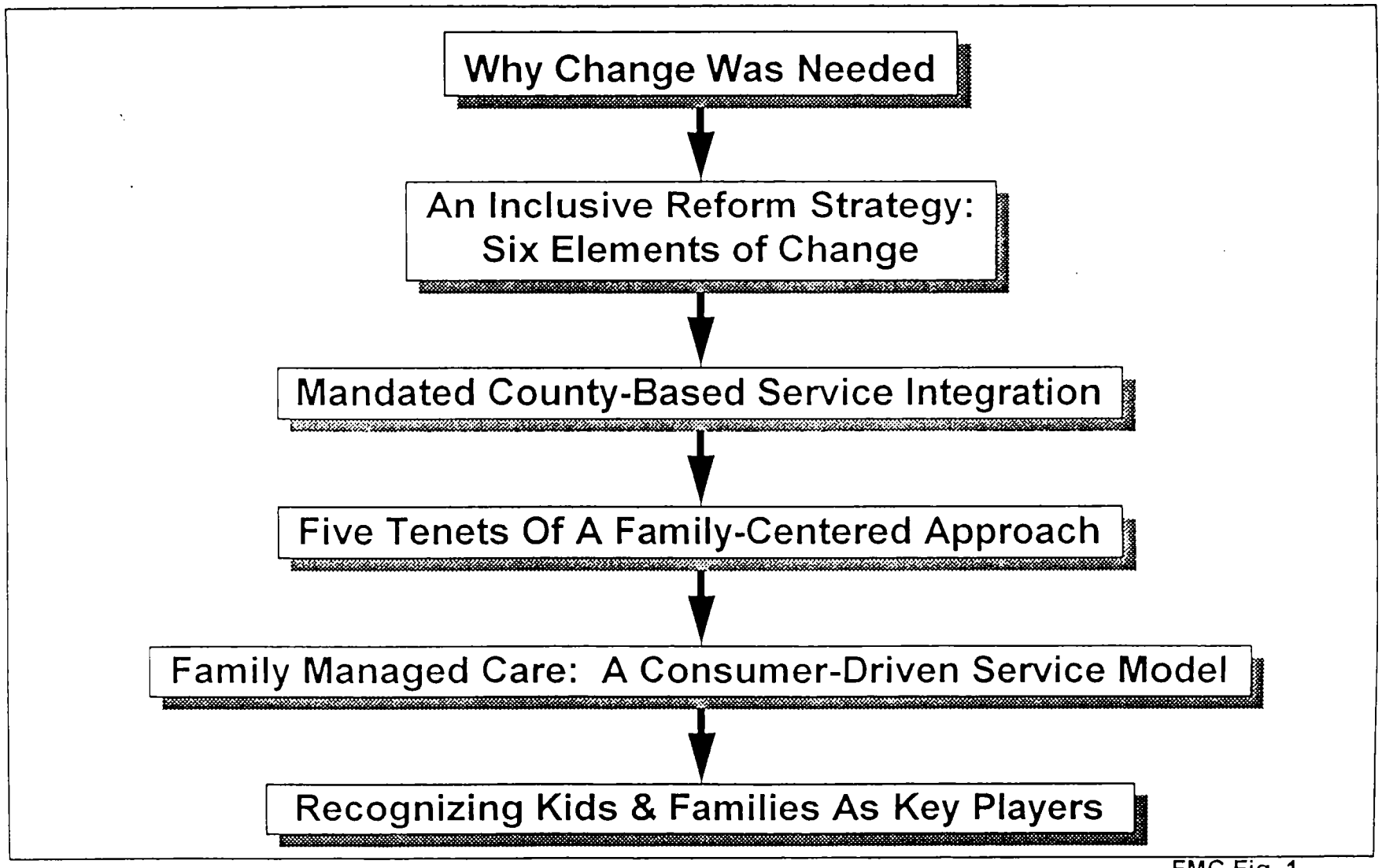
TOWARD FAMILY EMPOWERMENT

A WORKSHOP ON FAMILY MANAGED CARE IN NEW JERSEY

Presentation for the Existing Program we designed.

Developed by BAI

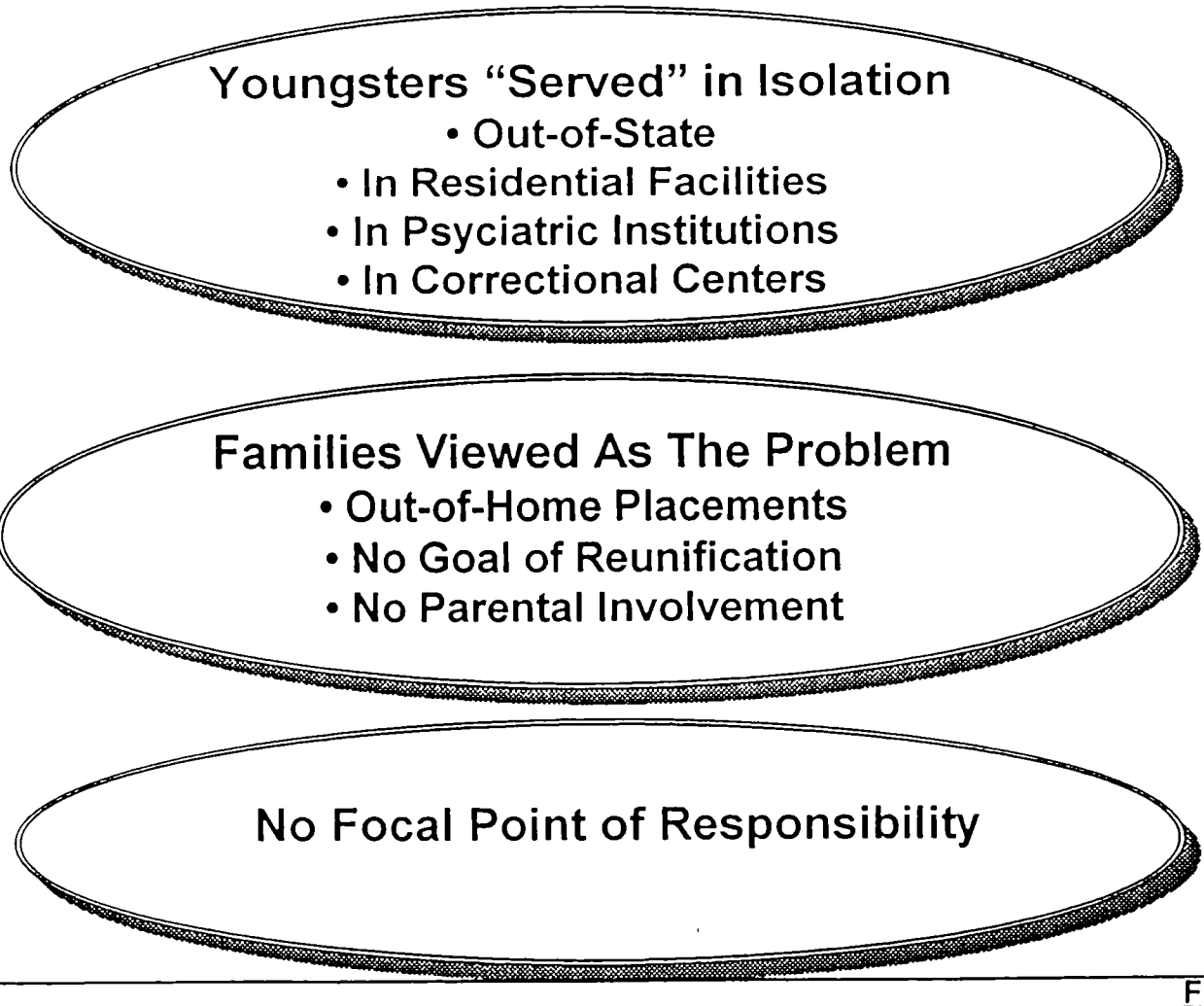
A HISTORICAL PERSPECTIVE OF SYSTEMS CHANGE IN NEW JERSEY
Overview



FMC Fig. 1

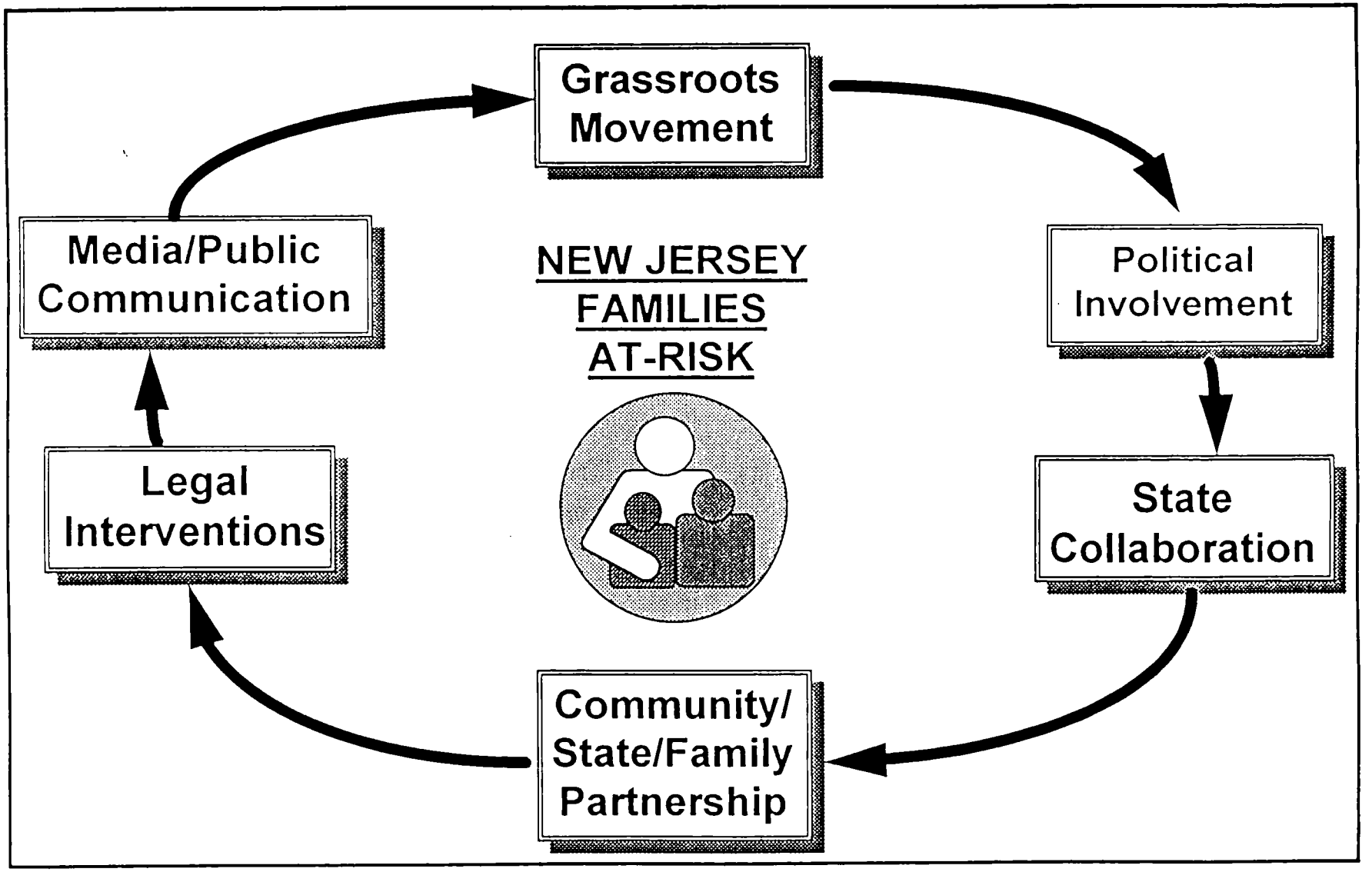
A Historical Perspective of Systems Reform in New Jersey

The Need For Change:



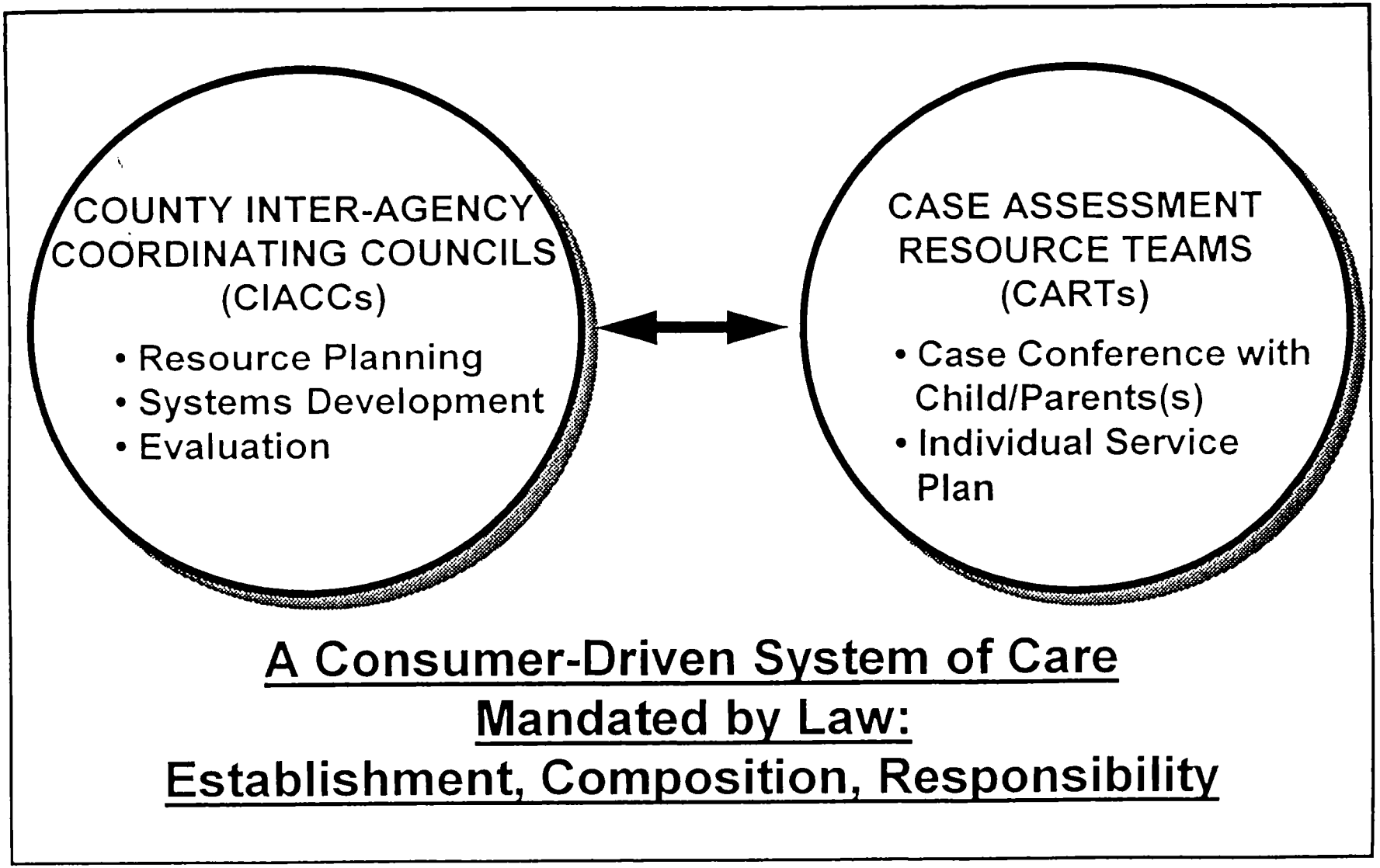
FMC Fig. 2

Six Elements of Systems Change



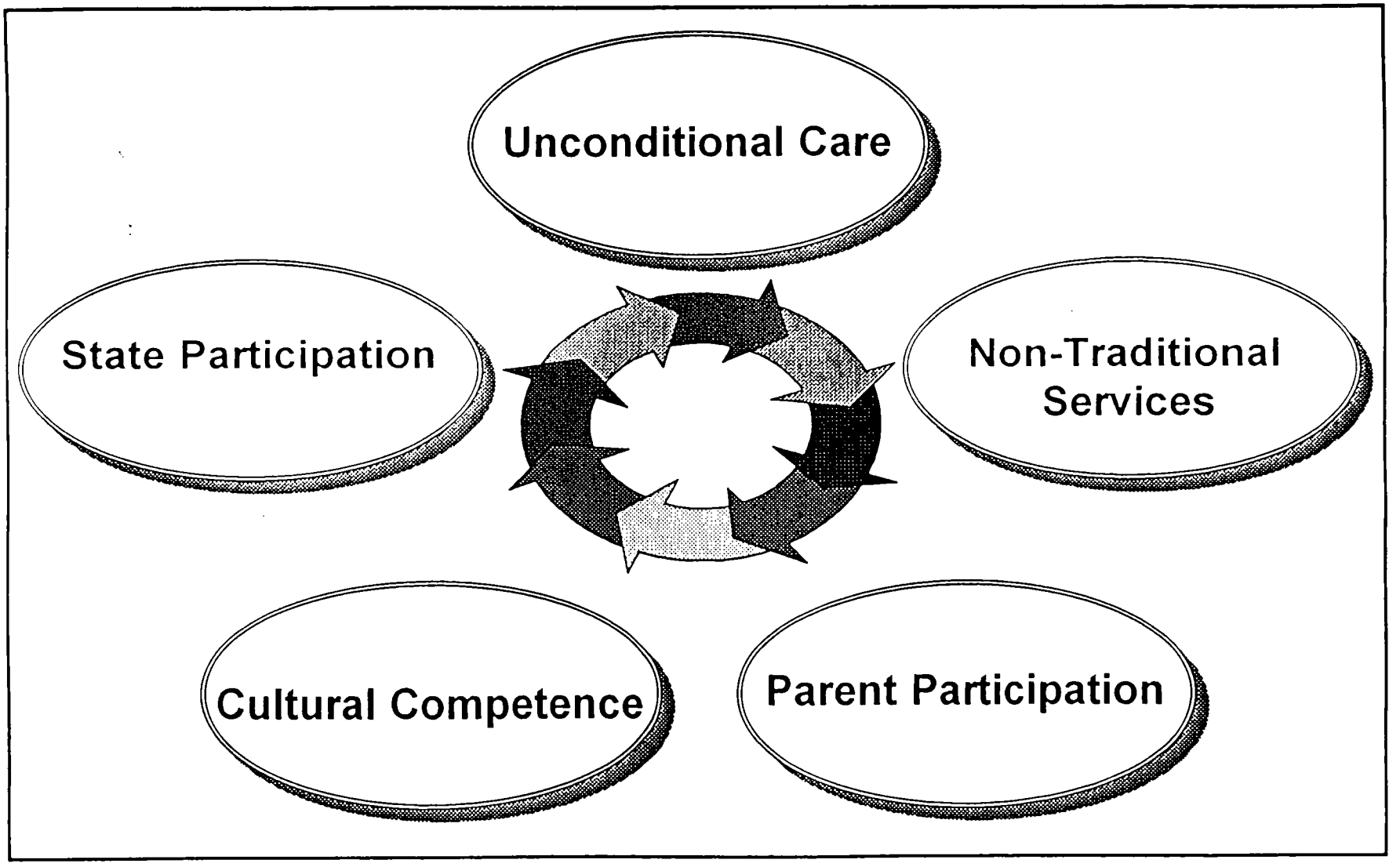
FMC Fig. 3

County-Based Service Integration Mechanisms



FMC Fig. 4

Five Tenets of a Family-Centered Approach

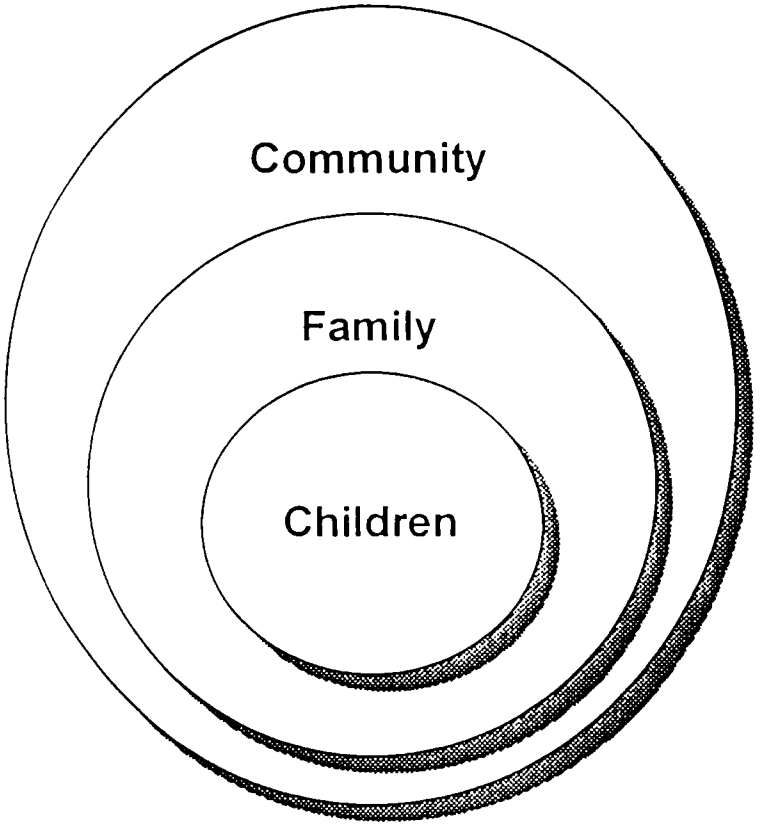


FMC Fig. 5

Family-Centered Policy

Families At-Risk

- Chaotic & Disorganized Family Life
- Unsafe & Stressful Habitation or Homelessness
- Lack of Awareness of Family Health
- Sporadic or Total Reliance on Crisis Response Health Care
- Low Quality, Culturally Biased Education with No Family Involvement
- Boredom & Social Isolation



Stable Families

- Family Life with Responsible Parenting, & Support for Growth
- Safe, Supportive, & Affordable Habitation
- Awareness of Family Health & Wellness
- Access to Affordable, Comprehensive, Health & Behavioral Health Care
- Appropriate & Culturally Relevant Education with Family Involvement
- Access to Recreational Opportunities & Personal Support Networks

FMC Fig. 6

The Challenge of Family Intervention

Families At-Risk

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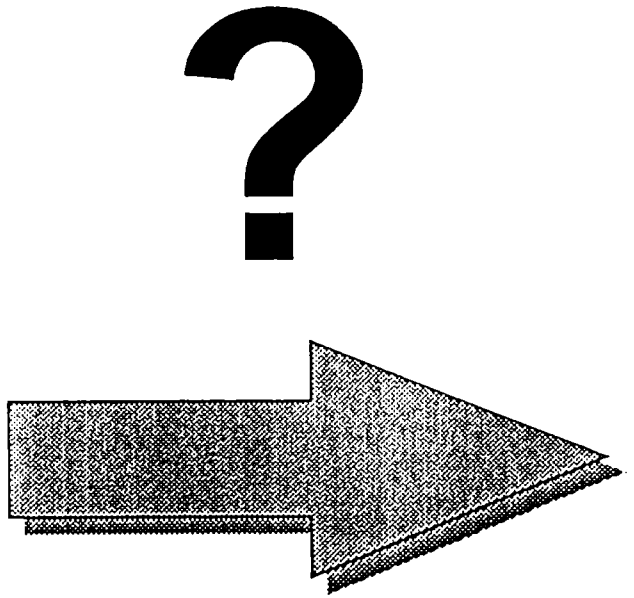

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FMC Fig. 7

Family-Centered Values

Comprehensive & Holistic

- Children in Context of Families, Families in Context of Communities
- Build on Strengths
- Address Weaknesses Expeditiously and Holistically
- Empowerment **WITH** Consumers not **FOR** Them

Children, Families & Community

- Strengthen Family as Basic Unit of Community
- Accept Complexity of Family's Economic, Social, Educational, and Health Needs
- Provide Services & Support Relevant to Family's & Community's Cultural Reality

Advocacy

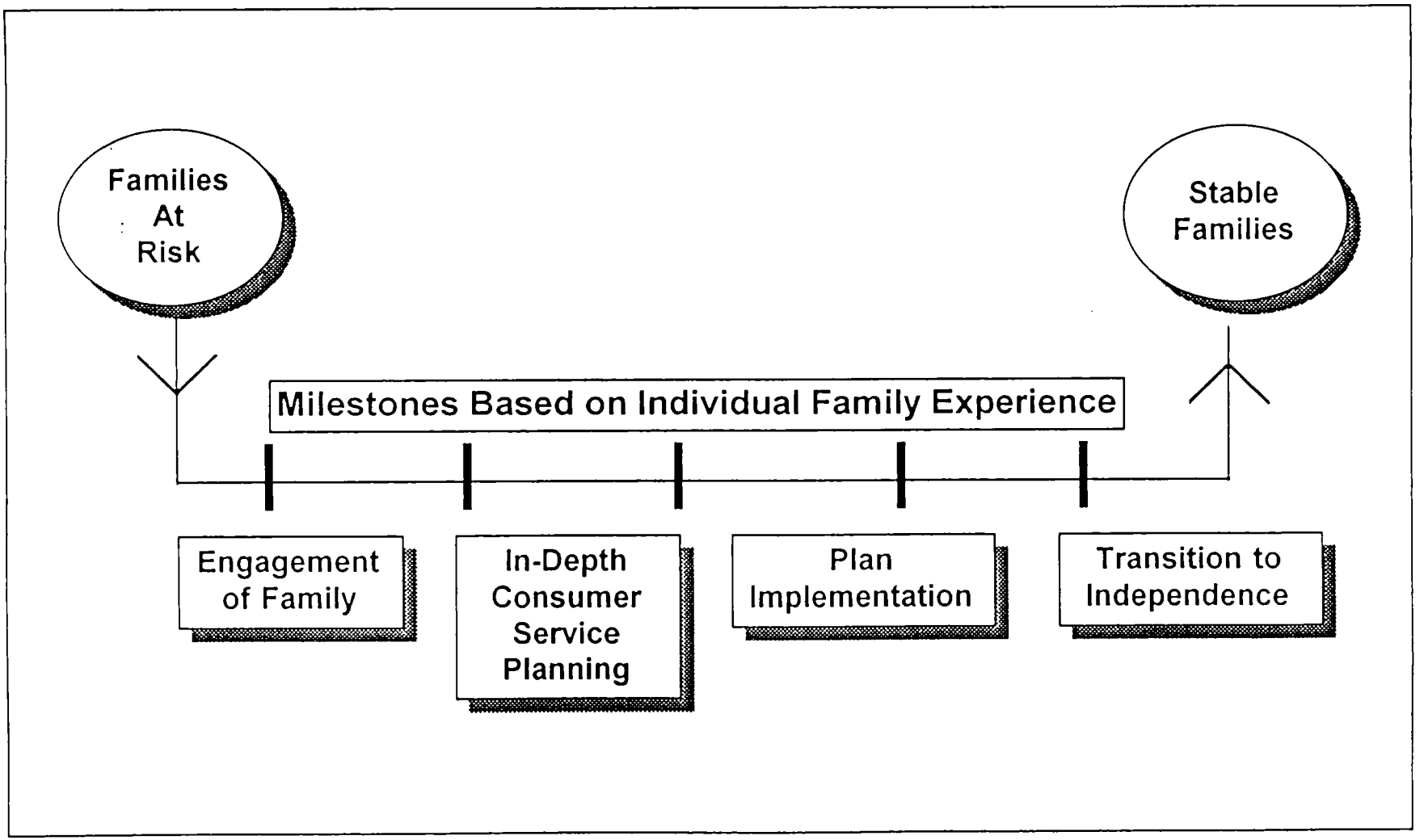
- Primary Consumer Relationship with Family Therapist
- Coordinate Services for Consumer **not** Program or Providers
- Emphasize Individualized Attention & Customized Services
- Accept Disruption & Problems as Opportunities for Growth

Partnership

- Egalitarian Relationship Between Consumers & Program
- Mutual Obligation Based on Consumer Focused Outcomes, **not** Progress Through Program
- Program Obligated to Establish Consumer Trust
- Developmental Futures Planning **not** Static Milestone Check-off

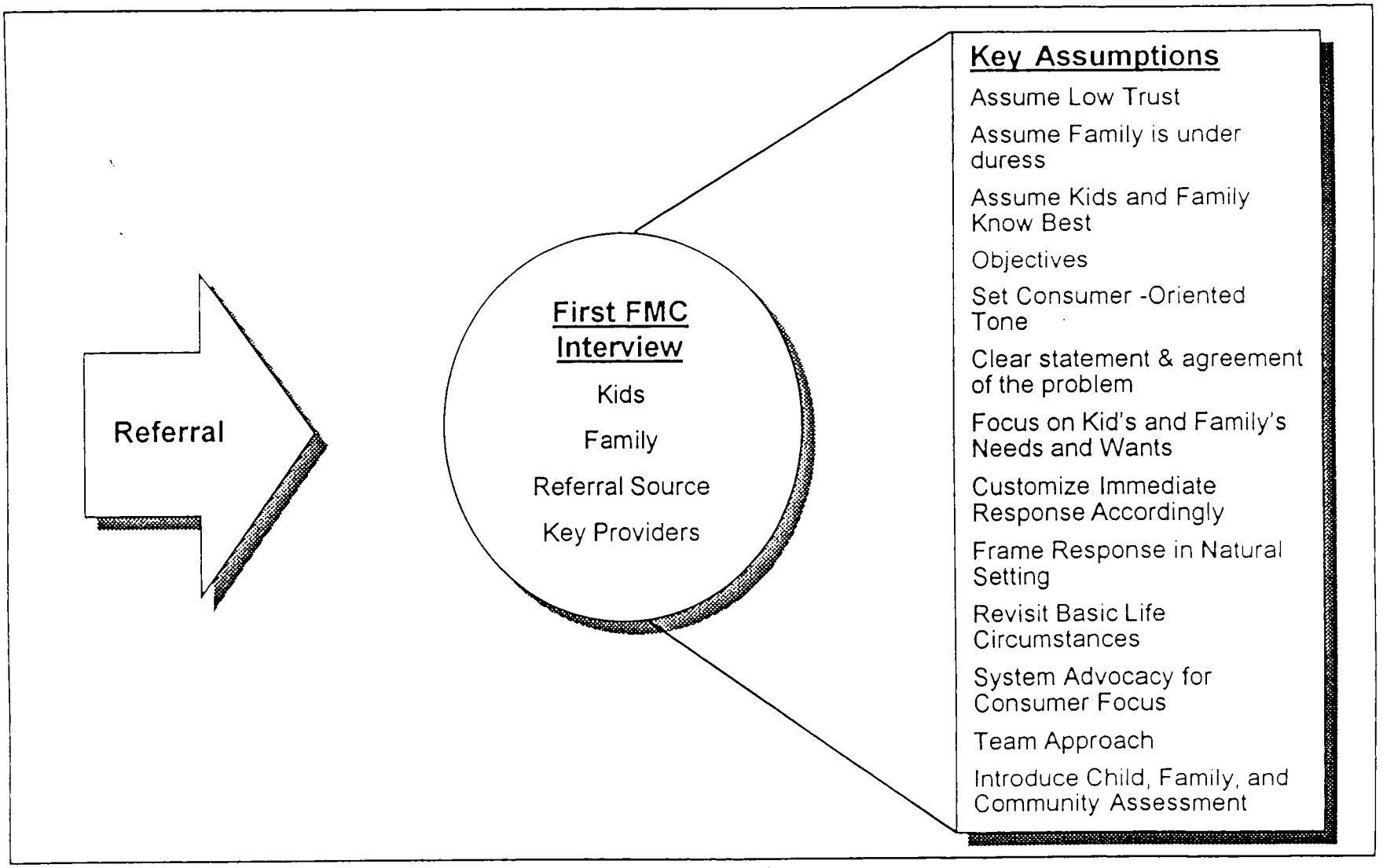
FMC Fig. 8

Family Managed Care Approach



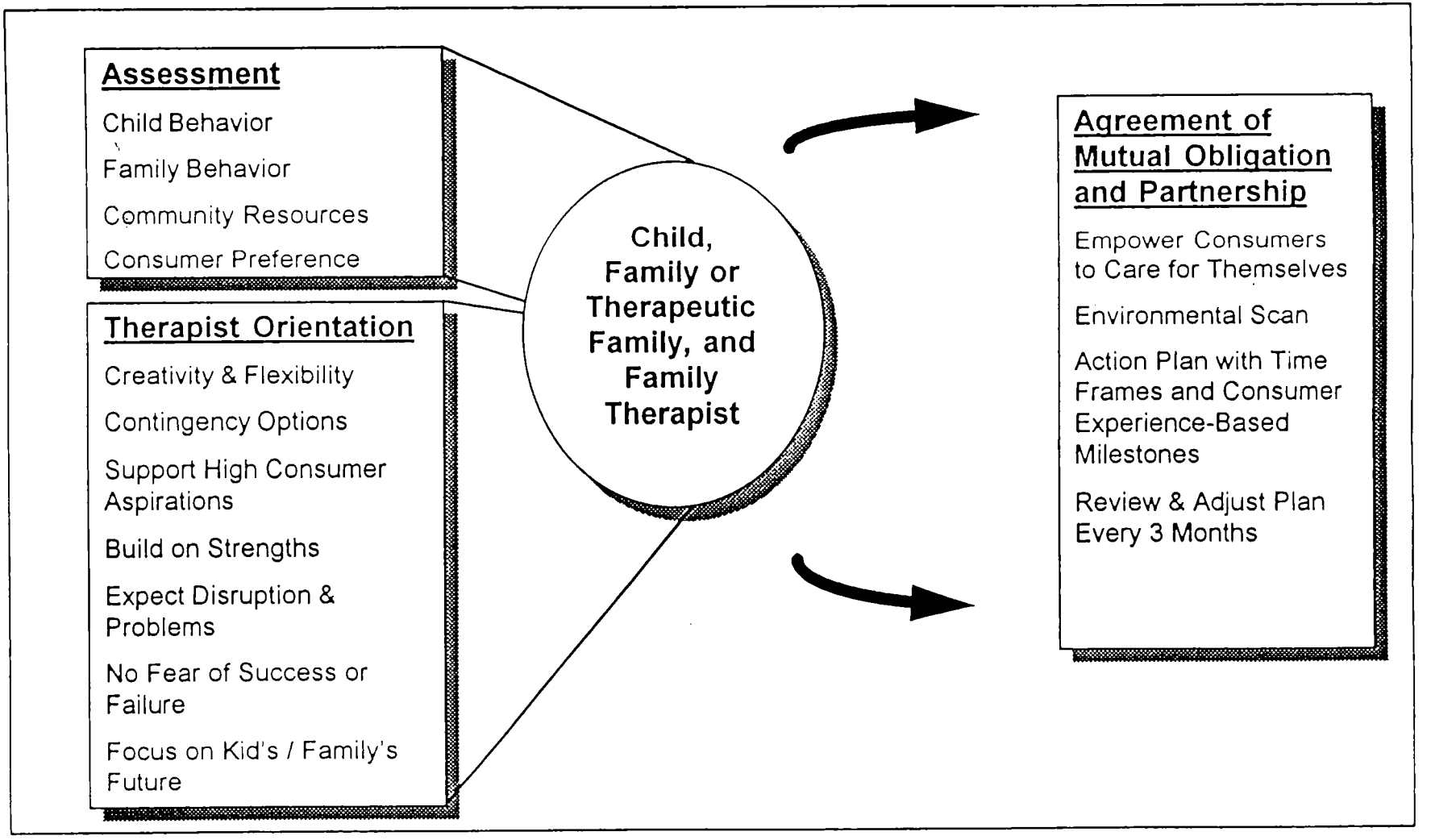
FMC Fig. 9

Family Managed Care
First Meeting



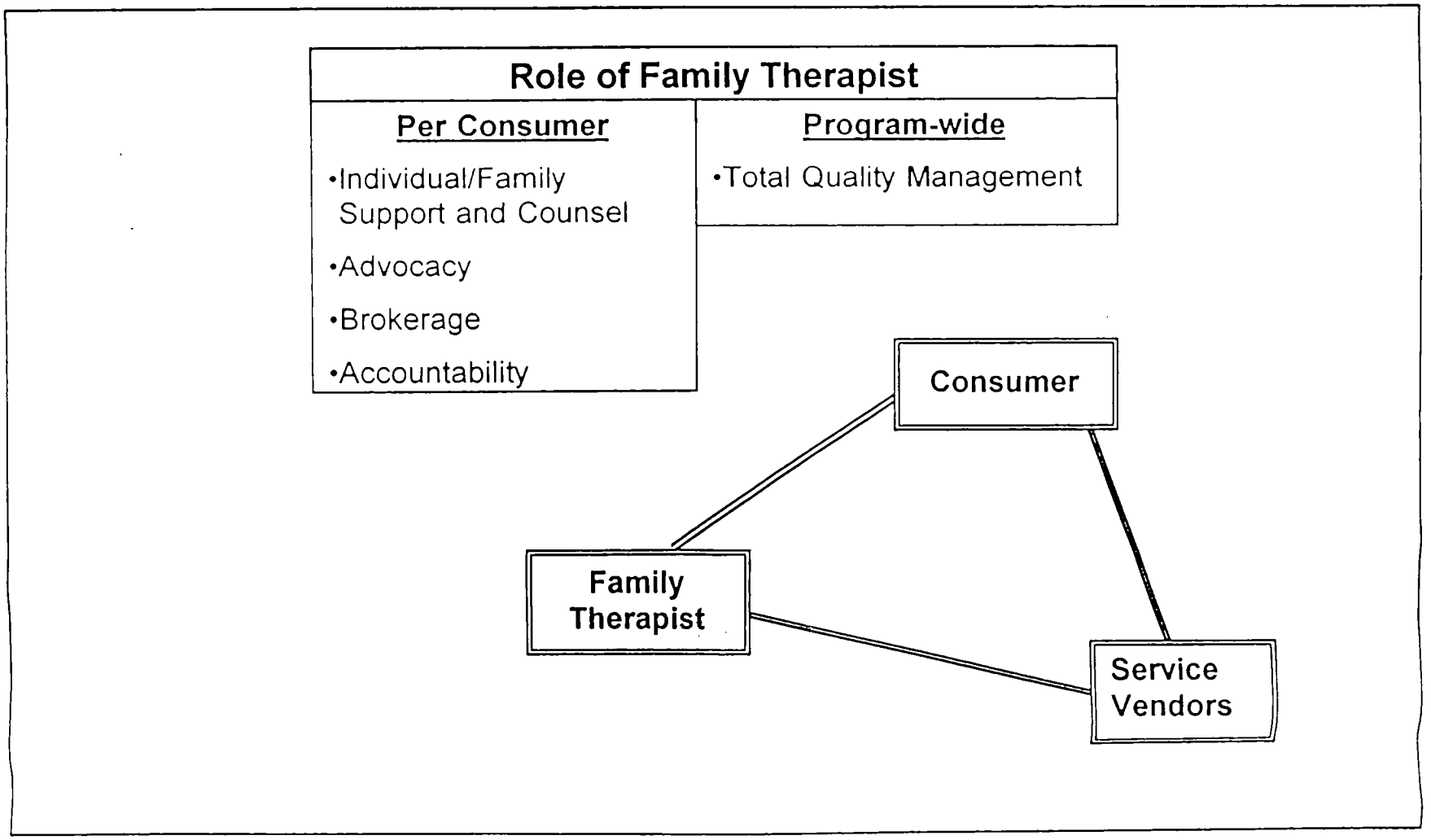
FMC Fig. 10

Family Managed Care
In-Depth Consumer Service Planning



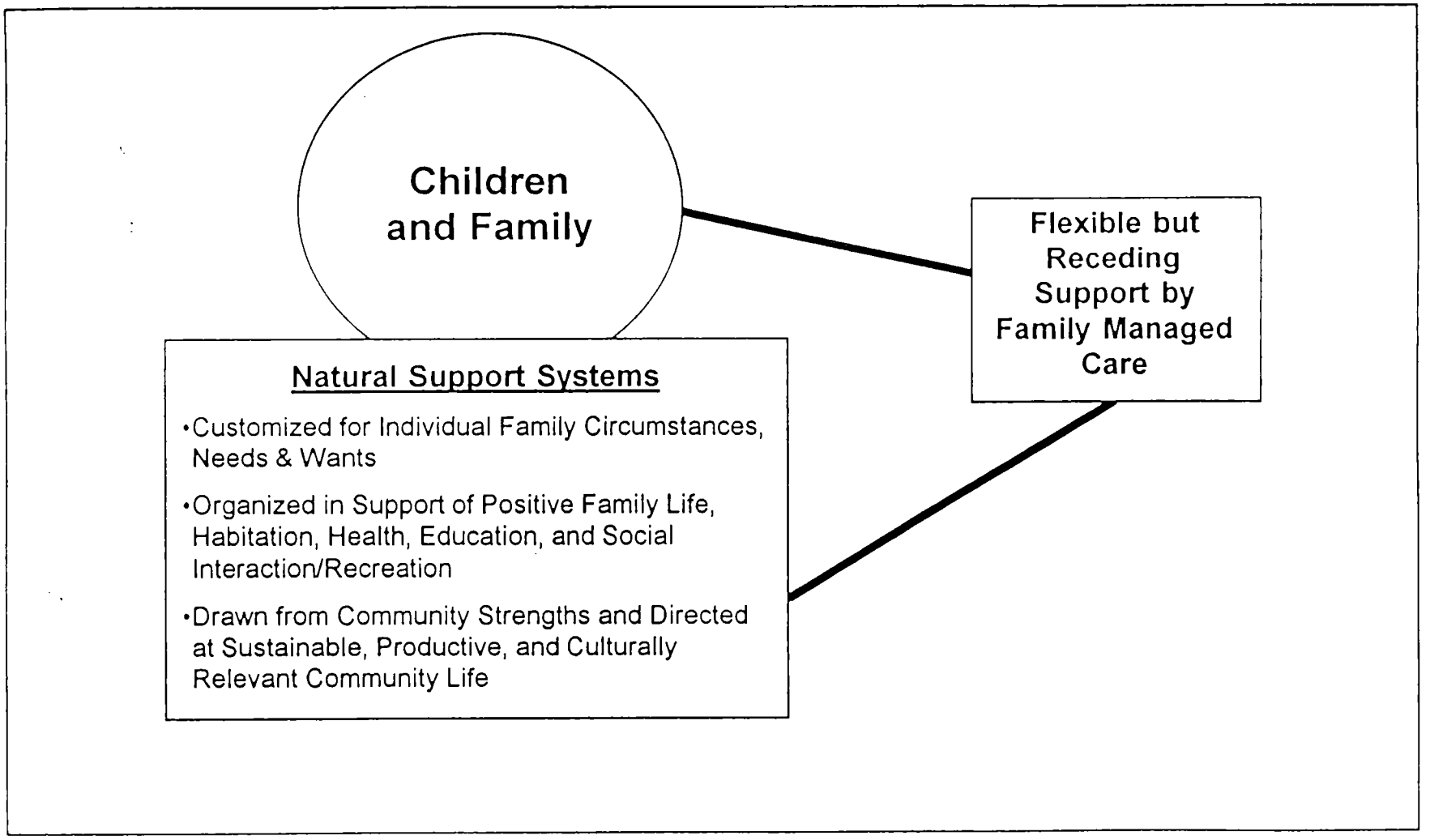
FMC Fig. 11

Family Managed Care
Consumer Service Plan Implementation



FMC Fig. 12

Family Managed Care
Transition to Independent Future



FMC Fig. 13

WHAT IS MANAGED CARE?

The Integration of the Financing

and

Delivery of Services

COMMON ELEMENTS OF MANAGED CARE

- Enrollment
- Single point of entry
- Comprehensiveness
- Standards for selection
- Reimbursement mechanisms
- QA & UR
- Financial incentives

FORMS OF MANAGED CARE

- HMO
- PPO/IPA
- PHP

MANAGED CARE
AND
BEHAVIORAL HEALTH

- Escalating costs
- Subjectivity of care
- Inclusion of services by plans (or carve-out)
- Wide variety of service coverage
- Limitation of availability

MANAGED CARE AND MEDICAID

- Federally-qualified HMOs
- State-licensed HMOs
- PHP

CURRENT MEDICAID LAW PERMITS 5 TYPES OF MANAGED CARE

- Voluntary participation
- Target case management
- State plan exceptions
- Freedom of choice waivers
- 1115(a) waivers for "research and development"

SECTION 1115(a) WAIVER

- Eligibility expansion
- Cost sharing
- Managed care enrollment

COMPARISON TO CHILD WELFARE SYSTEM

- Services are involuntary
- Different goals
- State's role
- Limitations of control

HOW COULD CHILD WELFARE BENEFIT FROM MANAGED CARE?

- Shared responsibility
- Change in financial incentives
- Improved, diagnostic skills
- Uniform utilization data
- Development of practical protocols
- Defined outcomes

CHALLENGES OF MANAGED CARE AND CHILD WELFARE

- Cost containment
- Control
- Values

STATE OVERVIEW

- Child welfare operations in at least 21 states are under court supervision

- 41 of 49 state child welfare services administrations surveyed by CWLA are considering applying or are planning on applying managed care principals to child welfare services

- As many as 10 states will be granted waivers allowing more flexibility in designing and operating their child welfare programs.

WHAT ABOUT YAP STATES?

In New Jersey --

- Mandatory Medicaid Managed Care phasing-in statewide by 1997

- Medicaid Behavioral Health Managed Care will go to a single entity to administer services statewide

- DYFS contract reform initiative

- Newly formed J.J. Commission dispensing $7 million in new $ through County Y.S. Commission

WHAT ABOUT YAP STATES? (continued)

In Ohio --

- Anticipated to be 1st state to receive new waiver approval
- Described as a "classic managed care proposal"
- Counties will have option to contract out "service management" to private companies
- Kinship care and wrap-around greatly emphasized

WHAT ABOUT YAP STATES?
(continued)

In Pennsylvania --

- Waiver Pending
- Southeast Region implementing voluntary July, 1996/mandatory January, 1997
- Partnership with mental health centers for Medicaid reimbursement
- Draft M.R. bulletin for "other than mental health services
- Alliance forming in southeast and central PA

WHAT ABOUT YAP STATES?
(continued)

In New York --

- Medicaid waiver pending but expected by end of year
- New York plans to use capitated payments for many child welfare services
- First YAP county likely to move ahead with a managed care contract
- Saving will be used to fund non clinical social work and case management

WHAT ABOUT YAP STATES?
(continued)

In Washington, DC --

- Proposed contract for August
- Proposals using rate setting and caps to develop a community-based therapeutic model of services
- Focus on returning kids from out of District placement.
- Proposal to develop community based therapeutic model
- District's financial crisis

WHAT ABOUT YAP STATES?
(continued)

In Texas -

- Waiver pending
- Focus quality outcomes
- Rehab services being redefined
- Pilots in six counties
- Recent Legislation created
  Community Youth Development Program
  - high incidences of juvenile crime
  - Reduce family and community conditions leading to juvenile crime

•Lone star Medicaid Initiative

CHALLENGES AND OPPORTUNITIES

- Change is Inevitable
- Opportunities in the Managed Care Environment
- The Risks
- Meeting the Challenge

OPPORTUNITIES

- Customized services to kids and families
- Alignment of Financial Incentives and Programmatic Goals around kids, family and community solutions
- Systems Change Inevitable. Isn't this what we wanted?
- Mavericks can move to the forefront
- Shift in core of system from out-of-home to community-based care
- Effectiveness can beat tradition
- Some $'s will be threatened, others become available

THE RISKS

- $ could drive everything (government and contractors)
- Services could fall into the wrong hands
- New players could zap YAP (or anyone else)
- Quality could be sacrificed
- Services could be rationed
- Kids could suffer

MEETING THE CHALLENGE

- Leadership in the Public Environment and making an impact on Public Policy
- Strategic/Programmatic Alliances
- Demonstrate effectiveness and efficiency through outcomes
- Importance of accessible, accurate kid and $ information
- Re-configuration of services and organizations to demonstrate value
- Understanding and plunging into market
- Strange Bedfellows
- Preparation for COMPETITION
- Elements of success and failure

FAILURE

- Fear of Failure
- Fear of Success
- Obsessive, Compulsive Behavior

SUCCESS

- Ability to relax
- Ability to Imagine
- Ability to Accept Ambiguity

BLATNER ASSOCIATES, INC.
Health and Human Service Consulting

As we near the end of the twentieth century, our world is becoming a more challenging and bewildering place. The fields of health and human services deal with some of the greatest areas of uncertainty. What can we do to ensure the well-being of our children amidst the shifting role and structure of families? How can we best deal with the prevalence of mental illness and substance abuse? AIDS? Youth alienation and juvenile crime? What effect will the shifting health care system continue to have on these issues? Is there a way to ease public dependency on the welfare system?

There is general agreement that many of the expensive programs initiated to address these issues in the last half of this century have not produced the desired results. At the same time, there is general discomfort with budget-slashing that leaves people in need without help. This paradox has compelled leaders in all sectors of our economy -- private, non-profit and public -- to grapple with bold, new ways to meet the human and economic challenges of our day.

The new century will require responses to seemingly intractable health and social issues -- responses that offer new paths to effectiveness and efficiency. At Blatner Associates, Inc. we believe these responses should be guided by ideas and actions that provide solutions for the long term, not simply band aids to soothe current conditions.

Blatner Associates, Inc. is an organization devoted to developing, supporting, managing and evaluating solution-centered projects in all areas of health and human services. We have successfully defined and implemented new approaches to a broad spectrum of social problems including:

- Welfare reform and employment initiatives
- Medicaid managed care
- Behavioral health services and systems
- Services for people infected and affected by HIV/AIDS
- Children, Youth and Family services
- Early intervention services for special needs children
- Aging

Blatner Associates, Inc. 83 Princeton Avenue Suite 2C Hopewell, NJ 08525
Phone (609)466-0200 Fax (609)466-1010

Our primary services include:

- **Community Compliance, Planning and Research (CPR)**, including community research and needs assessments, planning, evaluation and monitoring.
- **Community Projects and Solutions (CPS)**, including consulting, project management and rapid implementation.
- **Training and Systems Change (TSC)**, including project specific skills, training and management strategies for positive change.

We Help our Clients Evaluate their Environment:

- Understand their legal mandates and responsibilities;
- Analyze how much funding is being spent on what, why and with what results;
- Analyze organizational and management practices for duplication and inefficiencies;
- Analyze current policies and practices and their reference to future needs and trends;
- Understand consumer, citizen and taxpayer satisfaction (or lack thereof);

We Help our Clients Change their Environment:

- Chart out new directions for every aspect of their operation to achieve better results at less cost;
- Design and implement initiatives in privatization, down-sizing, re-engineering, re-configuration, and consolidation;
- Design and implement new programs that promote self-sufficiency, personal responsibility, and independence, not dependence, dependence, dependence;
- Develop performance contracting and outcome measures that promote the judgment of outcomes, not process;
- Design human resource, financial, management, and community strategies to successfully implement these activities;

If desired, we will manage these initiatives for our clients or provide them on a private basis.

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Our leadership is comprised of:

Thomas Blatner, President and CEO. Mr. Blatner, the founder of Blatner Associates, Inc., has held numerous public sector/human services positions and provided leadership in many community advocacy efforts. His government experience includes serving as the Director of the New Jersey Division of Youth and Family Services. Within the New Jersey Department of Human Services he held the positions of the Director of the Office of Policy, Planning and Advocacy, and the Deputy Director of the Division of Mental Health and Hospitals. In New York City he served as Assistant Director of the Bureau of Alcoholism Services for the Department of Mental Health and Mental Retardation Services. Mr. Blatner holds a Masters in Public Affairs from Woodrow Wilson School of Public and International Affairs, Princeton University; with a field of concentration in Deviance and Social Control Agencies.

Lori Rankin, Executive Vice President- Principal: Ms. Rankin holds a Master of Political Science degree from Eagleton Institute of Politics, Rutgers University. She began her career as a Legislative Liaison for the New Jersey Division of Medical Assistance and Health Services (Medicaid). In addition, she has held numerous public service positions including Director of Communications for the the Hudson County Executive, Deputy Press Secretary to Congressman Jim Florio, District Manager for New Jersey General Assembly Speaker Alan J. Karcher and as a Political Consultant implementing successful New Jersey campaigns. She has served on numerous non-profit Boards and currently serves on the Board of the NJ Democratic Leadership Council, a public policy organization devoted to advancing progressive policy alternatives.

Geri Botwinick, Senior VP for Community Compliance, Planning and Research (CPR): Ms. Botwinick holds a Masters Degree in Public Affairs, specializing in Urban and Domestic Policy from the Woodrow Wilson School at Princeton University and a Masters in Urban Education from Rutgers University, New Brunswick. Ms. Botwinick served as the Executive Director of the New Jersey Mental Health Association with eight County Chapters. She held the positions of Deputy Director, Acting Director and Director of Community Services within the New Jersey Division of Mental Health and Hospitals. Ms. Botwinick has served on the National Public Policy Committee of the National Mental Health Association, has reviewed Children/Adolescent State Plans for the Federal Center for Mental Health Services, and is currently a member of the New Jersey State Community Mental Health Board.

Colleen Maguire, Senior VP for Community Projects and Solutions (CPS): Ms. Maguire has 20+ years of experience in human services - both in direct

services and management and administration. She holds a Masters in Government Administration from the Fels Center of Government Studies, University of Pennsylvania and a Bachelor's degree in Psychology from St. Joseph's University in Philadelphia. Ms. Maguire recently served as Director of Operations Support for the New Jersey Department of Human Services. She served as Regional Children's Coordinator for the Division of Mental Health Services. Within the New Jersey Division of Youth and Family Services she held various positions including: Regional Administrator, Coordinator of the Essex Administrative Team, Director of the Organizational Development Unit, County Manager in Passaic County, Senior Management Assistant, Litigation Supervisor, and Social Worker. Ms. Maguire is also an adjunct Instructor of Social Policy and Organizational Development at Rutgers University Graduate School of Social Work.

BAI's Projects include:

- Provided consultation to the Central Jersey Early Intervention Collaborative for their establishment as a nonprofit including their 501CR application, program development and a comprehensive community needs assessment. In addition, BAI worked with three additional EIC's in a variety of capacities.

- As a subcontractor to MGT., Inc. on the Family Preservation Planning Project within the New Jersey Department of Human Services, BAI conducted an analysis of the departmental organization, administrative functions and resource allocation within the federal, state and county governments responsible for providing services to families and children. In addition, we conducted a similar analysis of the planning process within each level of government.

- Designed a capitated managed care mental health continuum for children/adolescents with serious emotional illness (and their families), who were previously in psychiatric institutions or out-of-state residential facilities. The dollars ($1 million total) which were previously used to institutionalize youngsters was redirected for community-based residential, mental health, and support services (CCSS approach) for many more young clients. The Family Managed Care Program is entering its third year in Essex County, N.J., and involves one lead agency responsible for case management/assessment/service planning/monitoring/evaluation, and three diverse subcontract agencies providing a wide variety of services, including an alternative educational program.

- Assisted in designing a comprehensive continuum of addiction services for Hudson County, N.J., which has enabled the County to stop its dependence upon out-of-County treatment, and enhance access and continuity of care. Services are provided by a consortium of private non-profits, and several components are specialized to serve the County's large heterogeneous Latino population, as well as pregnant women, and HIV/AIDS clients. In addition, BAI conducted a comprehensive needs assessment and prepared a successful Ryan White Supplemental Grant application.

- Assisted in a successful proposal on behalf of the City of Philadelphia's Mental Health Authority to establish creative financial mechanisms for children's mental health services (including Medicaid, EPSDT, etc.)

- Worked with Buffalo General Hospital to design the Buffalo 2020 Project, a "Community Wellness Program" for a targeted neighborhood in Buffalo.

- Developed a program development plan for a major Pennsylvania Mental Health/Developmental Disabilities nonprofit provider.

Child Welfare Background

I met w/ this group in Madison. The State is considering this approach for their takeover but not sure they want the WAFCA leading it. Instead, they're talking about a management Company. We continue to talk w/ state officials awaiting their decisions.

DRAFT: Revised 11/29/95

CHILD WELFARE SYSTEM OF WISCONSIN

A framework for a service delivery system
for children in the
Milwaukee County Child Welfare System
that is outcome-driven and neighborhood-based.

I. VISION STATEMENT

VISION STATEMENT FOR CHILD WELFARE REFORM *

As the Milwaukee County child welfare system undergoes fundamental change, we envision a system:

- That values the safety, security and well-being of all children and families.
- That is systemic in its approach and includes prevention and child welfare services integrated with juvenile justice, mental health, health care and education services.
- That has an efficient and accountable system of care management, based on modern management practices, including continuous improvement and documented outcomes.
- That assures community participation and ownership through all phases of design, development, implementation and operation.
- That recognizes the challenges of urban child welfare including the concentration of poverty, domestic and community violence, and alcohol and drug abuse.

* *Approved by the Wisconsin Association of Family and Children's Agencies*

II. OUTCOMES

Outcomes will be the primary driving force in this system. The system will accept responsibility for achieving agreed-to outcomes. The system will be designed to give maximum flexibility on how those outcomes are achieved.

A. Service success will be based on outcome measures such as:

1. ____ Reduction in confirmed reports of child abuse and neglect

2. ____ Reduction in re-abuse following investigation

3. ____ Fewer deaths due to child abuse by parent(s)

4. ____ Reduction of time in out-of-home care

5. ____ Increased adoptive placements

B. The initial outcome-based contract with the system will be for five years, with either party able to terminate the contract based on negotiated areas.

III. SERVICE COMPONENTS

All services will be provided by agencies that follow cultural competency guidelines developed by the Child Welfare League of America.

While the following service components illustrate the traditional categories of service, it is imperative that service be defined and understood as *a single body of services*. (The closest descriptive term currently in use is wraparound services.) The goal of this service delivery system is to be a seamless system from the perspective of the families and children who are served.

The services listed in the following outline are meant only as a starting point for the development of a comprehensive service continuum:

A. **Family Support Services** - including hospital-based healthy family outreach programs and neighborhood-based family resource centers.

B. **Child Protective Services** - including family assessments and child abuse and neglect investigations.

C. **Family-Based Services** - including family preservation programs and in-home services.

D. **Out-of-Home Placement** - including foster care, kinscare, group homes and child caring institutions.

E. **Permanency Planning** - including termination of parental rights, adoption, reunification and independent living services.

F. **System Leadership** - including public education, coordination with related services, and government relations responsibilities.

IV. RELATED SERVICES

A. **Behavioral Health** - While many mental health/alcohol and drug abuse services are not currently included in the child welfare system, the inter-relatedness is strong and therefore needs to be spelled out in the design as to its relationship with the system.

B. **Juvenile Corrections** - While the juvenile justice system and programs of the Department of Corrections for juveniles are not currently included in the child welfare system, the inter-relatedness is strong and therefore needs to be spelled out in the design as to its relationship with the system.

C. **Health Care** - While health care is not currently included in the child welfare system, the inter-relatedness is strong and therefore needs to be spelled out in the design as to its relationship with the system.

D. **Wisconsin Works (W-2)** - While the current planning for welfare reform and its assignment to a different department is not currently included in the child welfare system, the inter-relatedness is strong and therefore needs to be spelled out in the design as to its relationship with the system. (It is assumed that child care would be dealt with in this section.)

E. **Education** - While education is not currently included in the child welfare system, the inter-relatedness is strong and therefore needs to be spelled out in the design as to its relationship with the system.

V. PARTIES INVOLVED WITH THE CHILD WELFARE SYSTEM

A. **Neighborhood-Based Child Welfare Service Networks** - (Hereafter known as the NETWORKS). A NETWORK is a consortium of culturally competent agencies that will contract with the CARE MANAGEMENT ENTITY to organize and provide a comprehensive continuum of child welfare services in a defined geographic area of Milwaukee County. Network boundaries could be based on zip codes, school districts, and/or W-2 prime contractor caseloads.

B. **System Management** - (Hereafter known as the CARE MANAGEMENT ENTITY). This entity will contract with the State of Wisconsin Department of Health and Family Services (DHFS). Its responsibilities will include contract management, financial risk management, information systems, fiduciary responsibility, contracting with the provider network, oversight and evaluation of the provider networks, and intake and triage. The CARE MANAGEMENT ENTITY will follow cultural competency guidelines.

(The system will have system outcomes as well as service outcomes as listed under "OUTCOMES" on page 2. Example - The NETWORKS and Care Management Entity could have a system outcome of a diverse service and management provision that reflects the population being served.)

C. **State of Wisconsin Department of Health and Family Services (DHFS)** - The state has the responsibility of bringing recommendations to the legislature on a design for child welfare services. After enabling legislation, DHFS will prepare and publish a request for proposal, followed by awarding of the contract. The state will have an active, ongoing role of oversight, contract management and evaluation.

D. **Child Protective Services (CPS)** - This system stipulates that child abuse and neglect investigation will be provided by Milwaukee County. It could be a direct purchase by the Department of Health and Family Services or a purchase by the CARE MANAGEMENT ENTITY. (The latter is the preferred model.)

E. **Outside Providers** - The CARE MANAGEMENT ENTITY and NETWORKS may need to go outside the network to purchase specialized services, especially for children with unique treatment needs.

F. **Judiciary** - The court system must be a part of this system for it to succeed. The CARE MANAGEMENT ENTITY and providers (CPS, NETWORKS) will work with the court to provide orders for children as they enter the child welfare system under a CHIPS (Child in Need of Protective Services) petition to allow for continuum of service delivery.

VI. FUNCTIONS OF THE SYSTEM

A. **Intake and Triage** - This function will assign children to differing parts of the system or outside providers in accord with the child's service plan. The placement of this function within the system (CARE MANAGEMENT ENTITY or NETWORKS) is closely connected to the level of financial risk accepted by each part of the system.

B. **Case Management (CARE MANAGEMENT ENTITY/NETWORKS)** - A child will have one case manager who will determine levels of treatment. Caseload size is to be determined.

C. **Utilization and Review (CARE MANAGEMENT ENTITY/NETWORKS)** - Each child's case will have regular utilization and review by a case management supervisor.

D. **Quality Assurance** - The system will utilize total quality service as the continuous improvement system. The system will also utilize quality assurance as required by the state or accreditation standards.

E. **Accreditation** - The system will explore having the national Council on Accreditation (COA) accredit the CARE MANAGEMENT ENTITY and the NETWORKS.

VII. PRINCIPLES

It is very important to enunciate generally held operating principles that will guide the design of this system. Suggested principles include:

A. The financial risk should be as close to the child and family as possible to facilitate decision- making favorable to the client.

B. The movement of financial risk to the level closest to the child and family should be evolutionary.

C. The control of utilization should be in the hands of the child and family wherever feasible.

D. All of the NETWORKS should accept a research-based Best Practices protocol.

E. Strong central control is critical to the success of this system.

F. The child and family are best served in their immediate neighborhood by an organization that knows and understands the child's family and community culture.

G. This design proposes a fully capitated system within five years. All providers will accept capitation for services placed with the system. (Other providers and specialized services may be managed via a fee-for-service format where appropriate.)

VIII. ORGANIZATIONAL STRUCTURE

The following is one organizational model that assumes a legal joint venture for the NETWORKS. If a 501(c)(3) corporation is formed, the organization would have a Board of Directors and other components of such a corporation. *(It is critical for the providers to be in a formalized relationship rather than a loosely configured consortium.)*

A. The President/Executive Directors of participating organizations will make up the NETWORK Cabinet for the purpose of setting policy, strategic planning and agency composition.

B. The Cabinet will elect a Management Council to run the NETWORK, making administrative decisions.

C. The Director of the NETWORK will be the Chief Operating Officer (COO) of the NETWORK.

D. The NETWORK will be a legally formalized joint venture of the participating agencies.

E. Each agency will contribute to the initial capitalization for the NETWORK to become a reality. The CARE MANAGEMENT ENTITY will provide capital for ongoing operations via the contract with the state.

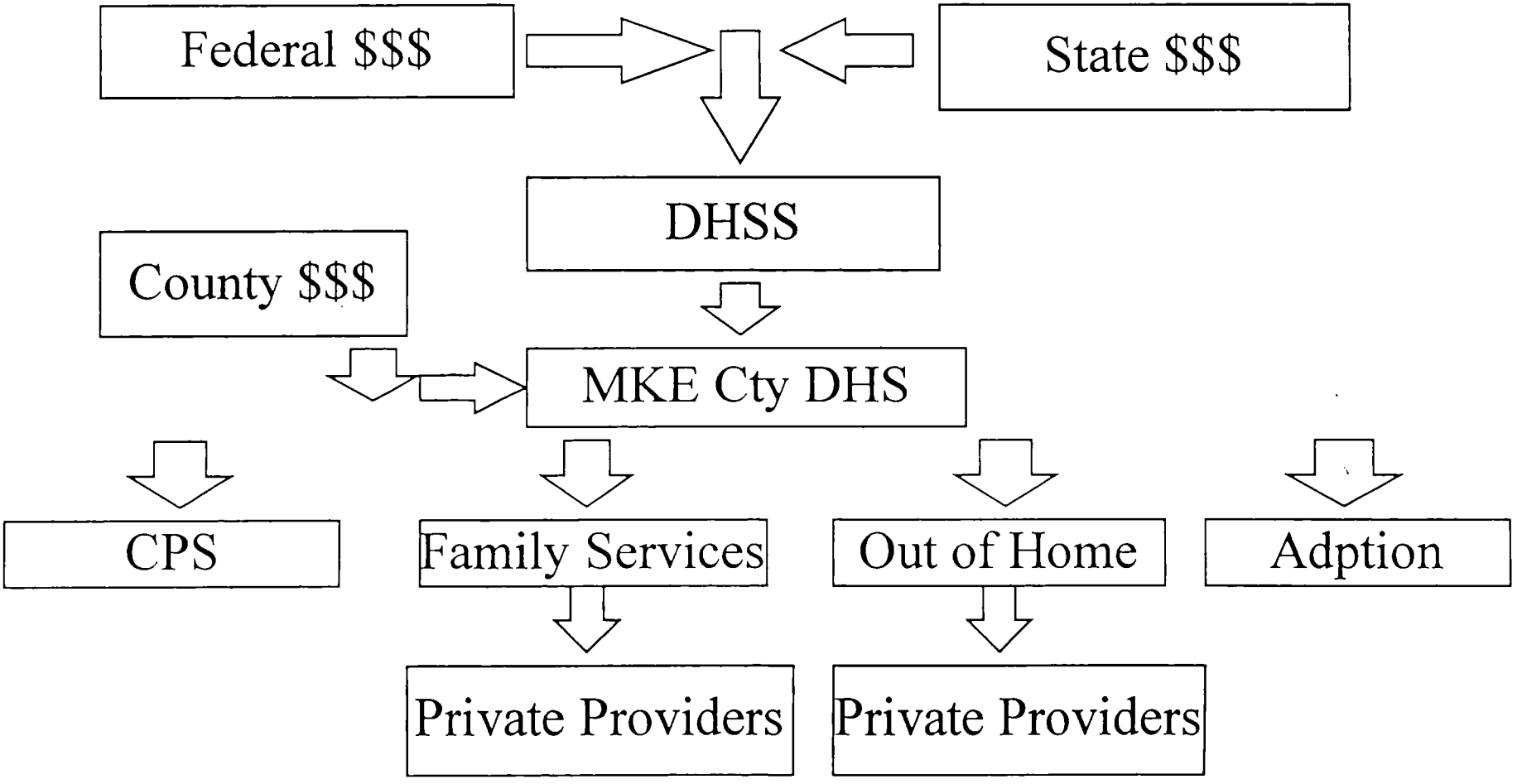
Wisconsin Association of Family and Children's Agencies (WAFCA) Task Force on Child Welfare System Reform

- James Sampson, Chair of Task Force
  Executive Director of St. Charles Youth and Family Services

- Robert Duea, Model Design
  President and CEO of Lutheran Social Services of Wisconsin and Upper Michigan

- John Grace, Staff to the Task Force and Executive Director
  Wisconsin Association of Family and Children's Agencies

CHILD WELFARE SYSTEM PRESENT



CHILD WELFARE SYSTEM PROPOSED