January System Infrastructure Workgroup Meeting Agenda

January 20th, 2025
3:00-4:30PM
ZOOM

1. **Welcome & Introductions**
2. **TCB Administrative Updates**
    a. TCB Updates
    b. Workgroup Updates
    c. Cross Agency Data Sharing Workgroup - Updates
3. **Review of Children's Initiative Concept Paper**
    a. Discussion

Children's Initiative

Concept Paper

I. *Introduction*

Background

Children's advocates have long identified a need for fundamental structural reform of New Jersey's System of Care for children with emotional and behavioral disturbances and their families. Like virtually every other state, a number of child-serving systems, each with its own mandates, perspective, and priorities, have responsibility to serve these children. Children and families enter DHS services through many different doors (child welfare, mental health, juvenile justice, education and the courts), often with similar needs for behavioral health and other community support services. The access route generally defines the problem and the services available. This, in turn, tends to define treatment goals and objectives based on the mandates and priorities of the specific child-serving system. The available services within these systems are then organized as programs, requiring children to fit the program's structure rather than structured to meet the individual needs of the child and family.

Each child serving system has had ongoing difficulties accessing services from the others, and has developed separate, overlapping systems, offering many parallel and duplicative services. Efforts to bridge these gaps between parallel systems have been only partially successful. Services from parallel systems are coordinated by County Case Assessment Resource Teams (CARTs) on an ad hoc, case-by-case basis with mixed results that are highly dependent on the ability of individual case managers and families to overcome the inherent barriers of a segmented service system. CART's generally come into the situation too late, and with too little authority and inadequate resources to support needed levels of service intensity and integration.

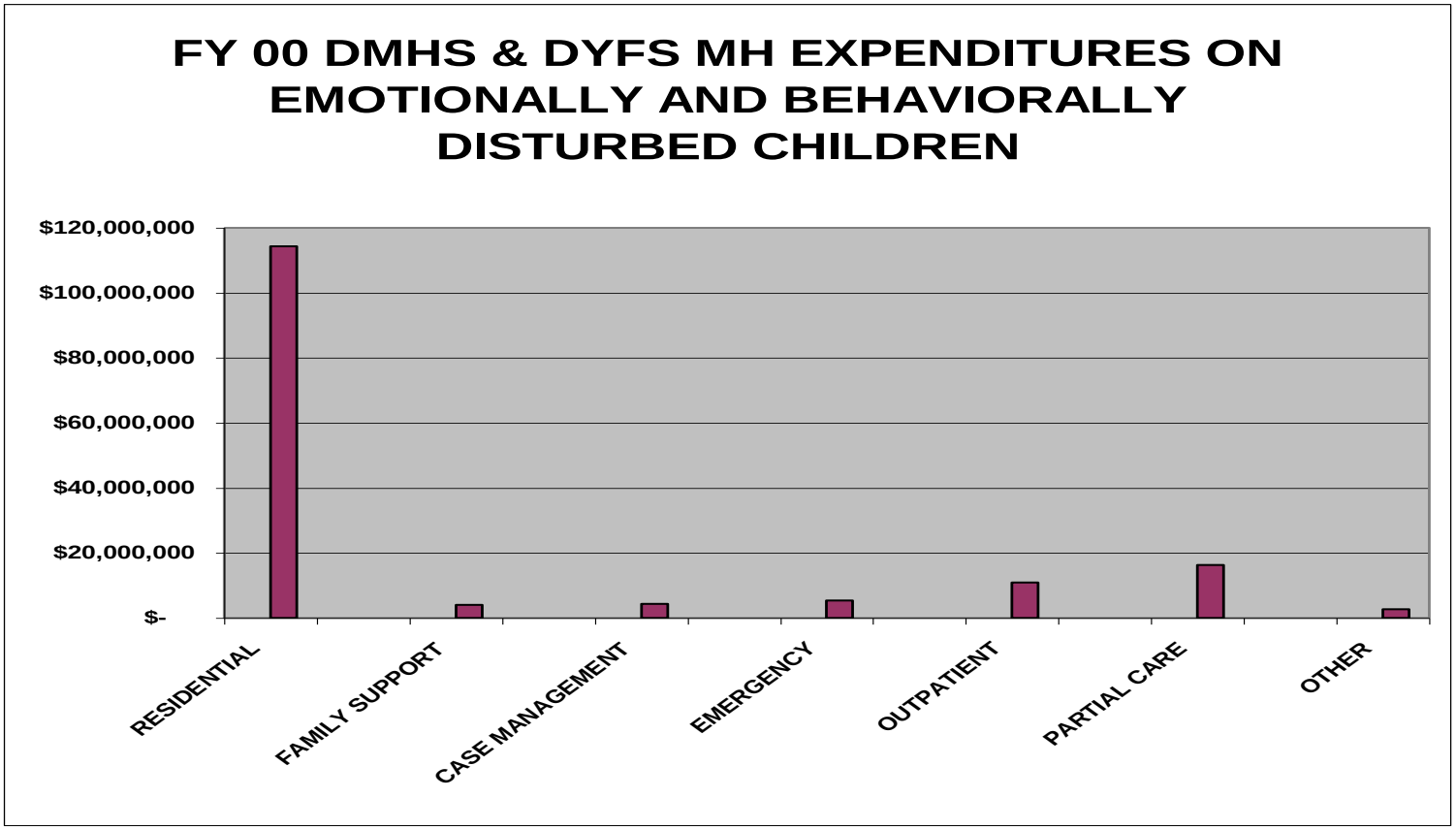
Children and families can receive uncoordinated and duplicative services from a variety of child-serving entities without effective resolution of common issues. Under the worst circumstances, the child's ties to family, school and community are severed.

These are problems related primarily to structure and financing. New Jersey has strong individual programs and providers that deliver excellent services. Many providers are nationally recognized for innovation, clinical competence and commitment to children and families. Funding, however, has not matched the level of need; most resources go to facility-based services, located outside the communities in which children and families live. This is a major reason families, too often, are unable to participate fully in the treatment their children receive. A much smaller proportion of resources go to community-based services. (See Chart One.) New Jersey has developed innovative home-based services that complement an extensive system of low intensity outpatient

services within communities. Community-based services, however, generally lack the resources to address the needs of high-risk children and families with complex needs.

All child-serving systems acknowledge the fragmentation of the current service system, the paucity of high-intensity community-based services, and the absence of meaningful collaboration between facility-based and community-based services. All child-serving systems similarly acknowledge the need for higher levels of service coordination and integration at the community level.

CHART 1



Vision and Purpose

The New Jersey Department of Human Services has concluded that fundamental structural reform is essential to support children and adolescents in achieving their highest potential, while living in a safe and permanent home and attending local schools. The Department's vision for this structural reform includes maintaining and strengthening whenever possible the ties between children, families, and communities.

The Children's Initiative will build on strengths of existing services and develop a more effective system of care, responsive to this objective.

A common screening and assessment process used across the various DHS child-serving entities will be the basis for determining service needs. Children and families need comprehensive, culturally competent services based on plans tailored to their individual needs with child-centered and strength-based goals. These services will be coordinated and integrated at the community level, and available across child-serving systems in a timely manner, regardless of the specific door through which children and families enter. Services will be accessible and organized to build on family and community strengths.

These services will be financed through flexible funding mechanisms and provided within an integrated system of care accountable to outcomes directly related to the well being of children and families. Information will be available and shared across child-serving systems.

The Department believes that better outcomes are possible for children and families and the system reform envisioned through the Children's Initiative will ensure that:

- Children have improved emotional stability
- Children are more likely to remain in their communities.
- Residential lengths of stay are reduced.
- Acute psychiatric hospital re-admissions are reduced.
- Families and caretakers provide more stable living environments for children.
- Children are likely to improve in educational performance and overall social functioning.
- Fewer crimes are committed by youth involved with services.

Budget

Governor Whitman's Fiscal Year 2001 budget will contain approximately $39 million dollars in a combination of new state and federal funds for the Children's Initiative. These new funds will be **combined with $167 million dollars** identified in the State Fiscal Year 2000 budget for services to children and youth with emotional and behavioral disturbances to develop an integrated **funding pool of $206 million dollars** for the Children's Initiative. DHS anticipates the investment of additional state and federal funds over the course of this multi-year initiative with the pool of available funds totaling approximately $280 million dollars by the end of the five- year implementation period. The Initiative will be managed at the Department level and reflect a partnership among the Divisions of Medical Assistance and Health Services, Youth and Family Services and Mental Health Services.

	CURRENT EXPENDITURES			***PROPOSED FUNDING***		***TOTAL***
	FY'2000			***FY'2001***		***FY'2001***
	(DYFS)	**(DMHS)**	**(DMAHS)**	**TOTAL**	**New Funding FY'2001**	**Pooled Funding Current and New**
State	$86.2M	$21.7M	$6.6M	$114.5M	$10M	
Federal/Title 19	$14.8M	$5.6M	$2.6M	$23.0M	$29M	
Federal/Title 4E	$16.0M			$16.0M		
Support by Other Funds		$13.5M		$13.5M		
TOTAL	**$117.0M**	**$40.8M**	**$9.2M**	**$167M**	**$39M**	**$206M**

II. New Jersey Reform Agenda

For the past year, the Department of Human Services has reviewed the status and needs of the New Jersey System of Care for Children and Families, and studied reform initiatives in other states. From this work, the Department has developed a reform agenda consistent with New Jersey's longstanding commitment to core principles and values, and the Governor's Vision for the reform of children's services. The Department will proceed incrementally over a three to five year period to transition this reform agenda into a new system, building on current system strengths to develop the capacity for system management consistent with available resources. It will also require a commitment to change on the part of all system stakeholders. The elements of the DHS reform agenda will:

- **Focus on children, adolescents and young adults with emotional and behavioral disturbances and their families. Young adults are defined as individuals ages 18-21 transitioning from the children's system.**

- **Increase revenue and expand under-funded services while controlling growth** to assure development of an organized system of innovative providers with services and settings that match population needs.

- **Increase family participation in service planning and system development through family-run organizations.**

- **Establish common screening and assessment tools and a single process for entry into the system.**

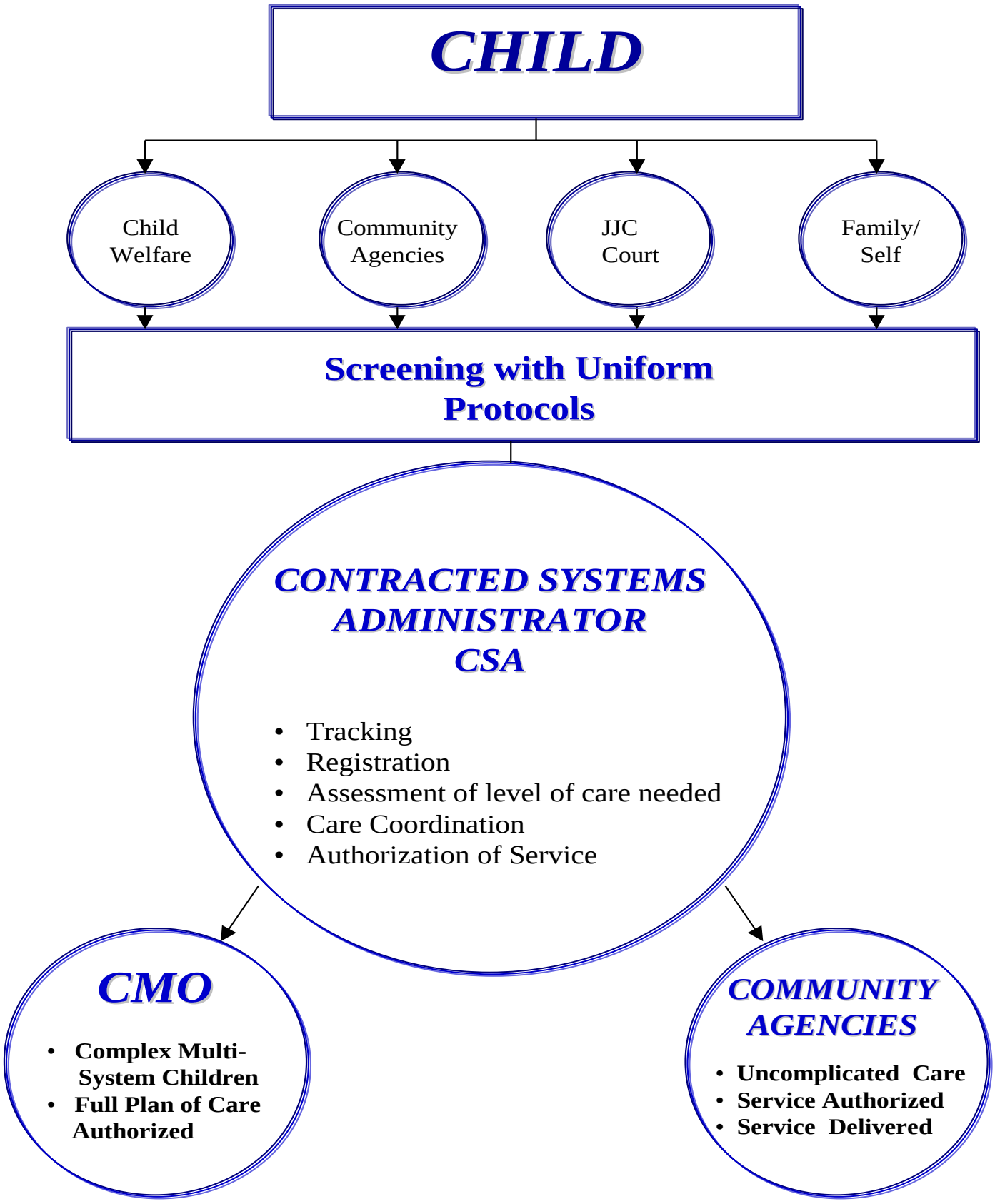
- **Install utilization management methodologies that assure rapid access to services and care coordination** to ensure comprehensive treatment planning, active family involvement, clinical innovation, and provider accountability to treatment goals and objectives through a **Contracted System Administrator (CSA)**. **There will be no incentive for the CSA to restrict care for children and youth.**

- **Develop community-based Care Management Organizations (CMOs),** a new type of entity, that will be accountable for identifying, organizing and, over time, purchasing local services and community resources for children requiring the most intensive services.

- **Establish the organizational structure for ongoing collaborative planning and system management among all child-serving systems** to assure effective integration of policy, resources, and procedures to support an organized system of care for children and families.

- **Provide training and consultation** to ensure full family participation, build provider capacity and ensure the development and delivery of quality services.

- **Re-align services and programs operated directly by the DHS** to operate as accountable participants in the new system of care while continuing to be operated by DHS. Potentially, the role and mission of these programs and facilities will change so that the service system will operate as a managed continuum. This continuum will include long-term inpatient psychiatric hospitalization and residential treatment at Arthur Brisbane Child Treatment Center, residential care at the Woodbridge Diagnostic, Ewing and Vineland Residential Treatment Centers as well as service planning and case management provided by the Divisions of Youth and Family Services and Mental Health Services.


CHILD
Child Welfare
Community Agencies
JJC Court
Family/ Self
Screening with Uniform Protocols
CONTRACTED SYSTEMS ADMINISTRATOR
CSA
• Tracking
• Registration
• Assessment of level of care needed
• Care Coordination
• Authorization of Service
CMO
• Complex Multi-System Children
• Full Plan of Care Authorized
COMMUNITY AGENCIES
• Uncomplicated Care
• Service Authorized
• Service Delivered

Target Population

The Children's System of Care will address all children with emotional and behavioral disturbances and their families across DHS child-serving systems, including children eligible for child welfare, mental health and/or Medicaid services ages 0-18 and youth 18-21 transitioning to the adult system. Child and family need will dictate the services received and the intensity of care coordination.

Many children and families have stable living arrangements, with easily identified needs. Their involvement with a child-serving system will likely be brief, and they will be quickly and directly referred to service providers. This segment of the target population will be tracked to facilitate early identification of more complex issues requiring a more intense service and greater care coordination. Tracking will also establish individual case files in a centralized database.

It will also provide focus on those children whose emotional and behavioral disturbances, while not yet as persistent as the most seriously involved children, nevertheless require increasingly complex treatment and a greater degree of care coordination.

Other children and families have serious emotional or behavioral disturbances and multiple system involvement. Many of these children are in, or at imminent risk for, placement outside their home or community. The Children's Initiative will provide comprehensive, intersystem assessment, treatment planning, and community-based care management for the most seriously involved children and youth through the Care Management Organizations.

Principles and Values

The Children's Initiative is grounded in New Jersey's long-standing commitment to core principles for organizing and delivering services for children and families that support the dignity and integrity of children, families, and the communities in which they live. These principles and values have driven the ongoing development of existing community-based approaches to service delivery, and continue to drive this reform agenda. Those core principles include:

- **Services will be child-centered and strength-based**

  The Children's Initiative is designed to break down barriers between child-serving systems. It is not a Mental Health Initiative; not a DYFS Initiative, not a Medicaid Initiative; not a Juvenile Justice Initiative. It is a Children's Initiative and addresses the whole child in all aspects of family and community life, focusing on strengths that support community living and healthy social development for children and families.

- **All services and functions will be family-focused and family-friendly**

  The Initiative will engage families as active participants at all levels of planning, organization, and service delivery to build on family strengths and assure the family perspective throughout the entire process of system planning and implementation. All services will be designed to meet family needs for accessibility and will be respectful of family rights and responsibilities.

- **Services will be community-based and culturally competent**

  Child and family needs and strengths are defined culturally. To be effective, all services must address cultural diversity at the community and family level and deliver care consistent with community strengths and values.

- **All services and functions will be outcomes accountable**.

  The Children's Initiative will not simply expand services, though more services will be provided and are certainly needed. The system of care will be accountable for organizing, coordinating, and delivering services that result in improved outcomes for children, families, and communities, in targeted DHS policy areas of:

  - Permanency of placement and living arrangements
  - Community Safety
  - Mental health

History of National System Reform

Reforming the structure and financing of children's services has been ongoing throughout the nation over the past decade. Many states have taken advantage of increased availability and flexibility in federal funding streams to expand services. States have used a variety of system reform strategies including private sector managed care technologies, operational changes within state or county government, and community-based systems of care that link clinical services with community resources and family-to-family support. Nationally, reform of Children's Services is clearly a work in progress. Evidence from other states demonstrates that expanded revenue without management of growth results in increased services but not necessarily improved access or capacity in critical areas. Without management of service development, revenue enhancement can simply expand some types of services without filling service gaps or promoting better service coordination and outcomes.

Other states have borrowed managed care strategies from the private sector managed care industry. While managed care gate keeping and utilization management methodologies can organize segmented service systems, they have often presented impenetrable obstacles for children with intense service needs.

Additionally, when these technologies are applied within the mental health system alone rather than across systems, children's long-term needs are often shifted from the mental health system to the child welfare system. Additionally, private sector managed care companies are not embedded in the local communities in which children and families live. This makes it difficult to focus on developing the natural community supports and partnerships with families necessary to support community living and placement stability. Over fifty local systems of care are operating in 35 states. Designed to serve children with intense, multi-system service needs, they have achieved the following successes:

- maintained children in their own homes and communities
- enabled families and caregivers to provide more stable living environments for children
- improved educational performance and overall social functioning
- decreased the number of crimes committed by youth involved with services
- reduced the length of stay and number of placements in residential treatment
- reduced acute psychiatric hospital admissions and readmissions

The challenge is to link these systems of care with other system reform strategies to ensure a unified approach for all children with varying degrees of emotional and behavioral disturbances.

Finally, states have tried to re-engineer state government functions to mirror managed care organizations. State governments, however, have found that outsourcing critical system management functions to outside vendors and improving planning and contract management capability within state government is more effective.

The Children's Initiative includes components to expand services and manage growth, to ensure that all care is coordinated and appropriate and to ensure that locally organized systems of care through caremanagement organizations are in place for children and families with the most intensive service needs. To support structural reform of service organization, management, and delivery, the Children's Initiative will require the following system components:

System Requirements

1. Family Support Organizations

The role of parents and other family members and substitute caregivers in individual service planning and development of the system of care will be enhanced including new roles for parents in training and evaluation processes.

Family Support Organizations will be identified to provide Family-to-Family support to all children and families receiving services. DHS will provide technical assistance in conjunction with the New Jersey Parents Caucus and the National Federation of Families for the development of Family Support Organizations. Their services will be available on a voluntary basis to all children and families who receive services. The Family Support Organizations will be particularly involved with plans developed for children and families with complex issues, needing care coordination and community-based care management.

This support may include:

- Help and information
- Guidance and support
- Advocacy to ensure service access and delivery
- Participation in treatment planning and care management.

2. A State-wide Contracted System Administrator (CSA)

Although DHS will retain all service dollars and full authority and management responsibility for all operations, a number of critical administrative functions for the Children's System of Care will be developed, installed and operated by a Contracted System Administrator (CSA) serving as an agent of DHS policy and authority. The CSA will be procured through a competitive bidding process and contracted to provide comprehensive services that support planning, implementation, management and development of the Children's System of Care, including:

- Organization and management of access/entry services and procedures, crisis management services, assessments and treatment planning.

- Tracking and monitoring service outcomes by establishing individual case files in a centralized database.

- Organization and implementation of care coordination, service authorization and utilization management services for children and families with complex needs and multiple service requirements.

- Identification and referral of children and families for community-based care management.

- Administrative support, technical assistance, and performance monitoring for local Care Management Organizations.

- Monitoring, tracking, and reporting key process and outcome indicators to ensure quality and improve performance.

- Interface with other DHS Management Information Systems.

Specifications and performance requirements for CSA functions are under development by DHS. The CSA will be procured through a competitive RFP process and contracted to provide comprehensive services through a single vendor. The procurement process will include clear specifications for CSA functions consistent with its role as an arm of the DHS Children's Initiative. The CSA will be held accountable to defined performance standards for management effectiveness based on desired outcomes for children and families. The CSA contract will not be risk bearing. The CSA will have no financial incentive to limit access to appropriate levels of care. The CSA will be required to incorporate on an on-going basis stakeholder input on the criteria used to make service authorization and level of care decisions.

Entities with a demonstrated organizational capacity to provide these administrative functions statewide are eligible.

3. An Organized Provider Continuum of Expanded Services

The Children's Initiative will work closely with providers for development of a defined set of services consistent with population needs and DHS policy objectives. The following list delineates which services from the continuum will be added to the Medicaid program as EPSDT rehabilitation services. Medicaid requirements for rehabilitation services allow services to be provided in any location and supervision by any appropriate professional. Over time, the array of services will be expanded to include, minimally:

	CURRENT MEDICAID SVS.	NEW MEDICAID SVS.
♦ Assessment (Screening, Evaluation & Diagnostic Services)		X
♦ Mobile Crisis/Emergency Services		X
♦ Out-of-Home Crisis Stabilization Services		X
♦ Acute Inpatient Hospital Services	X	
♦ Residential Treatment Center Care	X - Some	
♦ Group Home Care		X
♦ Treatment Homes/Therapeutic Foster Care		X
♦ Intensive Face-to-Face Care Management		X
♦ Outpatient Treatment	X	
♦ Partial Care	X	
♦ Intensive In-Home Services		X
♦ Behavioral Assistance		X
♦ Wraparound Services		X
♦ Family-to-Family Support		X

System reform will require adjustments by the provider community. **Providers** of services to children and youth with emotional and behavioral disturbances **will need to function as part of an integrated system.** Substantial changes in patterns of utilization and types of services are envisioned over time, including:

- Development of common screening protocols and comprehensive assessment procedures for all critical domains of child and caretaker status and functioning.

- Expansion or development of services that enhance crisis response and management capability, such as mobile crisis and new out-of-home crisis settings.

- Expanded capacity for services delivered in-home or at other off-site locations.

- Individualized plans of care that address a child and family's treatment and social support needs from acute care through transition services and community support.

- Integration of residential care with community-based services.

- Partnership with families and other substitute caregivers in service planning and system development.

Providers will need to be organized geographically to assure ongoing links between facility-based and community-based services and to ensure the availability of the full continuum of care to support community-based care management. Locally based services are important in order for children to maintain ties to their families and communities. All providers will be accountable to outcomes consistent with treatment planning and objectives as monitored by the Contracted System Administrator and/or Care Management Organizations.

Management capacity for this new system of care will be gradually enhanced including the incremental introduction of new procedures for administrative oversight, contract management and reimbursement. The Department acknowledges the essential role of providers as partners in this change process and their need to maintain clinical integrity and business viability. DHS will support provider transition into the new system. **Initially, current service providers will continue to contract directly with DHS.** Gradually, working with the provider community, the Department will realign our methods of contracting and reimbursement to support the purchase of individualized plans of care once needed data is available to make this a viable shift.

These developments will require substantial input and ongoing feedback from providers and family members, with ongoing training, consultation, and technical assistance. DHS will offer a number of venues to assure early and ongoing involvement of providers in the implementation and operation of the new Children's Initiative System of Care.

4. Community-based Care Management Organizations (CMO's)

Care management Organizations, a new type of entity, will identify, organize, deliver, and coordinate services and community resources for children with multiple service needs across child-serving systems, whose ties to family and community are at risk. CMO's are specifically designed to develop the organizational structure and care management processes needed to address these complex and multi-system issues. The CMO is responsible and accountable for the design and implementation of interdisciplinary Individual Service Plans (ISP's) that address needs and maintain the child's connection to family and community. CMO's are supported by a flexible funding process among participating child systems and will authorize all services delivered under an ISP with goals that incorporate clinical needs and permanency planning. Providers delivering services within the ISP will be directly accountable to the CMO for service utilization and quality of care.

To be a CMO, organizations will have to demonstrate commitment and capacity to organize an effective system of care at the community level that builds on strengths and effectively addresses needs. They will have to identify and develop natural social supports and community resources, as well as the professional services needed to support them.

CMO's are not traditional providers, and their business is not intake and referral to existing services within their own organization. CMO's are organized to identify and organize family and community resources and coordinate them with a wide array of interdisciplinary and intersystem services. An Individual Service Plan is more than a collection of services. It integrates services with family strengths and natural support systems to achieve common goals. The CMO will also arrange for a face-to-face care manager to work with the child and family to develop and implement the ISP. The CMO structure and business models must be designed around this capacity.

As business entities contracted with DHS, CMOs are the single point of organizational accountability for developing the system of care needed to deliver desired outcomes for children with emotional and behavioral disturbances, whose ties to home and community are threatened. Providers may reconfigure and create independent business structures as CMOs, but, as CMOs, their governance, organizational structure, and functional capability must clearly reflect the capacity needed to deliver the services and outcomes described above. In order to ensure that there is no appearance of conflict the Department may decide to propose limits on the amount of business that can be purchased or arranged by the CMO from any of its related or parent agencies.

CMO's will be contracted to organize and develop community capacity for managing and delivering services to targeted children and families. CMOs will:

- Identify, organize, and work with a network of local services and community resources that build on family and community strengths and natural supports and meet the defined clinical and social needs of children and their families as specified by DHS. Over time, the CMOs may directly purchase services and supports from providers and other community resources.

- Provide comprehensive, intersystem, strength-based assessment, treatment planning, and intensive care management for children and families that support community living, using locally organized services and resources.

- Develop individual plans of care that fully involve families, community resources, and child-serving systems in the organization and delivery of care to achieve common objectives.

- Accept DHS referrals on a “no eject/ no reject” basis.

- Have governance and management structures and processes that reflect community interests and culture.

- Implement individualized plans of care with fiscal accountability under budgets linked to projected need and utilization.

  Community-based Care Management Organizations will be procured through a competitive RFP process. The CMO Procurement process will provide core requirements for structure and function, with ample latitude for clinical innovation and flexibility to achieve desired outcomes for children and families. The DHS will require the CMO’s network of professional services include any willing and qualified provider (i.e. providers eligible to receive DHS contract funds and/or Medicaid reimbursement). The key to determining an organization’s capability as a CMO, will be how clinical services are integrated with natural community supports and a child and family’s strengths. Wraparound Milwaukee and Children Come First from Dane County Wisconsin, Kids Oneida in New York as well as Sonoma, Santa Barbara and San Mateo County in California are well-known initiatives that use this system of care management. They have successfully produced positive changes in community living status and overall functioning for children with emotional and behavioral disturbances and their families.

  A fiscally viable CMO minimally needs a population base of approximately 350,000 people or 50,000 children. At this point, the DHS anticipates phasing in up to 15 CMOs across the state.

  As locally based Care Management Organizations are introduced, the use of child family teams (CFT) will be expanded under the direction of the CMO. As the CFT process continues to grow, the CART structure will be gradually phased out. The County Interagency Coordinating Councils (CIACCs) will continue to exist and play an advisory and planning role.

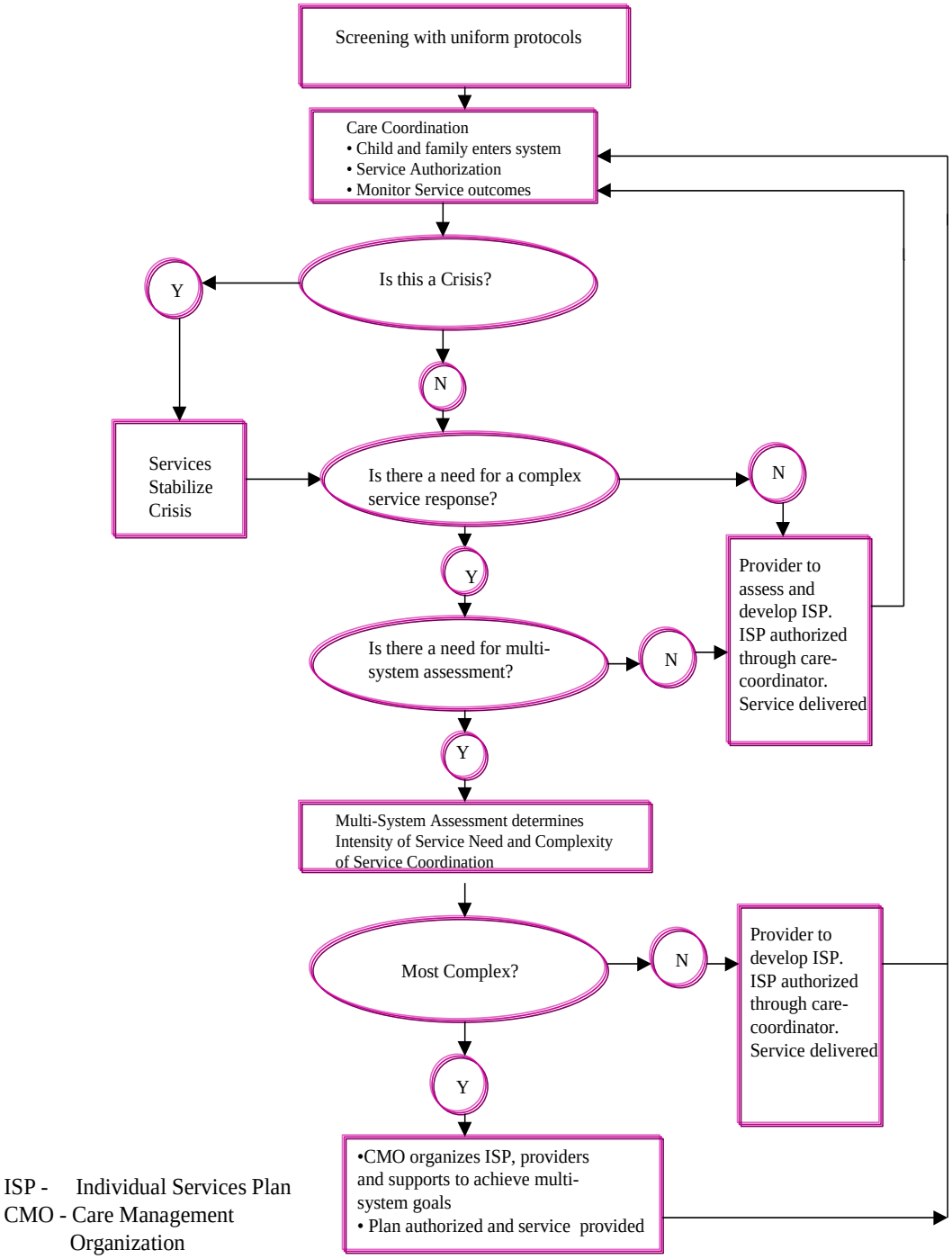
III. Child and Family Flow

By establishing the components to operate this new System of Care, the Children's Initiative should result in a more accessible, better integrated, individualized and more accountable system of care for children and families that will provide:

- **Focus on comprehensive needs of the child and family**
- **Timely, family-friendly access to services**
- **Consistent, comprehensive screening for risk and clinical need.**
- **Immediate and effective response to crises.**
- **Rapid referral to direct service for uncomplicated cases.**
- **Coordination of care for children and families with complex needs for multiple services.**
- **Comprehensive community-based care management for children and families with multiple system involvement at risk for placement outside the home or community.**
- **Management and coordination of information needed to support treatment planning and service delivery.**
- **Monitoring of critical indicators of quality to assure accountability to desired outcomes and objectives.**

Children and families will move through the system as follows:

SYSTEM OF CARE
THE CHILDREN'S INITIATIVE - CLIENT FLOW CHART



ISP - Individual Services Plan
CMO - Care Management Organization

1. Access Screening, Crisis Management, and Referral

Children and families will continue to enter the system of care through a variety of doors. They may be **referred from one of the child serving systems** (Mental Health, DYFS, JJC, the Courts, Education, or Substance Abuse). They may **directly access a provider or crisis management service**. Alternatively, they may directly seek help and referral through the telephone-based access service established by the Children's Initiative to operate on a full-time, real-time basis by the Contracted System Administrator (CSA).

Children and families will be screened by all providers at the point of access for risk and clinical need using common, consistent procedures and tools across all access points, regardless of the access route. The development of screening tools and procedures for use across child-serving systems has begun and will include input from providers and families. The purpose of access screening is to assure children and families:

- **Receive rapid response to crisis and risk as the first and foremost priority.**
- Access appropriate services as quickly as possible.
- Are assisted in planning and coordinating multiple services when needs are complex.
- Are offered family-to-family support for accessing and utilizing services.

Results of this screening will provide the basis for design and implementation of individualized treatment plans. A **Contracted System Administrator (CSA)** will gather and organize information from all access points and establish an individual file for each child and family in a centralized database. The CSA will monitor and coordinate referrals to appropriate levels of care including crisis management through facilities or mobile services.

Depending on levels of risk and complexity of need as indicated by screening at the point of access, children and families may:

- Be immediately triaged for crisis management and continued assessment.
- Remain with, or be referred to, an individual provider for delivery of indicated services.
- Be assigned a CSA care coordinator for organization of treatment planning and service delivery.
- Be assigned to a Care Management Organization for development of an individualized service plan.

The CSA will provide information to families regarding the availability of the **Family Support Organization** for ongoing family-to-family support and assistance in service access and delivery, as needed and desired by the family. The CSA will ensure that families whose children have intense, multi-system needs are referred to the Family Support Organization.

2. Assessment and Care Coordination

Children and families with relatively uncomplicated needs that can be met by a single service provider will be referred for direct service to a provider of their choice (or continue with the provider initiating the request for service authorization) within the continuum of licensed/certified, eligible providers. That provider will perform an assessment that addresses needs and strengths and results in an individualized treatment plan with clear objectives. Treatment plans consisting primarily of individual, group or family therapy will be registered with the CSA and presumptively authorized up to a specified number of units of service (current thinking is up to 20). This segment of the target population will be tracked to monitor service outcomes and to facilitate early identification of more complex issues requiring a more intense service and greater care coordination. Services beyond the specified number of units will be subject to review of a more comprehensive treatment plan by the Contracted Systems Administrator.

Children and families with more complicated needs, characterized by high levels of risk and/or clinical complexity, requiring multiple services will also be assigned **a CSA care coordinator** to work closely with the child and family to develop an integrated treatment plan. The care coordinator will:

- Identify, organize and coordinate assessments based on a common protocol as indicated by initial screening for risk and clinical needs.
- Coordinate involvement of family-to-family support in treatment planning through a family-run organization.
- Design and authorize service packages based on assessment results.
- Manage information and monitor service progress.
- Assist in problem solving as identified by the family.
- Identify candidates for Care management through the community Care Management Organization.

3. Community-based Care Management

Families with multiple system involvement and children with serious emotional and behavioral health needs in, or at imminent risk for, placement outside the home and community are candidates for community-based care management delivered by contracted **Care Management Organizations (CMO)**. The CSA Care Coordinators using DHS screening criteria and standards, currently under development, will identify eligible children and families. Initial selection of children for enrollment in a designated Care Management Organization will be done in consultation with DHS.

The CMO will design, organize and implement a single, integrated plan of care that incorporates interdisciplinary clinical services with family and community resources. The plan of care will be implemented under the direction and authority of a child and family team, organized and facilitated by a CMO Care Manager. Care managers will be individuals at the masters level with extensive experience with children with emotional and behavioral disturbances and their families who are involved with multiple child-serving systems. For children with the most intensive needs the care manager to child ratio is expected to be 1:10. This is the ratio recommended by the federal Center for Mental Health Services. The Child and Family Team may include representatives from all involved child-serving systems, as well as key providers, family members, and community residents. All services will be delivered and monitored under the authority of that team, and accountable to outcomes endorsed by the family.

CMO Plans of Care will be registered with the CSA. **The CSA will authorize service plans as a total package, so that it will not be necessary to obtain separate authorization for each service within the plan.** The CSA will monitor Plan of Care implementation for quality and outcomes.

4. Ongoing Information Management and System Support

The CSA will install systems for gathering, coordinating, organizing and distributing information needed for management at all administrative and clinical levels. The CSA will also interface with other DHS management information systems. The CSA will monitor and report on all critical process and outcome indicators for system of care functions, and all system of care components. Information will be distributed to system of care participants as an ongoing quality improvement process.

IV. DHS Management

The Department of Human Services will retain full responsibility and authority for system of care design, implementation, and management. By its very nature, the Children's Initiative will necessitate a cross-divisional, coordinated DHS approach, requiring ongoing reform of policy and reorganization of resources.

This reform process will be managed by:

- An Executive Oversight Board, Chaired by the Commissioner of Human Services including critical policy and decision-makers among child serving systems for ongoing adjustment of policy and reorganization of resources.

- A Stakeholder Implementation Advisory Committee of involved and affected stakeholders for ongoing input.

- The DHS will establish a Children's Initiative Management Team that reports directly to the Deputy Commissioner of DHS. The team will include full time staff directly accountable to the project and dedicated staff from participating divisions and departments as liaisons for system of care design and implementation.

  The DHS Children's Initiative Management Team will be directly responsible for:

  - System of Care design and performance specifications.
  - Needs-based planning for system capacity and performance expectations.
  - Procurement of CMOs and Contracted System Administrator.
  - Contract management of CMOs and Contracted System Administrator.
  - Development of Family Support Organizations.
  - Confirmation of children and families initially selected for CMO case management.
  - Oversight of System of Care operations.
  - Identification of issues requiring modification of DHS policy reforms and resource reorganization.

DHS will gradually enhance its ability to manage this new system of care through the incremental introduction of changed or new administrative requirements. The Department acknowledges the essential role of providers as partners in this change process and their need to maintain clinical integrity and business viability. DHS will support provider transition into the new system.

V. Financing

Financing Strategies

The Children's Initiative calls for pooling resources currently supporting many DHS children's programs and managing those resources so that services are expanded and can be tailored to the individual child. The Initiative will increase

the amount of federal funds for which the state is eligible under Medicaid. The DHS 2001 budget will contain approximately $39 million in a combination of new state and federal revenue. These new funds will be combined with $167 million dollars identified in the State fiscal Year 2000 budget for services to children and youth with emotional and behavioral disturbances to develop an integrated funding pool of $206 million dollars.

Exploration of New Payment Methods

The Children's Initiative will begin application of care management principles and methodologies to the organization, coordination, and delivery of child welfare and child mental health services. New procedures for contract management and reimbursement for this new system of care will be introduced incrementally. The Department acknowledges the essential role of providers as partners in this change process and their need to maintain business viability. DHS will support provider transition into the new system. **Initially, current service providers will continue to contract directly with DHS.** Gradually, working with the provider community, the Department will realign our methods of contracting and reimbursement to support the purchase of individualized plans of care once needed data is available to make this a viable shift.

This shift may include exploring the use of case rates to allow for more flexibility for CMOs and to align fiscal incentives for providers with DHS policy objectives to improve the quality of services. Implementation of the Children's Initiative will provide cost and utilization data that will allow accurate and fair rate setting. This rate-setting process for case rates will occur over the first three years of implementation, and will not be used until consistent and reliable information of projected utilization and costs is available. These new methodologies will be gradually introduced in conjunction with training and technical assistance.

VI. Implementation Plan

The Department will phase-in the Children's Initiative System of Care over a three to five year period. Initially, system reform efforts and service expansion will focus on children with the most complex needs involved with multiple systems, especially those children whose emotional and behavioral disturbances require increasingly intense service responses placing them at-risk for multi-system involvement and placement outside the home and community. The development of Care Management Organizations (CMO) to address this population will begin in several counties during the first year, expanding throughout the state in years two and three. Increasing CMO service capacity on a gradual basis is important because CMO's will go beyond organizing a treatment response to clinical needs. They will build community capacity through developing and organizing natural helping networks to support community living for children and their families or caretakers.

The Contracted System Administrator (CSA) implementation priorities for the first year will be to develop an operational infrastructure and database to organize services for the child-serving systems partners including child welfare, mental health and juvenile justice. This includes establishing procedures to ensure that the service needs of children requiring multiple services or involved with multiple systems are met. This also includes establishing operational relationships with the CMOs. Providers will be oriented to the new system and gradually brought into the care coordination and utilization management process towards the end of the first year of the CSA contract.

Next Steps for Planning and Start-up

- Concept Paper Publication – Early Winter 2000
- Regional Public Forums – February 2000
- Formal Input – Until March 15, 2000
- Stakeholder Implementation Advisory Committee - Ongoing
- CSA Bid Process Announced – Spring 2000; Start-Up Late Fall - 2000
- CMO RFPs Issued – Late Spring 2000; Start-Up Late Fall 2000
- Service Expansion – Fall 2000

The State views the publication of this Concept Paper as the beginning of an interactive process for public input. The Department will also conduct regional public forums to provide interested individuals and organizations an opportunity to share their perspectives, concerns and ideas with the State regarding the development of the Children's Initiative. Public comments and participation in these forums will be crucial to the development of a system that will be responsive to the needs of those it serves.

Comments on this Concept Paper may be sent to:

Michele K. Guhl, Commissioner
NJ Department of Human Services
240 West State Street
PO Box 700
Trenton, New Jersey 08625

Comments will be accepted up to March 15, 2000.

BACKGROUND INFORMATION

Current Utilization Patterns for Children

Within the Department of Human Services, the Divisions of Mental Health Services (DMHS) and Youth and Family Services (DYFS) have primary responsibility for providing services to children with emotional and behavioral disorders. The following Table provides information on the current utilization patterns for DMHS and DYFS services. The numbers do not represent unduplicated counts.

CHILDREN WITH EMOTIONAL AND BEHAVIORAL DISTURBANCES

1. Children in various residential placement for emotional and behavioral disturbances*

	DYFS	*DMHS*	*MEDICAID*	*TOTAL*
Residential Treatment Ctrs.	887			
Group Homes	369			
Treatment Homes	465	18		
Psychiatric Community Residences		276		
Out-of-State Psychiatric Hospital			20	
TOTALS	**1721**	**294**	**20**	**2035**

* Slots available, not necessarily children

2. What types of children are in residential services?

34% - at least one psychiatric hospitalization
61% - Court ordered
7% - Last placement Juvenile Justice Commission

3. Children admitted to Psychiatric Hospitals

Children Crisis Intervention Service CSIS Units	3572
Arthur Brisbane	66

* Children referred to Brisbance after an admission in and CCIS

4. Children with emotional and behavioral disturbance receiving community based services*

Partial Care	3204
Youth Casemanagement	2693
Wrap-around Services	900
TOTAL	6797

Transforming Systems to Meet the Needs of Youth and Families: The NJ Story
Presented by: Elizabeth Manley, Innovations Institute
Annotated Bibliography

Armstrong M.I., Blase, K., Caldwell, B. Holt., King-Miller, T., Kuppinger, A., Obrochta, C., Policella, D.N., &Wallace, F. (2006). *Final report: Independent assessment of the New Jersey's children's behavioral health care system.* Tampa, FL The University of South Florida. Louis de la Parte Florida Mental Health Institute. (FMHI Publication #239). Retrieved from: http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/NJ-FinalReport.pdf

> In 2006, the NJ Division of Child Behavioral Health Services (Children's System of Care) commissioned a comprehensive review of early implementation of the NJ Children's System of Care Initiative. The evaluation was completed by the University of South Florida with Mary Armstrong leading the evaluation team. The report captured information through varies methods including focus groups, data analysis, interviews with key stakeholders, internet survey and review of existing documents.
>
> The team concluded that the grounding in systems of care across the state did have impact and recommended that the state continue to invest in strategies such as value-based contracting, a robust continuous quality improvement plan and consistent training for the workforce are essential for long term sustainability. The report served as a roadmap for the leadership to continue to support implementation and sustainability efforts across the state of NJ.

Bath, Howard (Fall 2008). The Three Pillars of Trauma Informed Care. *Reclaiming Children and Youth, volume 17, number 3. Retrieved from: https://elevhalsan.uppsala.se/globalassets/elevhalsan/dokument/psykologhandlingar/trauma-informed-care.pdf*

> The NJ Children's System of Care is grounded in trauma responsive care as articulated within *The Three Pillars of Traum Informed Care.* The NJ customized crisis system, known as Mobile Response and Stabilization Services, is grounded in the idea that providing young people and their families strategies to address safety, connections, and management of emotional impulses within their own homes, schools and communities can transform the experience of young people and their families and support the concept of urgency being met with urgency. The concept that trauma informed living environments in which healing can take place are a precursor to any formal therapy and that much of complex trauma can take place in non-clinical setting, assist the workforce in understanding the impact of trauma with a focus on sequencing formal interventions in a way that sets that stage for authentic engagement with young people and their families.

Blau, Gary; Caldwell, Beth and Lieberman, Robert (edited by). *Residential Interventions for Children, Adolescents, and Families: A Best Practice Guide.* Routledge, NY, NY 2014

The NJ Children's System of Care has focused attention on meeting the needs of young people by providing the right service at the right time for the right duration. An important principle is that residential interventions, such as psychiatric residential treatment facilities (PRTF) are embedded within the system of care. NJ has worked to decrease silos by restructuring access to a single point of access for the service delivery system that ensures that residential interventions are well coordinated by child family team using High Fidelity Wraparound as the first level of decision making and connected to home and community-based aftercare services. Understanding residential interventions' best practices is not limited to residential partners and state oversight but is inclusive of young people and their families. This reference guide was helpful in engaging state leadership, residential partners, care management organizations, family support organizations and mobile response teams on core concepts of residential best practices to support the ability of the workforce to support young people who are touched within residential interventions and their families.

Caldwell, B., Lieberman, R.E., LeBel, J., and Blau, G. (2020). *Transforming Residential Interventions: Practical Strategies and Future Directions*. Routledge, NY.

Residential reforms have been a driver to the systems transformation in NJ. The Children's System of Care role as the oversight organization is instrumental in reforming the experience of young people who touch on the system including increasing the communication, coordination, and connection of all systems partners. The work of NJ's oversight is highlighted within this publication.

Dennis, Karl and Lourie, Ira. *Everything is Normal Until Proven Otherwise: A Book About Wraparound Services.* CWLA Press, Washington, D.C., 2006.

Intensive care coordination that is grounded in High Fidelity Wraparound is a key feature in NJ's transformation of the behavioral health, intellectual/developmental and substance use service delivery system. Care coordination requires teams to be grounded in unconditional care, a concept that NJ focused attention on by building a no eject, no reject service delivery system. The principles of these ideas are clearly articulated in Everything is Normal Until Proven Otherwise. This book provides guidance to the field by showing how systemic changes can be implemented to meet the unique challenges of young people leveling the table and engaging young people and their families in decision making at the individual planning and policy tables.

Glasser, Howard. *Transforming the Difficult Child*. Nurtured Heart Publications, 1999

In 2015 the NJ Children's System of Care was awarded a 12 million grant, Promising Path to Success, to implement new strategies to move away from restraint, seclusion, and coercion within the system. The Nurtured Heart Approach, developed by Howard Glasser, was identified as an approach that allowed the state to provide tools to the workforce, parents/caregivers, and young people to focus on recognizing and engaging

the young person's greatness. The Nurtured Heart Approach is required training for all systems partners.

Lyons, J., Weiner, D. (2009). *Behavioral Health Care: Assessment, Service Planning, and Total Clinical Outcomes Management.* Civic Research Institute, NJ.

The Total Clinical Outcomes Management model and the suite of Child, Adolescent, Needs and Strengths (CANS) tools were established at the beginning of the NJ reforms. NJ developed a statewide implementation plan to bring Information Management and Decision Support System (IMDS) for Children and Families. This process included a phased implementation process inclusive of the development of three tools, the Needs Assessment used a screening tool, the Strengths and Needs Assessment used within an intensive care coordination process and the Crisis Assessment Tool (CAT) used by the Mobile Response and Stabilization teams (MRSS). The IMDS process in NJ includes assessing the need for intensive care coordination, service planning, contract management and rate setting, quality improvement and outcome monitoring and allows for the rightsizing of the system to meet the current needs.

The MRSS in NJ is reviewed in detail including key program functions, program description, and the use of the CAT. Evaluation of levels of risk behaviors, follow-up on reassessed youth, thresholds to support level of care decisions and the MRSS Assessment

Lyons, J., Woltman, H, Martinovich, Z., Hancock, B. (2009). *An Outcome Perspective of the Role of Residential Treatment in the System of Care, Residential Treatment for Children & Youth.*

This study on the role of residential treatment in systems of care features some of the NJ reforms and supports the process of developing a system of care approach and the important work of matching the needs of youth with interventions that meet the identified needs. This paper outlines the connection between improved connection to care and improvement within-episodes outcomes from residential treatment. The study implications found that hinged analysis provides feedback on the functioning of the system with particular focus on efficiency and effectiveness of interventions provided. The study helped the NJ leadership make the connection between the use of Child and Adolescent Needs and Strengths Tool (CANS) and the outcomes for youth who touch in a residential intervention by better understanding the unique needs of each youth who required residential to meet their needs and residential interventions design to meet the identified needs.

Manley, E., Schober, M., Simons, D. & Zabel, M. (2018). *Making the Case for a Comprehensive Children's Crisis Continuum.* National Association of State Mental Health Program Directors.

In this publication, the need for a comprehensive crisis system that is customized to meet the unique needs of children, youth, and young adults, specifically highlighting the need for Mobile Response and Stabilization. A crisis continuum of care is necessary to

deescalate and ameliorate a crisis before more restrictive interventions become necessary and to ensure connection to necessary services and support. A high-quality child and youth crisis continuum should be available 24/7 features screening and assessment specifically designed for young people and families and connection to psychiatric consultation.

McGill, K., Rea, K. (2015). New Jersey's Historical Development of a Statewide Children's System of Care, Including Lessons Learned from Embedding CANS Tools: Developments, Innovations, and Data Analysis. *Sage Press*. Retrieved from: https://journals.sagepub.com/doi/pdf/10.1177/2158244015602806

New Jersey has made significant investments in the creation of a "statewide" reform effort to better serve the most vulnerable children and their families. Many states can learn from New Jersey's statewide reform, which now celebrates completion of its first decade. This article details the historic timeline of the implementation processes as well as the structural components of a system of care. The role of each system entity is identified as well as their adaptation of the Child and Adolescent Needs and Strengths (CANS) assessment tool to best serve the children/youth in a statewide system of care. This article also examines the methods for effectively training and embedding the CANS tools.

National Association of State Mental Health Program Directors (NASMHPD) (2008). *The Six Core Strategies* (Revised 11/10/2006 by Kevin Ann Huckshorn).

NJ has implemented the Six Core Strategies as part of the Promising Path to Success System of Care Expansion Grant awarded in October 2015. The Six Core Strategies is an evidenced based intervention that focuses on restraint and seclusion within residential interventions. The six strategies include: leadership toward organizational change; the use of data to inform practice; workforce development; use of seclusion/restraint prevention tools; youth and family engagement in residential; rigorous debrief.

Assessment used a screening tool; the Strengths and Needs Assessment used within an intensive care coordination process and the Crisis Assessment Tool (CAT) used by the Mobile Response and Stabilization teams (MRSS). The IMDS process in NJ includes assessing the need for intensive care coordination, service planning, contract management and rate setting, quality improvement and outcome monitoring and allows for the rightsizing of the system to meet the current needs.

PerformCare NJ; the Contracted Systems Administrator for the NJ Children's System of Care. Retrieved from: PerformCare - New Jersey Children's System of Care (performcarenj.org)

A core partner for the NJ Children's System of Care, PerformCare serves as the contracted systems administrator (CSA). The primary responsibilities include operating the single point of access inclusive of the 24/7/365 call center, management of the

electronic record and utilization management functions. PerformCare serves as a partner in continuous quality improvement and transparency of data and outcomes.

Pires, Sheila. *Building Systems of Care, A Primer, 2nd Edition*. National Technical Assistance Center for Children's Mental Health. (2010)

The Building Systems of Care document is foundational to NJ's systems reform. The Primer outlines the strategic framework and operational characteristics necessary for systems transformation. The Primer provides an overview of the role of governance, partnering with young people and their families and cultural humility, infrastructure and functions and the core elements of effective systems.

Rutgers University Behavioral Health Care Children's System of Care: Training and Technical Assistance Program. Retrieved from: Rutgers University Division of Continuing Studies

NJ Children's System of Care has partnered with Rutgers University Behavioral Health Care to provide training and technical assistance to the network of system partners, parents/caregivers, and young people. Training includes certification for care managers within care management organizations, mobile response teams, peer support partners and behavioral assistants. Additionally, training courses are available both in person and via webinars. The mission of the Training and Technical Assistance program is the development of a workforce that is prepared to meet the needs and challenges of the young people and their families with the skills and tools based on evidence informed practices and providing access to most up to date technical assistance.

Rutgers University Child Welfare Data Hub retrieved from: NJ Child Welfare Data Hub | Data Hub (rutgers.edu)

The New Jersey Child Welfare Data Hub is a collaboration between the NJ Department of Children and Families and the Institute for Families at the Rutgers University School of Social Work. The data hub disseminates data from the Division of Child Protection and Permanency and the Children's System of Care.

SAMHSA and CMS May 7, 2013. Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions.

This Informational Bulletin was developed to assist states in designing a Medicaid service array to meet the unique needs of children, youth, young adults, and their families. The bulletin highlights Intensive Care Coordination grounded in Wraparound, Peer Services both parent and youth, Intensive In-Home Services, Respite Services, Mobile Crisis Response and Stabilization Services, Trauma Informed Systems and Evidence-Based Treatment Addressing Trauma and Flex Funds.

State of New Jersey Department of Children and Families, Children's Interagency Coordinating Councils (CIACC) Data Dashboard and Commissioners Data Dashboard: retrieved at DCF (nj.gov)

The NJ Children's System of Care provides a monthly data dashboard to each county level governance team who are responsible for the local oversight for the system of care. The dashboard has both a county level dashboard and a state level dashboard.

The Commissions Data Dashboard provides additional data and overview of the Department of Children and Families.

State of New Jersey Department of Human Services, *The Children's Initiative Concept Paper: A System of Care for Children with Emotional and Behavioral Disturbances and Their Families.* Christine Todd Whitman and Michele Guhl. Published January 2000. Retrieved from: State of New Jersey Department of Human Services (nj.gov)

The Children's Initiative Concept Paper serves as a vision document that outlines the reform agenda to create a comprehensive system of care for children and families in NJ by committing to maintaining the integrity of family and community life for children for children while delivering effective clinical care and social supports. This document creates the framework for transformation. The vision of the architects includes the ongoing investments inclusive of the Family Support Organizations, a statewide contracted systems administrator, community-based care management organizations, mobile response and stabilization services and single assessment tool specifically the Child and Adolescent Needs and Strengths Tool (CANS). The document addresses goals, fiscal implications, implementation strategies and data/

State of New Jersey Department of Human Services, *Dual Diagnosis Task Force Report: Collaborating to Provide Services and Supports for Children and Adults with Co-Occurring Developmental Disabilities and Mental Health/Behavior Disorders.* Donna Icovina and T. Missy Balmir, Co-Chairpersons. Published October 2008. Retrieved from: DDTFR report:Layout 1.qxd

The Dual Diagnosis Taskforce Report serves as a vision document that outlines the transition of all services and supports for children, youth, and young adults with intellectual/developmental disabilities into the Children's System of Care. The work of the task force outlined the urgent need for reform and highlighted the unique needs of young people and their families. Additionally, the report highlighted the painful experience of families attempting to meet their needs in a siloed approach. This document supported the development of seamless systems approach to meeting the needs of families inclusive of customized crisis continuum, intensive in-home supports and services, statewide information management and decision support and intensive care coordination.

Stroul, B., Dodge, J., Goldman, S., Rider, F., & Friedman, R. (2015). *Toolkit for Expanding the System of Care Approach*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health. Retrieved from: Toolkit_SOC.pdf

The Toolkit for Expanding the System of Care Approach includes an introduction to System of Care Expansion, strategic planning guidance, self-assessment of expansion strategies, planning strategies. These tools were instrumental to the NJ leadership as the Children's System Expanded to include youth with intellectual/developmental disabilities and substance use challenges.

Stroul, B. and Blau, G. (2008). The System of Care Handbook: Transforming Mental Health Services for Children, Youth and Families. Paul H. Brookes Publishing.

The System of Care Handbook documents the role that NJ parent/caregivers played in setting the vision for the state. The effort of parents of young people prepared and submitted a 10-point position paper that stressed full family involvement that set the stage for the Children's Initiative Concept Paper. Additionally, the System of Care Handbook includes NJ history with a focus on the role of care management organizations, cross agency coordination, early identification/screening, funding consideration, locus of management and workforce development.

Stroul, Beth and Manley, Elizabeth (2018). Custody Relinquishment to Obtain Children's Behavioral Health Services: Current Findings and Strategies to Address the Practice. Retrieved from: custody relinquishment to obtain children's behavioral health services: current findings and strategies to address the practice (ca.gov)

Custody relinquishment was one of the initial drivers of the early reforms. NJ has been thoughtful in developing a process that provides care for young people as determined by their clinical needs and not ability to pay for necessary care. Families take drastic steps to help children in mental health crises (wfyi.org)

System Infrastructure
January 20th, 2026
3:00 – 4:30 PM
Zoom

TCB System Infrastructure Workgroup Meeting Summary

Attendees			**TYJI Staff**
Aishwarya Sreenivasan	Gabrielle Hall	Tammy Freeberg	Emily Bohmbach
Aleece Kelly	Jason Lang	Tammy Venenga	Erika Nowakowski
Alice Forrester	Jennifer Nadeau	Tanja Larsen	Stacey Olea
Edith Boyle	LaToya Hinton	Victoria Stob	
Emuna Patterson	Matt Hoppler	Frank Gregory	

Agenda:

- **TCB Administrative Updates**
  - TCB and Workgroup Updates
- **Strengthening The System of Care for all Children in CT Presentation**

Meeting Summary:

1. **TCB Administrative Updates**
   a. The TCB Senior Project Manager provided updates from the January monthly meeting, including a preview of potential legislative recommendations for the 2026 session. An update was also shared regarding a presentation to the Commission on Women, Children, Seniors, Equity, and Opportunity (CWCSEO), which focused on recommendations related to disordered eating behaviors. The next monthly meeting is scheduled for February 11 and will be streamed and recorded on the TYJI YouTube channel and through the Connecticut News Network (CTN). Additionally, a brief overview of upcoming meeting dates for the Prevention, School-Based, and Services workgroups was provided.
2. **Strengthening the System of Care Presentation:**
   a. The Co-Chair of the workgroup provided an overview of New Jersey's System of Care (SOC) and compared it to Connecticut's current framework. Connecticut's 2015 Plan for Children, building earlier system-of-care efforts, called for a comprehensive, statewide SOC that integrates blended funding, coordinated care management, cross-system insurance alignment, and shared data infrastructure. While Connecticut has implemented components of this vision, a fully integrated model has not yet been achieved.
      i. The purpose of a System of Care is to strengthen family and community connections, reduce out-of-home and out-of-state placements, and improve youth outcomes through coordinated, wraparound, and family-centered services. New Jersey's long-standing SOC demonstrates

improved stability for youth, reduced hospitalizations and emergency department utilization, lower incarceration rates, and stronger family capacity to maintain children at home.

ii. New Jersey's System of Care features a centralized single point of access, family-driven care management organizations, stable family support funding, a tiered continuum with strong in-home services, blended funding streams, and clear DCF governance. The model coordinates services while also directing funding and guiding service expansion. Although Connecticut's per-child spending is similar, it lacks the same level of integration and centralized structure. The discussion highlighted an opportunity for TCB and cross-agency partners to further explore and advance a more unified Connecticut System of Care model.

3. **Discussion**
    a. Workgroup members held a comprehensive discussion about whether Connecticut should prioritize advancing a more integrated System of Care (SOC) as part of the 2026 work plan. A majority supported moving in that direction, with the understanding that sustainable funding must accompany any implementation and that providers cannot absorb additional strain without new resources.
        i. Participants acknowledged significant system pressures, including long waitlists, high acuity, and access challenges, and emphasized the importance of equity, particularly for young people with intellectual and developmental disabilities and low-income families who face barriers to screening and services. While New Jersey's model was discussed as an example of a fully realized SOC, members clarified that the intent is not to replicate another state's system but to determine what makes sense for Connecticut.
    b. There was strong agreement on SOC values, but differing views on strategy. Some advocated for incremental improvements, while others emphasized the need for a clear, statewide vision to guide meaningful change. Members stressed the importance of first assessing Connecticut's existing infrastructure, reviewing prior family engagement efforts, and avoiding duplication of past work. Ideas discussed included conducting an environmental scan or fidelity assessment, compiling existing data into a centralized resource, leveraging available technical assistance, and exploring opportunities within the Rural Health Grant.
        i. Cross-agency alignment, across DCF, DSS, DDS, DMHAS, education, and the courts, was identified as essential to avoid continued fragmentation. Strengthening care coordination, improving access to services, and preventing unnecessary escalation to higher levels of care were highlighted as core goals.
    c. The group agreed that the immediate priority is to define a clear vision and outline next steps for 2026, leveraging Connecticut's existing foundation while identifying specific opportunities to strengthen coordination and improve statewide system integration.

Next meeting is on February 17th, 2026 at 3:00 PM on ZOOM