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Dear Community Alliance Member:

Governor Bush and I are strongly committed to better, more effective interventions on behalf of abused and neglected children as reflected through our department’s mission statement:

“The Department of Children and Families is committed to working in partnership with local communities to ensure safety, well-being and self sufficiency for the people we serve.” (Department mission statement)

The Department and the Legislature deemed Community Alliances as the central source of broad-based community input and interagency coordination. The Community Alliances will work to identify the desired outcomes and the best system of care for their own communities.

We firmly believe that your community-based systems of care can result in more self-sufficient and safe lives for our families. Long term improvements will follow: 1) shared ownership, 2) shared vision, and 3) shared responsibility. The role and function of the Community Alliances are essential for our Department to more effectively carry out its mission.

I hope that you will find this Community Alliance Resource Handbook helpful as you form and develop your Community Alliances. We pledge our support to you in this process. Your primary contact for any questions regarding this initiative is David Fairbanks, Director of Community-Based Care (David_Fairbanks@dcf.state.fl.us, 850-487-1987).

Thank you for your commitment to this bold initiative. I stand ready to assist you in any way I am able, and I look forward to hearing of your many accomplishments.

Very truly yours,

Judge Kathleen A. Kearney
Secretary, Department of Children and Families
COMMUNITY ALLIANCE RESOURCE HANDBOOK

FOREWORD

The Community Alliance Resource Handbook is designed as a working manual for each member of the Community Alliance as a working guide. The document provides Community Alliance members the available information and current “best thinking” toward formation and development stages. Each section follows a logical growth and development sequence for the Community Alliance. The stages described are not necessarily sequential or linear. That is to say that an Alliance may be working on issues in each of the four conceptualized stages at the same time. Each stage encompasses a framework of achievement, which allows for maximum creativity and the individuality of each community. Once Community Alliances meet the benchmarks in each stage, members will have the information they need to make informed recommendations regarding the specific, outcome driven services to children and their families in their.

The Handbook is divided into tabbed sections beginning with an overall introduction to the philosophy and intent of the Community Alliances. Here you will read a description of potential impact on the development of both outcomes and a community based system of care for children and their families. Each section describing one of Four (4) Stages of Development of the Community Alliances follows the same pattern:

- A goal,
- An outline of suggested activities and resources, and
- Benchmarks for achievement.

Examples of products and tools helpful for the achievement of the milestones are included as well. These are suggestions only, to assist the Alliance as needed.
There is no requirement to use these specific tools if the Alliance has other resources at hand.

The Handbook provides clear expectations and milestones for the formation, development, and way of work of Community Alliances and provides some of the tools necessary to achieve those milestones. The benchmarks/achievements are the outcomes/deliverables for the Alliance.

We are committed to providing updates of best practices from the developing Community Alliances to keep you abreast of the latest work within the state. To that end we plan to develop Version 2.0 of the Community Alliance Resource Handbook for you by June 30, 2001. Please provide us with feedback and information that we can share with other communities.

We look forward to working with you in the formation and development of your Community Alliance.

David Fairbanks, Ph.D., and
Staff of the Community Based Care Initiative
COMMUNITY ALLIANCES RESOURCE HANDBOOK

INTRODUCTION

The 2000 Florida Legislature amended Florida Statutes 20.19, the authorizing statute for the Department of Children and Families, to add a vital component to the way the Department does business.

(6) COMMUNITY ALLIANCES
(a) The Department shall, in consultation with local communities, establish a Community Alliance of the stakeholders, community leaders, client representatives and funders of human services in each county to provide a focal point for community participation and governance of community-based services. An Alliance may cover more than one county when such arrangement is determined to provide for more effective representation. The Community Alliance shall represent the diversity of the community.

The Department and the Legislature have deemed Community Alliances as the central point for broad-based community input and collaboration. The Department’s overarching strategy to build partnerships in the community, which significantly impact the outcomes, quality, effectiveness, and efficiency of services in the community is called Community-Based Care. It includes the parameters outlined in Florida Statutes Chapter 409, section 409.1671, Foster Care and related services; privatization.

The formation and support of Community Alliances is key to the success of the Community Based Care initiative. There are three keys to the success of the Community Alliance:

1) Community partnership,

2) Community outcomes, and

THE FIRST KEY IS PARTNERSHIP

The Legislature and the Department are clear in the role they envision for the Community Alliances, a role of community involvement that exercises a determining influence on outcomes regarding children and their families. The Community Alliance constitutes a collaborative partnership with the department and other community agencies. With this collaborative partnership, the Community Alliance has a tremendous impact on how its citizens are served.

With this authority and influence, the Community Alliance has considerable responsibility:

♦ To be informed about the services of their community,
♦ To discuss and reach agreement on desired outcomes for their community children and their families,
♦ To work to reduce the duplication and fill in the gaps in services across agencies,
♦ To listen to the needs and wants of their community children and their families, and
♦ To coordinate funding issues across agencies.

The tasks and responsibilities of the Community Alliance members are outlined in the law, which is attached for your review. (Attachment A-1, following the Stage 1 narrative)

In essence, the Community Alliance is a group of community partners who agree to help the department and the community to improve outcomes for children and their families in their community. This includes support of the coordination of prevention and early intervention initiatives as well as providing input to the design and oversight of systems of care for children and families. It is an advantage to the Department and other child serving agencies in the community to have the benefit of the informed counsel of the Community Alliance on all matters pertaining to services for children and their families. The Community Alliances are essential for the
Department to more effectively carry out its mission “to work in partnership with local communities”. Alliances offer the opportunity for a community to truly demonstrate that the whole is far greater than the sum of its parts.

“This is about community empowerment, which means that the ability to take action regarding the system of care will reside at the community level.” (Judge Kathleen Kearney, 2000)

The law constitutes a directive for the department to fully participate with the Community Alliance in all matters pertaining to the department’s community based services. However, the District administrator is also a named member in the statute with the same power and responsibility as the other six named members of the Community Alliance. Therefore, the Department is a full member of the Community Alliance with the same responsibilities and commitment to the achievement of the community’s designated outcomes as all other members.

DOES COMMUNITY INVOLVEMENT MAKE A DIFFERENCE?

The following is one community’s story. In Sarasota County, where the Department’s first Community-Based Care program was initiated, one of the first steps the District Administrator and Lead Agency took before planning the transition of child protection services was to convene a meeting of local stakeholders. Key stakeholders from the school system, Juvenile Justice Program, Department of Health, County Commission, Court, medical community, law enforcement, other social services agencies, and family advocates have personally and professionally made contributions to the department’s mission of “working in local partnerships”. This group’s support, guidance, commitment, oversight, and vision over the past four years contributed greatly to the development and success of this program and improved outcomes for children and families. With the support of this Alliance, the Lead Agency and the Department in this community we see:

- A community that understands the dynamics of abuse and neglect and learned ways to heal and strengthen families.
A community that understands the importance and value of other specialized programs and agencies working together, not separately.

Agencies willing to pool their resources and seek other financial supports to provide more effective, efficient services to greater numbers of children and families.

Stakeholders who analyze outcome data, then question and create solutions for improvement and higher quality.

Advocacy groups, consumers and other concerned citizens have a voice in shaping the local system of care through a continuous needs assessment process.

New programs developed in the community because of a documented unfulfilled need.

A group vigorously working on solutions for staff turnover because they realize how this adversely affects families.

And, finally, a community that has taken personal responsibility for the success or failure of this program, and the outcomes for children and families.

This stakeholder group, with its strong and yet constantly evolving focus, became the inspiration for last year’s legislation, which called on all communities to establish a similar Alliance. Community-Based Care cannot just be a contractual relationship between the Department and Lead Agency to provide child welfare services. This contractual arrangement in itself does not guarantee better outcomes for children and families.

"With community priorities and needs (and outcomes) as the focal point, the Alliance would be empowered to do what the department cannot: influence the performance of community groups beyond the reach of the department’s contracts, challenge the performance of the system instead of a single provider, and secure funds that are not available to us as a government agency." (Judge Kathleen Kearney, 2000)
THE SECOND KEY IS OUTCOMES

The foundation of the community partnership is a set of well defined and mutually agreed outcomes for children and their families in the community. An Alliance provides for community ownership and oversight of services to children and their families; a focal point for setting community priorities through designated outcomes; and serves as a catalyst for community resource and development. The outcomes provide a “true North” directional system for the community, always guiding and directing decisions regarding resources and services.

Outcomes are the basis of a community-based System of Care for children and their families and a logical process for the community partnership. The questions for a Community Alliance are simple:

1. What are we trying to achieve for children and their families?
2. What community services impact on what we are trying to achieve?
3. How well are we doing in what we are trying to achieve?

When we view outcomes in this manner, we embrace the philosophy of a community-based system of care that crosses all child-serving agencies in the local community. Everyone has a role in the achievement of community-based outcomes. It becomes an issue of community development and support, not just a single departmental/agency issue. One agency may have the lead on a particular outcome, whether it is family safety, education or juvenile justice, but all agencies impact the community’s achievement of each of its designated outcomes. Shared community ownership of the children and their families is the most important factor in the overall management of the organization and system changes needed to meet the designated outcomes.
THE THIRD KEY IS COMMUNITY BASED SYSTEMS OF CARE

Nationally, there is increased attention to the benefits of a seamless system of services that is community-based, outcome driven, and family focused with individualized culturally competent service plans for the child and family. This concern for improved access and enhanced quality through management of outcomes has produced stellar projects. These programs show that children and their families respond more positively with longer lasting outcomes when the services are provided in the community where they live and as close to home as possible, including hands–on services and teaching in the home.

System of Care development is inextricably an interagency collaboration challenge. Not only are there high percentages of children and adolescents in the child welfare system who need and/or receive mental health services, all are involved in schools and many are involved with the juvenile justice system.

An important lesson learned while reviewing home and community based systems of care is that no two sites (communities) are alike. Each community must take the concept and core values of a home and community based system of care and develop their own community-based plan. It is truly a community development issue.

THE FOUR STAGES OF COMMUNITY ALLIANCE DEVELOPMENT

The principles behind the Community Alliance four stages of development which provide a blueprint for their success are:

♦ Shared Ownership,
♦ Shared Vision, and
♦ Shared Responsibility
The formation and development of Community Alliances is conceptualized in four stages with milestones/benchmarks for each stage that provides an operational framework and guide. The four stages of Community Alliance development are outlined below and are more fully described in separate sections of this Handbook.

1) Vision, Mission, Membership and By-Laws,
2) Assessment of Existing Resources and Outcomes,
3) Community Based System of Care Plan, and
4) Business Partnership and Shared Accountability

Each stage includes a short description of the goal and scope and provides examples and tools to assist the developing Alliance membership in achieving their milestones/benchmarks.

It is important to note that Community Alliances are doing some of the activities in every stage all of the time, because the activities are not necessarily sequential or linear after Stage I. We present the stages in a sequence to give the reader anchors for the typical milestones and benchmarks at each interval of development.

Nationally, the communities most successful in implementing highly effective systems of care for children and their families are community-based, family-focused, and managed through outcomes. A key to this success is a collaborative infrastructure such as the Community Alliances, where systems and families come together to strategically plan for a better system of care in their community.
In this stage, the Alliance will develop its vision, mission, formal roster of membership and by-laws.

~ MAJOR FUNCTIONS OF A COMMUNITY ALLIANCE ~

- Provide for community education and advocacy on issues related to delivery of services (Stages 1-4 and ongoing)
- Needs assessment and establishment of priorities for service delivery (Stage 2)
- Determining community outcome goals (Stage 2)
- Promote prevention and early intervention services (Stage 3)
- Joint planning for resource utilization in the community (Stage 3)
- Serve as a catalyst for community resource development (Stage 4)

_Citation from Florida Statute 20.19 (6) describing duties of Community Alliances_

The primary purpose of an Alliance should _always_ be building and strengthening community partnerships and collaboration.

**Goal:**
- To develop the Community Alliance into a viable working community partnership through a common vision/mission, and designating common community outcomes.

_This goal will be met when the Benchmarks & Achievements are completed._
1. **Formal membership roster**

The Formal membership roster confirms the Alliance is in line with 20.19 (6), F.S., which names the 7 mandatory members

- The law pertaining to Community Alliances is found in Attachment A at the end of this section.
  - It contains the list of mandatory members as well as specific duties of the Community Alliance.
  - **Our challenge is to determine how we can most effectively engage our community partners and sustain their influence over time.**

- Several communities began the process prior to the actual Legislation and are now continuing their Alliance formation. Please see Attachment B for a description of the history of Community Alliances and their purpose.

- Other communities have an existing group or the framework for an Alliance that specifically focuses on the needs and outcomes of its citizens. District 9, Palm Beach County, has a Human Services Association. This group decided to amend their by-laws and created a new sub-committee for the Community Alliance that meets the statutory requirements.

- **Attachment C** is a description of how Citrus County in District 13 is using the existing Shared Services Network as the base for their Community Alliance.

- Other communities are discussing ways to combine, expand or redirect existing coalitions or workgroups to incorporate the legislative mandate. Please see **Attachment D**, a description of a multi-county Community Alliance in district 15.
The first meeting of the Community Alliance is an organizational meeting and sets the work for the short term until the by-laws are completed. **Attachment E** is an example of an agenda for an organizational first meeting.

Minutes are an important record for the Community Alliance. It is recommended that the Alliance consider minutes that concisely capture the actions taken and discussion held.

**Attachment F** is a good example of concise summary minutes from Districts 7 and 13.

2. **Vision / Mission Statements**

The discussion of vision/mission is an important step in the formation and development of Community Alliances.

It will guide the Alliance in all of their deliberations and is a cornerstone of their by-laws.

The vision/mission is based on a set of principles and values. Please see **Attachment G** for examples of principles and values.

The mission and goals of the newly formed Alliances can vary widely in scope and function.

**Attachment H** is a worksheet provided by District 7 that guides the Community Alliance members through the process of developing their mission.

Some communities are considering the entire span of service delivery for a wide span of populations while other Alliances are fairly narrow in their focus.

Alliances are encouraged to modify and expand their mission and goals, to reflect changes in community interests and development. Examples of mission statements are provided in **Attachment I**.
3. By-Laws

The initial meetings will cover the vision/mission and issues of membership and a way of work that will be the basis of their by-laws.

- The Community Alliance is formalized and official when the by-laws are passed.

- The by-laws are critical to the smooth working of the Alliance. **Attachment J** provides a worksheet for Community Alliance members to use to develop their by-laws. It was provided by District 7 and guides the Alliance through the by-law development process.

- Examples of three sets of by-laws are provided in **Attachment K** for your review.

- **Attachment L** provides a template for the Community Alliance by-laws. It is a “fill-in-the-blank” template based on the by-law structure of Districts 12 and 15.

HELPFUL HINTS

- To quickly develop and pass by-laws:
  
  ✓ Use the by-laws worksheet in Attachment J to develop your own mission and way of work,
  
  ✓ Use the by-laws template in Attachment L to capture the decisions made on the by-laws worksheet and print your individual by-laws,
  
  ✓ Pass the by-laws by majority vote.
The Alliance legislation also mandates that “The Department shall ensure, to the greatest extent possible, that the formation of each community alliance builds on the strengths of the existing community human services infrastructure.”

- Once the Alliance has an approved set of by-laws they will have the basis for naming additional members as outlined in the Florida Statute: “The community alliance shall represent the diversity of the community.”

**HELPFUL HINTS**

- It is important to include leaders from the business community, the faith community, neighborhood organizations, families, advocacy groups and others concerned with the well being of children and their families.

- Providers of services should not be voting members of the Alliance because of potential conflict of interest in the procurement process. They should be members of committees or sub-committees and attend and participate in Alliance meetings.

- Compliance with this section of the statute should include but not be limited to members or representatives from the following groups:
  - A representative customer or family member,
  - Persons from the business community,
  - Leaders in the faith community,
  - Persons from neighborhood organizations,
  - Persons from civic organizations,
- A Human service advocate,
- The elected leader of the Teen Advisory group representing those in the Independent Living program,
- A representative of the Foster Parent Association.

**Attachment M** offers helpful hints for the foster parent association in ways they can become involved in community planning.

4. **Press Release**

Spread the news, share information; respond to community issues and concerns.

- A press release describing the formation of the Community Alliance and its mission and expected outcomes is a good communication tool for the citizens of the community.

- All meetings of the Community Alliance fall under Florida’s Government in the Sunshine Law. **Attachment N** is a brief description of the law and its requirements as well as the web site address for further information.

- All meetings must be advertised in advance. It is helpful and less costly for the Alliance to set a 6 to 12 month calendar of meetings and advertise them as such in the administrative weekly.

5. **Orientation to Programs and Agencies**

As an essential component of developing plans, identifying service gaps and establishing outcomes - Alliance members need to be well informed about the Service array offered to local citizens.

- The Community Alliance should become familiar with the Department and its mission and outcomes.

- This is also a good opportunity for the Alliance to become familiar with other agencies in the community that will impact on the designated
HELPFUL HINTS

- This stage of development allows Alliance members to become familiar with each other’s agencies/programs and to begin the formation of the desired outcomes of the community human services system.

- While the legislation in F.S. Chapter 20.19, listed specific duties for Community Alliances; it did not limit their scope.

- One of the statutorily designated roles of the Community Alliance is to “Promote prevention and early intervention programs.” It is important to learn what prevention and early intervention programs are available and ongoing in the community across agencies.

- **Attachment O**, found at the end of this section, is The Department’s Prevention Strategic Plan for Children at Risk. This document will assist the Alliance in defining a community prevention effort. Other agencies may also have prevention and early intervention plans/strategies that involving communities.

- The following attachments are a compilation of orientation materials and other reference materials that may prove useful to the Alliances:

- **Attachment P** is a short three-page orientation to the Department’s services to children under Family Safety and the role of Community Alliances prepared by District 13,
- **Attachment Q** is the synopsis, *Funding a Family’s Journey through Child Protection* from District 15’s orientation notebook,

- **Attachment R** is a consensus model that does not require an “all or nothing” support of an issue. As the Alliance moves into complex and sometimes divisive issues within the community, a model of decision-making that allows for all concerns is very helpful.

- **Attachment S** is a list of Community Based Care definitions used in the contracts with the Lead Agencies.
DEVELOPMENT OF COMMUNITY ALLIANCES

An Alliance provides for community ownership and oversight; provides a focal point for setting community priorities; and is a catalyst for community resource and development.

Stage I ~ To develop the community vision, mission, values, membership and way of work for each individual Community Alliance that mirrors the common philosophy and values of the statewide effort to improve services to our children and their families.

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FLORIDA STATUTES 20.19:
COMMUNITY ALLIANCES
COMMUNITY ALLIANCE STATUTE CITATION

Chapter 20.19 (6), F.S. Department of Children and Families Services

(6) COMMUNITY ALLIANCES.--

(a) The department shall, in consultation with local communities, establish a community alliance of the stakeholders, community leaders, client representatives and funders of human services in each county to provide a focal point for community participation and governance of community-based services. An alliance may cover more than one county when such arrangement is determined to provide for more effective representation. The community alliance shall represent the diversity of the community.

(b) The duties of the community alliance shall include, but not necessarily be limited to:

1. Joint planning for resource utilization in the community, including resources appropriated to the department and any funds that local funding sources choose to provide.
2. Needs assessment and establishment of community priorities for service delivery.
3. Determining community outcome goals to supplement state-required outcomes.
4. Serving as a catalyst for community resource development.
5. Providing for community education and advocacy on issues related to delivery of services.
6. Promoting prevention and early intervention services.

(c) The department shall ensure, to the greatest extent possible, that the formation of each community alliance builds on the strengths of the existing community human services infrastructure.
(d) The initial membership of the community alliance in a county shall be composed of the following:

1. The district administrator.
2. A representative from county government.
3. A representative from the school district.
4. A representative from the county United Way.
5. A representative from the county sheriff's office.
6. A representative from the circuit court corresponding to the county.
7. A representative from the county children's board, if one exists.

(e) At any time after the initial meeting of the community alliance, the community alliance shall adopt bylaws and may increase the membership of the alliance to include individuals and organizations who represent funding organizations, are community leaders, have knowledge of community-based service issues, or otherwise represent perspectives that will enable them to accomplish the duties listed in paragraph (b), if, in the judgment of the alliance, such change is necessary to adequately represent the diversity of the population within the community alliance service districts.

(f) Members of the community alliances shall serve without compensation, but are entitled to receive reimbursement for per diem and travel expenses, as provided in s. 112.061. Payment may also be authorized for preapproved child care expenses or lost wages for members who are consumers of the department's services and for preapproved child care expenses for other members who demonstrate hardship.

(g) Members of a community alliance are subject to the provisions of part III of chapter 112, the Code of Ethics for Public Officers and Employees.

(h) Actions taken by a community alliance must be consistent with department policy and
state and federal laws, rules, and regulations.

(i) Alliance members shall annually submit a disclosure statement of services interests to the department's inspector general. Any member who has an interest in a matter under consideration by the alliance must abstain from voting on that matter.

(j) All alliance meetings are open to the public pursuant to s. 286.011 and the public records provision of s. 119.07(1).
HISTORY OF COMMUNITY ALLIANCES
Community-Based Care is the Department’s overarching strategy to build partnerships in the community, which significantly impact the quality, effectiveness, and efficiency of services to children and their families at the local level. The formation and support of Community Alliances is a key to the success of this initiative. Per 20.19, F.S. the Department and the Legislature have deemed Community Alliances as the central point for broad-based community input and collaboration. Our challenge is to determine how we can most effectively engage our community partners and sustain their role and influence over time.

One Community’s Story

In Sarasota County, where the Department’s first Community-Based Care program was initiated, the first step the District Administrator and Lead Agency took before planning the transition of child protection services was to convene a meeting of local stakeholders. Key stakeholders from the school system, Juvenile Justice Program, Department of Health, County Commission, Court, medical community, law enforcement, other social services agencies, and family advocates have personally and professionally made contributions to the department’s mission of “working in local partnerships”. This group’s support, guidance, commitment, oversight, and vision over the past four years has contributed greatly to the development and success of this program and improved outcomes for children and families in their community.
With the support of this Alliance, the Lead Agency and the Department, in this community we have seen:

- A community which better understands the dynamics of abuse and neglect and has learned ways to heal and strengthen families.
- A community that understands the importance and value of other specialized programs and agencies working together, not separately.
- Agencies willing to pool their resources and seek other financial supports to provide more effective, efficient services to greater numbers of children and families.
- Stakeholders that analyze outcome data, then question and create solutions for improvement and higher quality.
- Advocacy groups, consumers and other concerned citizens that have a voice in shaping the local system of care through a continuous needs assessment process.
- New programs that are developed in the community because of a documented unfulfilled need.
- A group that is vigorously working on solutions for staff turnover because they realize how this adversely affects families.
- And finally, a community that has taken personal responsibility for the success or failure of this program, and the outcomes for children and families

This stakeholder group, with its strong and yet constantly evolving focus, became the inspiration for last year’s legislation, which called on all communities to establish a similar Alliance. Community-Based Care cannot just be a contractual relationship between the Department and Lead Agency to provide child protective services. This contractual arrangement in itself does not guarantee better outcomes for children and families.

We are fortunate to have other communities that already have an existing group or the framework for one that is specifically focused on the needs and outcomes of its citizens. Other communities are discussing ways to combine, expand or redirect existing coalitions or
workgroups to incorporate the Community Alliance legislative mandate.

Legislation and Innovation

While the legislation in Chapter 20.19, F.S. listed specific duties for Community Alliances; it did not limit the scope. As stated in the statute, Community Alliances will provide for resource utilization and development, needs assessment, establishment of community priorities, development of outcome goals, provision for community education and advocacy, and promotion for prevention and early intervention services. Many Community Alliances, in partnership with the Department, will expand this scope either initially or gradually over time.

The same applies to the mandated membership list, which can be expanded after the by-laws are created, or later amended. Again membership and the “way of work” of the Alliance is a community decision. Community Alliances may establish workgroups or committees to address specific issues. These workgroups may include stakeholders who are not members of the Community Alliance including: local providers, department staff, advocacy groups, consumers, and others. These valuable contributors can influence their community and work with the Alliance without being an official Alliance member. An Alliance should always be about community partnerships and collaboration.

The Legislation creating the Alliances provides a basic framework for a true partnership while allowing for many possibilities regarding its mission, vision and scope. The mission and goals of the newly formed Alliances can vary widely in scope and function. Some communities are considering the entire span of service delivery for a wide span of populations while some Alliances are fairly narrow in their focus. Alliances are encouraged to modify and expand their mission and goals, to reflect community interests and development.
The Partnership

The Legislature and the Department are very clear in the role they envision for the Community Alliances; a role of community involvement that exercises a determining influence on the outcomes of children and their families. The influence of the Community Alliance is not a direct authority over the Department, but constitutes a collaborative partnership relationship. With this influence, the Community Alliance can have a tremendous impact on how its citizens are served.

The role and function of Alliances is essential for the Department to more effectively carry out its mission “to work in partnership with local communities”. The Department and the Legislature have deemed Community Alliances as the central point of contact for broad-based community input and interagency coordination. Alliances offer the opportunity for a community to truly demonstrate that the whole is far greater than the sum of its parts.

Nationally, communities that have been most successful in implementing a highly effective system of care for children and their families are truly community-based and family-focused. It is important to have a collaborative infrastructure such as the Community Alliances where systems and families come together to strategically plan for a better system of care. The Florida Legislature has given the communities in Florida the opportunity to share in a meaningful way for this successful outcome.
CITRUS COUNTY, DISTRICT 13 PAPER
USING A SHARED SERVICES NETWORK AS THE COMMUNITY ALLAINCE

Citrus County decided to build on the working relationships of an existing group rather than start a new one.
COMMUNITY ALLIANCES STRUCTURE
ALTERNATIVES

Using the Shared Services Network Structure as the Community Alliance
Citrus County, District 13

Citrus County, District 13, has an active Shared Services Network ending their third and final year of operation. The key members of the Community Alliance decided to cut down on some of the duplication of required meetings by altering the membership of the Shared Services Network to meet the mandatory requirements of FS 20.19 for Community Alliances and combining the intent and work of both bodies. The advantages for this action are:

- Use the established community working relationships to take on the responsibilities outlined for Community Alliances
- Adjust the current membership to accommodate the membership requirements for Community Alliances and eliminate any possible conflict of interest
- Fund, jointly by existing members, the existing well-trained facilitator to take on the work of the Community Alliance
- Develop by-laws that will put all of the above requirements and expectations into writing.

MEMBERSHIP CHANGES
The Shared Services Network’s Executive Roundtable consisted of leaders in the community and service providers. The membership included most of the required members for the Community Alliances. Members of the Shared Services Network in addition to those outlined for the Community Alliance, but not considered service providers, are:

- Representative of the State Attorney,
- Representative of the Department of Health
- Representative of the Community College
- Representative from the Department of Juvenile Justice
The only required Community Alliance members missing are:

- Representative from the Circuit Court, and
- Representative from the county United Way

The planning group decided to recommend an **eleven-member** Community Alliance with the required six members outlined in the statute for Community Alliances and five additional permanent members. The membership of the Community Alliance would then be the following:

1. The District Administrator
2. Representative from County Government
3. Representative from the School District
4. Representative from the county United Way
5. Representative from the sheriff's Office
6. Representative from the Circuit Court
7. Representative from the Community college
8. Representative from the Department of Health
9. Representative from the State Attorney's Office
10. Representative from the Department of Juvenile Justice
11. Representative from the Ministerial Alliance

The planning committee felt that it is vital to the success of the Community Alliance that the head of the member organization, or someone in the organization able to make decisions, be named the representative and attend each of the Community Alliance meetings.

The service providers that now sit on the Shared Services Network will become the Steering Committee of the Community Alliance, as a permanent Standing Committee. Membership of the Steering Committee would be expanded to include **all** of the providers of child and family services in the county, family members, representatives of advocacy groups, representatives of the Foster Parent Association. The Steering Committee would have a major function in the work of the Community Alliance but would **not**, by adoption of their by-laws, be a **voting** member of the Alliance.
The District 13 Administrator pledged a dollar amount to help jointly fund the existing Shared Services Network facilitator to continue in her position and be the facilitator for the Community Alliance. She will work closely with the District’s Community Based Care Coordinator is responsible for developing the Community Alliances in the District’s five counties.
DISTRICT 15 CONCEPT PAPER
FOR THE DEVELOPMENT OF A
FOUR COUNTY COMMUNITY ALLIANCE

This Community Alliance structure is based on the successful Shared Services Networks in this four-county district.
This paper is written for the benefit of the Shared Services Networks of Indian River, Martin, Okeechobee and St. Lucie Counties. The paper is designed to answer questions and provide information about using the community based care initiative to create a Four County Community Based Care Initiative.

1. Why was the decision made to ask the four Shared Services Networks to consider forming a Four County Community Based Care Alliance

The four counties of Martin, Indian River, St Lucie, and Okeechobee share many of the same regional and local issues, concerns, and values. There is a history in our four county area of working together. And, it is important to note that the four county area, as a whole, includes a strong legislative base for support. In addition to these reasons, there are significant and numerous additional reasons to work together as a Four County Region to implement Community Based Care:

- The implementation of Community Based Care for child welfare may be the driving force now, but it is believed that other Department of Children and Families services will eventually be privatized. This will require significant planning and support from the leaders in the four county area.
- All of the counties desire a **seamless and integrated** approach to children's services, AND a data driven, comprehensive and integrated approach to **funding decisions**.
- Data driven decision-making, service gap analysis and community service capacity building efforts within the four county area should build on community strengths. These efforts can be best done when major funders collaborate in decision making while representing individuals and legal mandates and responsibilities.
- These exists Shared Service Networks in each of the four counties.
- The Shared Services Networks have a stated mission and purpose that is closely aligned with the concepts of Community Based Care.
- Shared Service Networks include as members the major governmental agencies and respective Department Heads, as well as other critical community leaders, all who are able to impact, change or develop policy, and make funding decisions.
- The organizational structures of the Shared Services Networks in each county create natural springboards to form a Four County Alliance.
- The Community Based Care effort must have the support and ongoing guidance and direction from leaders in all four counties, and it seems to make sense to approach the task in this manner.
• A Four County Alliance can guide and direct the development of a Community Based Care child protection system that includes shared decision making and purchasing.

In summary, there are key concepts related to Community Based Care that must be maintained. Community Based Care approaches has the best chance of achieving outcomes when the community as a whole is invested in the process.

• The creation of a "Community Based Care Alliance" would ensure the integrity of the community-based system by maintaining, through formal structures, the community's involvement.
• The Community Based Care system will achieve outcomes only if all service systems are integrated across agencies (child welfare, juvenile justice, school systems, mental health, health, and all other systems impacting the lives of children and families).

The Alliance will facilitate a process where shared decisions about the nature and cost of services provided to children and families will enhance the integration of systems; thereby reducing unneeded barriers and service inefficiencies.

2. **How will a Four County Community Based Care Alliance be formed?**

It has been clearly articulated that the Department does not intend to impose a top down structure, but rather intends to support all facilitate the development of various types of community initiatives. This can include informal stakeholder groups, alliances, purchasing alliances, etc. Individual communities are free to decide which type of arrangement(s) suit them best, and would depend on the level of leadership and commitment in the community.

The design and structure of a (currently District Fifteen) Four County Community Based Care "Alliance" will ultimately be determined by the vision that is articulated by the major funding agencies, the Shared Services Networks in each County, and the Department of Children and Families. There are several models successfully operating nationally which may offer some beginning ideas for the community to consider.

3. **Can the Alliance be the Lead Agency?**

Funding agencies and polity makers who join forces to create a system of shared decision making are not intended to be providers or "administrative services organizations." In Florida, alliances are not "risk bearing" entities, not to say that this not possible if the community wishes to create such an organization. The current law indicates that the Department of Children and Families will contract with a single Lead Agency, a not for profit organization, with national accreditation. The Law
mandates that the Lead Agency be the "risk bearing" entity. Therefore, the Lead Agency has signification need to control risk. Lead Agencies must be willing and capable of serving all children, regardless of funding, provided that all funding is transferred. In a nutshell the Lead Agency must act as a managed care organization, and must provide strong utilization management.

It is hoped that the four counties of Martin, Okeechobee, St. Lucie and Indian River will choose to form a Community Based Care Alliance. The Alliance would provide a vehicle for shared funding decisions to be made, and would provide strong oversight and feedback to the Lead Agency and community. The relationship between the Lead Agency, the Alliance and the community can be very, very innovative and can have a significant impact on the service delivery system in each of the four counties. The Alliance may choose to move toward a position that would enable the entity to accept funds, and governance responsibility.

In closing, the Community Based Care initiative is as exciting as it is daunting. The design and implementation of a quality community-driven child protection system will take the effort and commitment of everyone. Together we can build and maintain a system that will provide successful outcomes for all of the children in our care.
EXAMPLE OF COMMUNITY ALLIANCE INITIAL MEETING AGENDA
Brevard Community Alliance
Initial Meeting
Two-Hour Time-Frame

Quick Introductions & Overview 25 minutes
Establish Temporary Chair 10 minutes
Process Delineation for Adding Members 25 minutes
By-Laws Process and Promulgation 20 minutes
Establish Vision/Mission Beliefs/Values 30 minutes
Adjourn with Next meeting date/location specified 10 minutes

(Goal is to get In and Out as quickly as things (products) may be accomplished!)
EXAMPLE OF
SUMMARY MINUTES from Districts 7 and 13
Citrus County in District 13 combines the agenda and the summary minutes into one concise document.
SUMMARY MINUTES
DISTRICT 15 SHARED SERVICES ALLIANCE OF OKEECHOBEE
AND THE TREASURE COAST
September 22, 2000

MEMBERS PRESENT:

Judge Burton Conner
Valerie Gryniuk
Joyce Johnston-Carlson
Nan Griggs
Jim Kirk
Judge Steve Levin
Vern Melvin
Beverly O’Neill
Ben Robinson
Diane Walgren
Dennis Williams
Harry Yates

- Welcome by Harry A. Yates

- Harry Yates gave an update on by-laws and finalization of the by-laws at today’s meeting.

- Discussion ensued regarding F.S. 20.19 being included in the by-laws. A MOTION was made by Judge Conner and seconded by Beverly O’Neill to amend Article 4, to include Section 4.1.a. “additional authority pursuant to article 20.19”. MOTION CARRIED.

- Executive Committee – Discussion ensued regarding members of the executive committee. A MOTION was made by Beverly O’Neill to add a treasurer to the officers, motion was seconded by Jim Kirk. MOTION CARRIED. Amend Section 5.3.4 to add treasurer to list of officers. The officers and district
administrator will make up the executive committee, this ensures that all four counties have equal representation.

- Nan Griggs made a **MOTION** to appoint Beverly O’Neill as treasurer seconded by Harry Yates. **MOTION CARRIED.**

- Foster Parent Appointment – Vern Melvin informed the alliance members that the Foster Parent Association of all four counties were contacted regarding their position on who would represent them, the Association chose Mary Harding of Martin County.

- November/December meeting dates – A **MOTION** was made by Valerie Gryniuk to have a joint meeting on December 8th, motion seconded by Beverly O’Neill. **MOTION CARRIED.**

- Presentation by Vern Melvin on Community Based Care, Building a Better Life for Children and Families in District 15. Brief overview of Community Based Care thus far.

- Harry Yates suggested the December 8th meeting be extended to noon so that the members can invite Chris Carr to discuss his model regarding Community Based Care.

- Judge Conner expressed concern with how to design a model to best serve the needs of the children in District 15 and reduce re-entry into the system.

The meeting was adjourned at 10:34 a.m.
AGENDA

1) Welcome & Introductions…………..…….....Pete Kelly, Superintendent
2) Approval of previous meeting minutes

3) FOCUS DISCUSSION

*Department of Children & Families Community Alliance

- Membership (vote on additional CEO positions)
- Vision/Mission
- By-Laws

*Meeting Issues

- Appoint CEO Roundtable Chair
- Set calendar in advance: Thursday, December 21?

4) Miscellaneous/Announcements

***Minutes from October 19 meeting:

- After welcome and introductions, minutes from 9-21-00 approved.
- George Magrill, YFA President, made a presentation about their new 18-bed runaway shelter; they hope to break ground in January 2001 and complete the construction in June.
- Pat Howard and Janice Johnson of DCF led the Roundtable in a discussion about Community Alliance issues; CEO members reviewed the recommendations of the special Community Alliance committee.
- The special committee stressed that SSN and Community Alliance will be one organization now; there will not be two separate meetings.
- CEO members agreed the right people must commit and attend; Supt. Pete Kelly felt that this group has the potential to be very powerful in terms of future decisions concerning funding; members wanted the Alliance only for Citrus County.
- Pat Howard said it’s a good idea to stand alone now, but to have chairs from each county in the district meet in the future would be beneficial.
- After discussion about restructuring the SSN framework, CEO members voted to accept the proposal, but agreed to vote on the additional Roundtable positions at the next meeting.
EXAMPLES OF PRINCIPLES/VALUES

HILLSBOROUGH COUNTY and
SARASOTA COUNTY
DISTRICT 13
DISTRICT 15
TEXAS
HILLSBOROUGH KIDS, INC. CONCEPTUAL SYSTEM OF CARE

Guiding Principles

Our guiding principles, as determined by numerous strategic planning activities in the community, seek to provide services that:

- Focus on children and are family centered
- Offer seamless, cohesive and comprehensive delivery of services
- Are culturally competent, relevant and respectful in delivery
- Provide individualized and strength-based delivery
- Emphasize prevention and early intervention
- Involve consumers, family members, and all other stakeholders
- Offer an array of fully-integrated, coordinated, and non-duplicated services
- Maximize existing resources
- Create new resources
- Develop non-specific, non-categorical funding
- Provides continuous quality assurance and improvement
COMMUNITY PARTNERSHIP FOR COMPREHENSIVE SERVICES

Mission

This coalition of community based agencies provides comprehensive services to children and families needing services due to abuse and/or neglect through a collaborative effort that unites our resources, holds all parties accountable to specific standards of care, evaluates performance and distribution of resources based upon specific and measurable outcomes, holds permanency of the child's living arrangement and the continuity of relationships for the child as the primary goals, and provides these services through an inclusive and informative relationship with the community and with the state.

I. Principles

A. Services will be provided with the safety and best interest of the child as our first consideration.

B. Foster care adoption and protective services is a community effort and issue. We shall involve the community through a Stakeholders Advisory Committee, the involvement of volunteers, the solicitation of donations, and annual participation in the evaluation of services.

C. This system of care will be held accountable for the provision of high quality care in the most efficient manner. We shall establish internal standards of care for each service being provided. There will be a continuous quality improvement system throughout the continuum of care. Measurable outcomes will be established. There will be an annual independent audit of the entire system. There will be competency based training for foster parents and staff.

D. All resources will be used in the most efficient method to reach the stated outcomes with families receiving services expected to contribute, whenever feasible.

E. We believe the State of Florida, the school system, the courts, law enforcement, foster parents, local governments, churches, the child and
family, local businesses and foundations as well as other community organizations are critical partners in attaining successful outcomes.

F. Services will be delivered through a rapid response and attentive approach. No family or child receiving services will go more than a week without direct contact (phone contact or face to face visit) unless a decision to reduce services is made by a formal staffing process or court order.

G. This system of services will develop concurrent planning that assures strategies for service and permanency regardless of the turns a particular family may take over the course of their involvement with this Coalition.

H. There will be a "single point of entry" approach that assures the children and families consistency of treatment, reduction of duplication of services and efforts, a match of children and their alternative care provider to allow for a successful placement, and establishment of a plan of service based upon a comprehensive assessment.

I. There will be an individualized case plan developed for each child and family receiving services, including input from the child and family, which will direct the course of intervention throughout the time of service.
These guiding principles were developed at the statewide forum sponsored by the Children’s Home Society. These principles were adopted as the guide for participants working together during all of the subsequent regional and local forums. The principles are:

1. The care of dependent children and assistance to their families must be a community responsibility involving critical partners such as the child and family, the State of Florida, foster parents, the school system, the courts, law enforcement, the faith community and other community organizations.
2. The system of care will be child safety focused, family-centered, respectful of individual needs, outcome-based, and directed toward the achievement of timely permanency.
3. Families and children in the system of care will experience responsive, flexible, relationship-based services from competent staff who maintain frequent contact to assist the family toward the timely achievement of self-sufficiency.
4. The system of care must be designed using an inclusive and participatory planning process. System changes will be appropriately phased-in and targeted to produce improved client outcomes through efficient resource management.
5. The local provider network is indispensable as the foundation for an orderly transition of child welfare services from the public to private sector.
6. Integrity is the core value of the privatized system creating a sense of normalcy for children through communication and developing trust relationships with the various stakeholders in the child welfare system.
7. Relationships within and between the users and providers of services are paramount in fostering a cooperative community voice regarding the protection of children.
8. Adequate resources will be required to address the myriad of issues in child protection and each community must participate in the mobilization of these resources.
9. Accountability will be required at all levels to assure equality of treatment through standard approach to develop a system that is outcome-based and data driven.
10. All stakeholders will be brought together with the intention of developing a common language and planning for the implementation of privatization.
DISTRICT 15
SYSTEM OF CARE
SERVICE/DELIVERY PRINCIPLES

1. Services will be provided with the safety and best interest of children as the first consideration.

2. Equitable services will be available to children and families in their residential county.

3. Services will be provided closest to the child and family’s natural setting, to include but not limited to, home, school, and other community-based settings. Provider settings will be utilized only by family choice or until natural setting provision of service is operationalized. Provider facilities will remain the location for service delivery if best practices require isolation from natural settings.

4. Services will be available in levels of intensity to accommodate a customized service plan.

5. Service plans will be considered dynamic documents, supporting changing child and family needs.

6. Time and location for service plan creation/amendment meetings will be flexible to allow family participation. All meetings involving plan creation/amendment will be held with family presence and active participation.

7. The family service plan will capitalize on the strengths of the child and family, while addressing their needs.

8. The comprehensive assessment tool utilized with children/families will address needs of the entire family. This tool will guide the creation of the family service plan, with appropriate providers at the table to pledge services and resources to support the plan at the time of its creation. Informal community supports will also be offered to the family by their representatives at the initial planning meeting. This collaboration of department, agency, and community providers to develop a child/family service plan will coordinate planning, funding and delivery of services to meet needs without duplication.

9. Services will be provided in a manner that preserves the rights and dignity of all children and families.

10. Planning for families will be done on concurrent multiple tracks, as necessary to assure the child a sooth transition toward permanency regardless of final placement.
11. A comprehensive assessment will be done with the birth family and child immediately upon initial referral into shelter care. Children will leave shelter care with an individualized service plan addressing all needs identified at that time. The service plan will be amended whenever the child experiences a change in placement, with previous/future caregivers in attendance to share relevant information regarding the child. All individual plans of service form providers will be included in the family service plan. Proposed revision or discharge from provider services will require a meeting to amend the family service plan.

12. Service planning will be sensitive to cultural, ethnic and disability issues.

13. The lead agency will examine categorical funding streams/revenues of providers and departments to determine if they can be converted to flexible funding to support individualized services for children and families.

14. System effectiveness and performance will be evaluated formally through outcome measures. These measures will reflect federal, state, and local community expectations of the system to meet the needs of children and families. System success will also be determined by the use of family survey instruments and the creation of a volunteer Stakeholders Council, advising the lead agency of continuing deficits/challenges.

15. The Lead Agency will contract for effective/efficient services, and hold providers responsible for creating new capacity and new services as identified in family service plans to address unmet needs.

16. Interagency and community provider agreements to allow participation in funding/service commitments to the Wraparound process will be developed. These documents will be held at the Lead Agency so monitors can track the effectiveness of the Lead Agency and their providers in creating a community-based approach for children and families services.


18. All staff who coordinate or provide services to families will be both skilled and educated in their tasks, with training provided to maintain and improve staff capability. Training of foster/adoptive families will be provided side-by-side with professional staff at no cost to participants, when subject matter is beneficial to the child in care.

19. Families may change family service coordinators within the Lead Agency if the relationship becomes irreparably unsatisfactory.

20. The lead Agency will provide family service coordinator will coordinate the match of children with their alternative care providers, as necessary.
21. The Lead Agency will provide family service coordination as their only service to children and families to establish a family-centered, family choice principle of service delivery. Brokering services from a related, parent or subsidiary organization concerned with capacity utilization or profit is detrimental to family choice and perceived as a conflict of interest. Services will become more creative, innovative, flexible, and cost-efficient within a competitive environment.

22. Family service coordination will be accomplished within the family’s residential county.

23. Family service coordinators will become the child’s first and continuing source of advocacy and support. Coordinators will be responsible for collecting updated information from providers and participating in court hearings.

24. A specific family service coordinating team will follow the child/family from intake to discharge form services identified in the family plan.

25. Mental health services provided to the child/family will maintain continuity of therapeutic relationship across placements.

26. Families relocating within the four-county area will experience no disruption of services if the Lead Agency receives advance notice to convene a service plan amendment meeting.

27. Families experienced with the system of care will have the option to work as paid peer advocates/mentors on the family service planning team of families entering the system of care.

28. Housing supports to families in the system of care will be independent of other services (once this need is identified and provided through the service planning process.)
TEXAS

PRINCIPLES OF A SYSTEM OF CARE

Principles

• Families are important and necessary partners in the development and implementation of an integrated service delivery system.
• Local control allows for better decision making and enhances community development.
• Managing funds and providers through a single local entity will produce better outcomes for children and families.
• Pool funding across child serving agencies to provide flexible and individualized services;
• Create one point of entry into care to improve access;
• Utilize a wrap-around approach to ensure individual treatment plans and improved outcomes;
• Strengthen family partnerships to improve overall quality;
• Develop independent care coordination for seamless services;
• Utilize informal and formal supports to assure children remain in the community; and
• Support community and neighborhood based providers to strengthen cultural competence.
DISTRICT 7
WORKSHEETS TO HELP DEVELOP
A
VISION / MISSION
Vision Statement Paper

A Vision Statement is a very brief declaration that tells the public some of the goals for this Alliance. The rules for a vision statement are:

1. It should be brief, under 10 words if possible.
2. It should be catchy and easy to remember.
3. It should be inspiring and a challenge to future achievement.
4. It should be believable and consistent with the strategic values and mission of the Alliance.
5. It should serve as a rallying point with important stakeholders.
6. It should clearly state what the Alliance must become.
7. It allows for flexibility and creativity in execution.

The Visioning Exercise

Visioning generates a common goal, hope, and encouragement; offers a possibility for fundamental change; gives people a sense of control; gives a group something to move toward; and generates creative thinking and passion.

But remember:

A vision without a plan is just a dream. A plan without a vision is just drudgery. But a vision with a plan can change the world.

Sample Vision Statements

US Air Force Research Laboratory

The Best People providing the Best Technologies for the World's Best Air Force.

Millecom

To create a better networked society by providing world leading communication solutions.
The Close Up Foundation

The Close Up Foundation will be the most innovative, inclusive, multifaceted, effective, and respected organization in civic education.

SEAL IT Corporation

A company is driven by its people, and people by their hearts and desires. Discover what is at the heart of SEAL IT.

Coca Cola Corporation

A Coke within arms reach of everyone in the world.

City of Gillette, WY

The Mission of the City of Gillette is to work in harmony with the Community to provide exceptional service and facilities addressing the needs of our progressive community now and into the future.

Orange County (CA) Social Service Agency

Orange County residents will enjoy a safe and supportive environment that promotes stability and self-reliance.

IGF Insurance Company

Committed to growth and success through quality, service and integrity to be the world leader in agricultural business risk management innovation, programs and performance.
The Visioning Questions

The following questions will help the Alliance create a strong visioning statement to guide our organization.

1. What do I see as the key to the future of our Alliance?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

2. What unique contribution should our Alliance be making in the future?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

3. What would make me excited about being a part of this Alliance in the future?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
4. What **values need to be stressed** in our Alliance?

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

5. What should be our Alliance’s **core competencies**?

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

6. What should be our **position** toward our customers, the public, the providers, etc.?

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

7. In what area do I see the Alliance’s **greatest opportunity for growth**?

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________
Key Words to Create A Vision Statement

- We will be seen in our community as . . .
- Our customers will recognize that . . .
- We will be the best in . . .
- We will become a major presence in . . .

Our Vision Statement

The Vision Statement for this Alliance should be:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________
EXAMPLES OF VISION/MISSION STATEMENTS:
SARASOTA COUNTY
HILLSBOROUGH COUNTY
WRAPAROUND MILWAUKEE and DAWN PROJECT, INDIANAPOLIS, INDIANA
COMMUNITY PARTNERSHIP FOR COMPREHENSIVE SERVICES

Mission

This coalition of community based agencies provides comprehensive services to children and families needing services due to abuse and/or neglect through a collaborative effort that unites our resources, holds all parties accountable to specific standards of care, evaluates performance and distribution of resources based upon specific and measurable outcomes, holds permanency of the child's living arrangement and the continuity of relationships for the child as the primary goals, and provides these services through an inclusive and informative relationship with the community and with the state.
HILLSBOROUGH KIDS, INC. CONCEPTUAL SYSTEM OF CARE

Mission

Our mission mandates that we oversee and coordinate a system of care assuring the safety and permanency of Hillsborough County children and families whom are now, or have been, at risk of abuse or neglect.

Targeted Population

As our mission states, HKI seeks to serve children and families who have experienced child abuse and/or neglect. We also work with those who, as defined in Chapter 39 of the Florida Statutes, are at risk of abuse or neglect. Our designed system includes multiple entry points for community members. These entry points seek to serve families; make referrals; and quickly access resources, services and supports.
Wraparound Milwaukee Vision

The Vision of Wraparound Milwaukee is to support, strengthen and empower families and children so they may live happier, healthier and productive lives safely in a community without prejudice or discrimination, and to encourage hope, self-worth and the ability to reach their dreams.

Wraparound Milwaukee Mission

- Promote collaboration among the Child Welfare, Juvenile Justice, Mental Health and School systems in equal partnership with families.
- Provide individualized and comprehensive care to families in the community in which they live.
- To be equal partners with families at all levels of decision-making concerning the design, development and implementation of Wraparound Milwaukee.
- Promote cultural competency and cultural diversity in the creation and provision of mental health services.
- Create and provide cost effective community-based alternatives to residential treatment and psychiatric hospitalization.
- Continuously improve the quality of Wraparound Milwaukee by evaluating outcomes and promoting change.
MISSION STATEMENT
The mission of The Dawn Project is to provide new and improved levels of help and assistance to children with serious emotional disturbances and their families. This mission is founded in the belief that children and their families are remarkably resilient and capable of positive development when provided with community centered support, truly defined by what is in the best interest of the child.

GUIDING PRINCIPLES
♦ People best develop by remaining with their families or being supported by them.
♦ The definition of “family” is varied: each family has its own special qualities.
♦ Most families have the potential and the desire to change.
♦ The dignity and right to privacy of all family members must be respected.
♦ Family members themselves are crucial partners in the helping process.
♦ Services and supports must be individualized.
♦ Services must be unconditional: services may change, the commitment to make a workable plan will not.
♦ Results must be measured.
♦ Plans must consider the best mix of community and family resources as well as formal services.
♦ Services should be developmentally appropriate and fit the needs of the child.
♦ Planning and services must be timely and action-oriented.
♦ Agency funding must be flexible to the needs of the family.
DISTRICT 7 QUESTIONS TO GUIDE THE DEVELOPMENT OF BY-LAWS

This by-law worksheet was provided by District 7 and Rokicki and Associates, Inc.
By-law Options/Worksheet for the Community Alliance

The following are some options that should be considered when creating the operating By-Laws for your Alliance. We will vote on each set of options and when completed the By-Laws will be written with the “winning” options included in them.

A simple majority of the statutorily assigned members of this Alliance who are attending this meeting will decide which option(s) to incorporate into the By-Laws. The vote on the By-Laws will occur at the next meeting of the Alliance. All Alliance members will have copies of the By-Laws prior to the meeting for their review and comments. The vote to accept the By-Laws will be by super majority, 2/3rds of the members of the Alliance.

The By-Laws in general should contain the following elements:

1. The name and objective of the Alliance.
2. The qualifications of the members of the Alliance.
3. The Officers, their election, and Responsibilities for the Alliance.
4. The meetings of the Alliance, special meetings, how called, etc.
5. How to amend the By-Laws

1. The Objectives of this Alliance are:

Select those appropriate for this Alliance

- To monitor and expand resource utilization targeted at children and families.
- To assess the needs and gaps in services targeted at children and families.
- To encourage the maximum use of all community resources to aid children and families.
- To set measurable outcomes for services targeted at children and families.
- To serve as a catalyst for the development of resources targeted at children and families in this County.
- To educate the community about the needs of children and families.
• To be an advocate for children and families.
• To promote prevention and early intervention services for children and families.
• Other: ________________________________________
• Other: ________________________________________
• Other: ________________________________________

2. **Officers of the Alliance shall be:**

The Officers of the Alliance will be:

• Chair.
• Co-Chair.
• Secretary.
• Other: ________________________
• Other: ________________________

Powers and Responsibilities of the **Chair** are:

• Call and preside over regular and special meetings of the Alliance.
• To represent the Alliance to the public and at other meetings.
• Other: ________________________________________
• Other: ________________________________________

Powers and Responsibilities of the **Co-Chair** are:

• To act as chair of the Alliance in the absence of the Chair.
• To represent the Alliance in the absence of the Chair or when appointed by majority vote of the Alliance.
• To serve as membership committee chair to recruit and interview prospective Alliance members.
• Other: ________________________
• Other: ________________________

Attachment J-3
Powers and Responsibilities of the **Secretary** are:

- To have the official minutes of the Alliance taken\(^1\).
- To serve as temporary Alliance Chair in the absence of the Chair and Co-Chair.
- To coordinate the release of public meeting notices with DCF.
- Other: ___________________________________________
- Other: ___________________________________________

3. **Standing Committees of the Alliance should be:**

Please select from this list:

- Membership/Nominations Committee.
- Resource Utilization Committee.
- Client Services Committee.
- Needs Assessment Committee.
- Other: __________________________
- Other: __________________________

4. **Membership of the Alliance**

In addition to the statutorily assigned members of this Alliance, the Alliance shall have the following additional members selected from the Community:

- Three additional members of the Public.
- Five additional members of the Public.
- Seven additional members of the Public.
- Other: __________________________

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\(^1\) The Secretary may arrange for one of their staff to take the actual minutes of the meetings.
NOTE: The public members of the Alliance will be selected after the by-laws have been adopted at the second meeting. Between now and then you may nominate individuals for these public positions.

One possible addition is to select some representatives from the business community.

5. Current DCF Providers Serving On the Alliance

Shall organizations or companies currently providing services to the Florida Department of Children and Families be eligible to serve as an Alliance member?

- Yes, they may serve as Alliance Members.
- No, they may not serve as Alliance Members.
- Other: ________________________________

If the decision is No, what should happen if an Alliance member’s organization or business later offers services to the Florida Department of Children and Families?

- They must resign immediately.
- They may serve out their entire “term” on the Alliance.
- They may serve until the next scheduled time for new nominations and appointments to the Alliance.
- Other: ________________________________

6. Term of Office for the Public Members of the Alliance

How long should the public members of the Alliance serve?

- One-year terms.
- Two-year terms.
- Three-year terms.
- Other: ________________________________

a. Staggered Terms for the Public Members
Shall the terms of the public members be staggered?

- **Yes**, with one-half being given **one-year terms**, and the remainder given **two-year terms**.
- **Yes**, with one-third given **one-year terms**, one-third **two-year terms**, and one-third **three-year terms**.
- **No**, terms should not be staggered.
- **Other**: __________________________________________________________
  ______________________________________________________________________

b. **Reappointment of Public Members**

Shall public members of the Alliance be eligible for reappointment to the Alliance?

- **Yes**, they can be reappointed.
- **No**, they cannot be reappointed.

**If yes**, then:

- They may be reappointed for one additional term on the Alliance.
- They may be reappointed for two additional terms on the Alliance.
- There are no limitations on the number of appointments for public members on the Alliance.
- **Other**: ____________________________________________________________

7. **Public Members Serving as Officers of the Alliance**

Can public members serve as officers of the Alliance?

- **Yes**, they can serve as officers.
8. Quorum for doing Business

For an official meeting to occur for the Alliance, how many members must be present?

- A quorum should be over one-half of the statutorily appointed and public members of the Alliance in attendance.
- Other: ________________________________

9. Regular Meetings of the Alliance

How often, other than for special meetings, should this Alliance meet?

- Monthly.
- Once a Quarter.
- Three times a year.
- Other: ________________________________

10. Public Input during Alliance Meetings

So long as not limited by Florida statutes, should public comments be limited to a specific part of the meetings of the Alliance?

- Yes, a specific time in the agenda should be set aside for public comments.
- No, no specific time in the agenda should be set aside for public comments. Public comments may be made at anytime, when recognized by the presiding officer of the meeting.
- Other: ________________________________
11. **Other Operating Guidelines for the Alliance**

So long as there is no pre-existing Florida statute governing the operation of the Alliance, shall *Robert’s Rules of Order, Revised*, be used to control regular, special and committee meetings of the Alliance?

- **Yes**, *Robert’s Rules of Order, Revised* should be used to control meetings of the Alliance and its committees in absence of either Florida statutes, or rules contained in these By-Laws.
- **No**, *Robert’s Rules of Order, Revised* should not be used to control meetings.
- Other: ____________________________________________________________  
  ____________________________________________________________

12. **Vote Required to Adopt the By-Laws and to Amend them**

What “majority” should be used to adopt and amend the By-Laws of the Alliance?

- A simple majority of the members present.
- A simple majority of all of the members of the Alliance.
- A super majority of all of the members of the Alliance *(2/3rds)*.
- Other: ____________________________________________________________

13. **The name of the Alliance for this County should be:**

- The Alliance for Children and Families of XXXX County, or
- The XXXX Alliance for Children and Family’s Issues, or
- The XXXX County’s Alliance for Children and Families, or
- Other: ________________________________
14. Other Operational Topics for the By-Laws

- 
- 
- 
- 
- 
-
EXAMPLES OF BY-LAWS

DISTRICT 15

DISTRICT 12

SARASOTA STAKEHOLDERS
DISTRICT 15
SHARED SERVICES ALLIANCE OF OKEECHOBEE &
THE TREASURE COAST

BYLAWS

ARTICLE I. NAME

SECTION 1.1 The name of this organization shall be the SHARED SERVICES
ALLIANCE OF OKEECHOBEE & THE TREASURE COAST
(hereinafter called the ALLIANCE)

SECTION 1.2 The designated service area of the ALLIANCE shall be the Indian River,
Martin, Okeechobee and St. Lucie Counties, Florida

SECTION 1.3 The principal office and place of business of the ALLIANCE shall be located
as so designated by the ALLIANCE.

ARTICLE II. MISSION

SECTION 2.1 The mission of the ALLIANCE is to provide the opportunity for all children
to reach their full potential.

ARTICLE III. PURPOSE

SECTION 3.1 The purpose of the ALLIANCE shall be, but not limited to the following;

3.1.1 Joint planning for local resource utilization in the community.

3.1.2 Needs assessment and establishment of community priorities for
service delivery.

3.1.3 Determining and evaluating community outcome goals.
3.1.4 Serving as a catalyst for community resource development.
3.1.5 Providing for community education and advocacy on issues related to delivery of services.

3.1.6 Promoting prevention and early intervention services.

3.1.7 Facilitating interagency communication.

SECTION 3.2

The ALLIANCE is a forum through which services for children mandated and funded by state and federal government are planned, organized and coordinated.

SECTION 3.3

The ALLIANCE shall use shared services and resources to achieve its mission and purpose.

ARTICLE IV. ALLIANCE GOVERNANCE

Section 4.1

AUTHORITY The governing authority of the ALLIANCE shall be invested in the ALLIANCE who shall have and exercise any and all powers in the management of the business and affairs of the ALLIANCE.

Section 4.2

COMPOSITION: Membership, governance and committees shall insure equal representation from each of the counties participation. The county representative shall be the Chairman of the Board or Executive Director (CEO) of a corporate entity that designates funding for children’s issues or the Chairman of the Board or Executive Director (CEO) of an agency with statutory requirement to deal with children’s issues.

Membership: the alliance shall consist of the following members:

1. District DCF administrator
2. Circuit/District Juvenile Justice Manager
3. Chairman or Executive Director of the Workforce Development Board
4. Five members from each of the participating counties appointed by the Executive Roundtable of that county.
5. Representative of the Circuit Court.
6. Foster Parent Representative.
SECTION 4.3  TERM OF SERVICE: Each ALLIANCE member shall serve a term of service, according to the following:

4.3.1 Districtwide Mandated Positions ALLIANCE members shall serve without limit of term coincident to eligibility.

4.3.2 County Representative Positions ALLIANCE members serving as representatives of their respective Shared Services Network and are not the designated mandated position as described in section 4.2.1 above, shall begin a staggered (2-2 year, 2 – 3 year, and 1 – 4 year) term of service as appointed by their respective Shared Service Network and shall serve three years thereafter until such term is repealed by the appointing Shared Services Network.

SECTION 4.4 VACANCY  If a vacancy shall occur among the ALLIANCE’S membership, the appointing/electing authority at its earliest convenience shall fill such vacancy. A member so appointed/elected shall serve for the unexpired position of that term of service.

SECTION 4.5 MEETINGS  The ALLIANCE shall meet at least 12 months of the first calendar year and quarterly thereafter.

SECTION 4.6 QUORUM  A majority of the ALLIANCE membership shall constitute a quorum necessary for official conduct of meetings of the ALLIANCE.

When a quorum is present, a majority vote of those members present and voting shall prevail in the decision of any matters brought before the meeting of the ALLIANCE, except where prescribed by these Bylaws.

SECTION 4.7 OFFICIAL FUNCTIONING The ALLIANCE shall operate as a public body, covered under provisions of the section 286.011 and the public records provision of section 119.07(1).

4.7.1 All meetings of the ALLIANCE shall be open to the public.

4.7.2 Members of the ALLIANCE are subject to the provisions of part III of chapter 112, the Code of Ethics for Public Officers and Employees.

SECTION 4.8 COMPENSATION Members of the ALLIANCE shall serve without compensation.
Members of the ALLIANCE may be reimbursed for actual and necessary expenses incurred in the performance of their official duties, subject to ALLIANCE approval.

ARTICLE V. OFFICERS

SECTION 5.1 COMPOSITION The Officers shall be Chair, Vice Chair and Secretary.

SECTION 5.2 ELECTION/TENURE/VACANCY All officers shall be elected by the ALLIANCE from among its members.

5.2.1 Each Officer shall serve for a one (1) year term. However, no Officer shall serve for more than two (2) consecutive terms in the same office.

5.2.2 The Nominating Committee shall present a slate of officers to the ALLIANCE at the October ALLIANCE meeting of each year.

5.2.3 Officer elections shall take place in November of each year.

5.2.4 The term of office for all Officers shall begin on January 1\(^{st}\) of each year.

5.2.5 Officer vacancies may be filled by the ALLIANCE at any regular meeting of the ALLIANCE, or at a special meeting called for that purpose.

5.2.6 No two (2) officers shall be from the same county. Districtwide positions shall not constitute representation of any one (1) county.

SECTION 5.3 POWERS AND DUTIES The Officers shall have such powers and duties as generally ascribed to their respective offices, and such further powers and duties as from time to time may be conferred by the ALLIANCE, including but not limited to the following:

5.3.1 Chair - preside at all meetings of the ALLIANCE; appoint the chair of ALLIANCE committees, serve as an ex-officio member
5.3.2 Vice Chair - exercise the authority and fulfill the duties of the Chair in the absence of that Office; and exercise such other duties as may be assigned by the Chair.

5.3.3 Secretary - maintain a current roster of the membership of the ALLIANCE; prepare a Record of Proceedings of all meetings of the ALLIANCE; serve as chair of the ALLIANCE’s Nominating Committee; and exercise such other duties as may be assigned by the Chair.

ARTICLE VI. COMMITTEES

SECTION 6.1 EXECUTIVE COMMITTEE The ALLIANCE shall empower an Executive Committee whose membership shall be:

1. Chair
2. Vice-Chair
3. Secretary
4. District Administrator

SECTION 6.2 COMMITTEES Will be appointed as deemed necessary and appropriate.
ARTICLE VII. RULES OF ORDER

SECTION 7.1 MEETING PROCEDURES All meetings of the ALLIANCE will be conducted according to generally accepted procedures for the conduct of meetings.

7.1.1 Should a procedural dispute arise, the official presiding will seek consensus on dispute resolution among the members present.

7.1.2 If the procedural dispute cannot be resolved in a reasonable amount of time, the most recently published version of Robert's Rules of Order will be used to resolve the disputed procedure.

ARTICLE VIII. AMENDMENTS

SECTION 8.1 PROPOSED AMENDMENTS These Bylaws may be altered, amended, or repealed, either in part or in entirety, upon written notice of the proposed changes to the duly appointed/elected membership of the ALLIANCE at least 30 (30) days prior to the date of the ALLIANCE meeting at which the proposed changes will be considered and acted upon.

SECTION 8.2 AMENDMENT APPROVAL These Bylaws (and any future alteration, amendment, or repeal to these Bylaws) shall require approval by an affirmative vote of two-thirds (2/3) of the duly appointed/elected membership of the ALLIANCE.
ARTICLE I. NAME

SECTION 1.1 The name of this organization shall be the COMMUNITY ALLIANCE OF FLAGLER AND VOLUSIA COUNTIES (hereinafter called the ALLIANCE)

SECTION 1.2 The designated service area of the ALLIANCE shall be the Flagler and Volusia counties, Florida

SECTION 1.3 The principal office and place of business of the ALLIANCE shall be located at the Daytona Beach Regional Service Center, 210 North Palmetto Avenue, Daytona Beach, Florida.

ARTICLE II. MISSION

SECTION 2.1 The mission of the ALLIANCE is to provide (to be included at a later date)

ARTICLE III. PURPOSE

SECTION 3.1 The purpose of the ALLIANCE shall be, but not limited to the following;

3.1.1 Joint planning for local resource utilization in the community including resources appropriate to the Department and any funds that local funding sources choose to provide.

3.1.2 Needs assessment and establishment of community priorities for service delivery.
3.1.3 Determining and evaluating community outcome goals to supplement state-required outcomes.

3.1.4 Serving as a catalyst for community resource development.
3.1.5 Providing for community education and advocacy on issues related to delivery of services.

3.1.8 Promoting prevention and early intervention services.

3.1.9 Facilitating interagency communication.

SECTION 3.2 The ALLIANCE is a forum through which services for children and adults mandated and funded by state and federal government and administered by the Department of Children and Families are planned, organized and coordinated.

SECTION 3.3 The ALLIANCE shall use shared services and resources to achieve its mission and purpose.

ARTICLE IV. ALLIANCE GOVERNANCE

Section 4.1 AUTHORITY The governing authority of the ALLIANCE shall be invested in the ALLIANCE who shall have and exercise any and all powers in the management of the business and affairs of the ALLIANCE.

Section 4.2 COMPOSITION: Membership, governance and committees shall insure equal representation from each of the counties participation.

In accordance with F.S. 20.19(6)(d) the alliance shall consist of the following mandated members:

7 District 12 DCF Administrator
8 A representative from Flagler County government
9 A representative from Volusia County government
10 A representative from Flagler County school district
11 A representative from Volusia County school district
12 A representative from the United Way of Volusia and Flagler counties
13 A representative from the Flagler County Sheriff's Office
14 A representative from the Volusia County Sheriff's Office
15 A representative from the Seventh Judicial Circuit
A representative from the Volusia Family Services Council (Children and Families Advisory Board)

11 A representative from Healthy Communities & KidCare
12 A representative from Flagler County Victim's Advocate
13 A representative from the Flagler County Department of Health
14 A representative from the Volusia County Department of Health
15 A representative from the Communities in Action Coalition
16 A representative from the Chiefs of Police Association - Volusia County
17 A representative from the Workforce Development Board in private business
18 A representative from the State Attorney's Office
19 A representative from the Department of Juvenile Justice
20 A representative from a Community Foundation
21 A representative of persons with developmental disabilities nominated by the Family Care Council.

SECTION 4.3 TERM OF SERVICE: Each ALLIANCE member shall serve a term of service, according to the following:

4.3.3 Statutorily Mandated Positions: ALLIANCE members shall serve without limit of term coincident to eligibility. Alliance will seek appointment of a new member from the appointing authority upon three consecutive unexcused absence of any member. Each member may appoint a designated informed alternate member to attend the meetings in his/her absence with full voting rights.

4.3.4 Additional Representative Positions ALLIANCE members serving as additional representatives that are not statutorily mandated as described in section 4.2.1 above, shall begin a staggered (2 year, 3 year, and 4 year) term of service as determined on appointment.

SECTION 4.4 VACANCY If a vacancy shall occur in the ALLIANCE membership, the appointing/electing authority at its earliest convenience shall fill such vacancy. A member so appointed/elected shall serve for the unexpired position of that term of service.
SECTION 4.5  **MEETINGS**  The **ALLIANCE** shall meet monthly during its first year and quarterly thereafter.

SECTION 4.6  **QUORUM**  A majority of the **ALLIANCE** membership shall constitute a quorum necessary for official conduct of meetings of the **ALLIANCE**.

When a quorum is present, a majority vote of the members or their designees present and voting shall prevail in the decision of any matters brought before the meeting of the **ALLIANCE**, except where prescribed by these Bylaws.

SECTION 4.7  **OFFICIAL FUNCTIONING**  The **ALLIANCE** shall operate as a public body, covered under provisions of the section 286.011 and the public records provision of section 119.07(1).

4.7.3  All meetings of the **ALLIANCE** shall be open to the public.

4.7.4  Members of the **ALLIANCE** are subject to the provisions of part III of chapter 112, the Code of Ethics for Public Officers and Employees.

SECTION 4.8  **COMPENSATION**  Members of the **ALLIANCE** shall serve without compensation.

Members of the **ALLIANCE** may be reimbursed for actual and necessary expenses incurred in the performance of their official duties, subject to **ALLIANCE** approval.

**ARTICLE V. OFFICERS**

SECTION 5.1  **COMPOSITION**  The Officers shall be Chair, Vice Chair and Parliamentarian.

SECTION 5.2  **ELECTION/TENURE/VACANCY**  All officers shall be elected by the **ALLIANCE** from among its members.

5.2.7  Each Officer shall serve for a one (1) year term. However, no Officer shall serve for more than two (2) consecutive terms in the same office.
5.2.8 The Nominating Committee shall present a slate of officers to the ALLIANCE at the October ALLIANCE meeting of each year.

5.2.9 Officer elections shall take place in November of each year.

5.2.10 The term of office for all Officers shall begin on January 1st of each year.

5.2.11 Officer vacancies may be filled by the ALLIANCE at any regular meeting of the ALLIANCE, or at a special meeting called for that purpose.

5.2.12 The three presiding officers should be representative of both counties. Districtwide positions shall not constitute representation of any one county.

SECTION 5.3 POWERS AND DUTIES The Officers shall have such powers and duties as generally ascribed to their respective offices, and such further powers and duties as from time to time may be conferred by the ALLIANCE, including but not limited to the following:

5.3.3 Chair - preside at all meetings of the ALLIANCE; appoint the chair of ALLIANCE committees, serve as an ex-officio member of all ALLIANCE committees; represent and act on behalf of the ALLIANCE as authorized by the ALLIANCE; and exercise such other duties as may of right appertain to the office.

5.3.4 Vice Chair - exercise the authority and fulfill the duties of the Chair in the absence of that Office; and exercise such other duties as may be assigned by the Chair.

5.3.3 Parliamentarian - to be well versed in Robert's Rules of Order; serve in the absence of the Chair and Vice-Chair; serve as chair of the ALLIANCE's Nominating Committee; and exercise such other duties as may be assigned by the Chair.
ARTICLE VI. COMMITTEES

SECTION 6.1 EXECUTIVE COMMITTEE The ALLIANCE shall empower an Executive Committee whose membership shall be:

5. Chair
6. Vice-Chair
7. Parliamentarian
8. District Administrator

SECTION 6.2 COMMITTEES Will be appointed as deemed necessary and appropriate.

ARTICLE VII. RULES OF ORDER

SECTION 7.1 MEETING PROCEDURES All meetings of the ALLIANCE will be conducted according to generally accepted procedures for the conduct of meetings.

7.1.3 Should a procedural dispute arise, the official presiding will seek consensus on dispute resolution among the members present.

7.1.4 If the procedural dispute cannot be resolved in a reasonable amount of time, the most recently published version of Robert's Rules of Order will be used to resolve the disputed procedure.

ARTICLE VIII. AMENDMENTS

SECTION 8.1 PROPOSED AMENDMENTS These Bylaws may be altered, amended, or repealed, either in part or in entirety, upon written notice of the proposed changes to the duly appointed/elected membership of the ALLIANCE at least one week prior to the date of the ALLIANCE meeting at which the proposed changes will be considered. Approval of the changes will be acted upon at the 2nd reading at the next scheduled meeting.
SECTION 8.2  AMENDMENT APPROVAL  These Bylaws (and any future alteration, amendment, or repeal to these Bylaws) shall require approval by an affirmative vote of two-thirds (2/3) of the duly appointed/elected membership of the ALLIANCE.
Sarasota County Coalition for Families and Children
STAKEHOLDERS ADVISORY COMMITTEE
Operating Principles

Article I
NAME

SECTION 1 - NAME
This Committee shall be known as the SARASOTA COUNTY COALITION FOR FAMILIES AND CHILDREN STAKEHOLDERS ADVISORY COMMITTEE (hereinafter “the Stakeholders Committee”).

Article II
PURPOSES, OBJECTIVES, DUTIES AND RESPONSIBILITIES

SECTION 1 - PURPOSES AND OBJECTIVES
To provide on-going oversight, advice and advocacy for Sarasota County Coalition for Families and Children in its privatization of services and management of the state’s child welfare system.

SECTION 2 - DUTIES AND RESPONSIBILITIES
As a member of the Committee one has made a commitment to be an active member of the Stakeholders and assume the responsibility for the promotion and support of the Sarasota County Coalition for Families and Children Privatization project. Among these responsibilities are:

1. Be committed to the projects and programs of the Sarasota County Coalition for Families and Children.

2. Attend Stakeholders Committee Meetings. A member of the Committee is required to attend regularly scheduled quarterly meetings.

3. Provide leadership in carrying out the mission of the Stakeholders Committee.
4. Actively participate. This includes but is not limited to:

- Membership on a standing subcommittee
- Participation in special projects of the Stakeholders Committee
- Providing consultation to the Stakeholders Committee and staff in areas of professional expertise
- Recruitment of volunteers for the Stakeholders Committee, its subcommittees, task forces or special projects.

**Article III**

**COMMITTEE MEMBERSHIP**

**TERMINATION OF MEMBERSHIP**

**SECTION 1 - APPOINTMENT AND COMPOSITION**

The Stakeholders Committee shall be composed of no more than thirty members who shall be appointed by the existing Stakeholders Committee. The composition of the Stakeholders Committee shall be as follows:

- Advocate Agencies (4)
- Funders (6) (At least one should be from DC&F)
- Government (4)
- Business (2)
- At Large (4)

*Up to an additional 10 members from varying backgrounds, as determined necessary by the Stakeholders Committee.*

**SECTION 2 - TERMS**

Each member shall serve a term of 3 years with the ability to renew membership for an unlimited number of terms. The Stakeholders Committee shall vote to renew each members’ membership when their term expires.
SECTION 3 - TERMINATION OF MEMBERSHIP
Upon failure of any member to perform as deemed necessary by the Stakeholders Committee, the Stakeholders Committee shall, by majority vote, remove that member and shall propose the names of possible replacements.

Article IV
OFFICERS, SUBCOMMITTEES AND TASK FORCES

SECTION 1 - COMPOSITION
The Stakeholders Committee shall have, at minimum, the following officers:

a) A Chairperson who shall preside at all Stakeholders Committee meetings; be an ex-officio member of all sub-committees and task forces; and perform such other duties as may be required to carry out the purposes and policies of the Stakeholders Committee.

b) A Vice Chairperson who shall act in the absence of the Chairperson and perform such other duties as are required by the Chairperson to carry out the purposes and policies of the Stakeholders Committee.

SECTION 2 - SUB-COMMITTEES AND TASK FORCES
The Chairperson, with the advice and consent of the Stakeholders Committee, is authorized from time to time to appoint sub-committees and/or task forces to perform various duties as shall be necessary to enable the Committee to carry out its purposes and policies. The Chairperson and Vice Chairperson shall serve as ex-officio members of all subcommittees and task forces and shall be entitled to vote on all matters before such subcommittees and task forces if present. There shall be an Executive Subcommittee made up of the Stakeholders Committee Chairperson, Vice Chairperson, and the Chairperson of all permanent task forces/subcommittees.

SECTION 3 - VACANCIES
Vacancies on the Stakeholders Committee shall be filled by majority vote of the Stakeholders Committee at any regular quarterly meeting. Vacancies in any office of the Committee shall be filled by vote of the Stakeholders Committee.
Article V

MEETINGS

SECTION 1 - REGULAR MEETINGS
The Stakeholders Committee shall meet quarterly. The date, time and place of regular meetings shall be scheduled and provided in accordance with Section 3 of this Article.

SECTION 2 - SPECIAL MEETINGS
Special meetings of the Stakeholders Committee may be called at any time by the Chairperson or by one-third (1/3) or more of the Stakeholders Committee members. The date, time and place of special meetings shall be scheduled and provided in accordance with Section 3 of this Article.

SECTION 3 - SCHEDULING AND NOTICE
Written notice, stating the date, time and place of any meeting of the Stakeholders Committee and every Task Force and Subcommittee shall be delivered either personally, by mail, or by fax to each member. Notices shall be delivered not later than five (5) days (for regular and special meetings) prior to the date selected for the meeting. If mailed, the notice shall be deemed delivered when deposited in the United States mail and addressed to the member at his or her address as it is shown on the records of the Committee. In the case of special meetings, the notice shall contain a statement of the purposes for which the meeting is called.

SECTION 4 - PUBLIC MEETINGS
All Committee meetings are public meetings and are open to the public at all times. Minutes of the meetings shall be kept, promptly recorded and open to public inspection.

SECTION 5 - PLACE OF MEETINGS
Meetings shall be held in a facility which does not discriminate on the basis of sex, age, race, creed, color, national origin, or economic status and which provides reasonable public access.

SECTION 6 - ACTIONS OF STAKEHOLDERS COMMITTEE
Committee shall act by majority of the members present at any duly called meeting.
Article VI
AMENDMENTS

SECTION 1 - BY COMMITTEE
These Principles may only be amended by the members of the Stakeholders Committee at a regular meeting provided that notice of the proposed changes have been provided in writing to all board members at least 72 hours before the scheduled meeting.

SECTION 2 - FLORIDA LAW
These Principles shall at all times be subject to applicable Florida law.
TEMPLATE TO DEVELOP COMMUNITY ALLIANCE BY-LAWS
COMMUNITY ALLIANCE

[NAME]

BYLAWS

ARTICLE I. NAME

SECTION 1.1 The name of this organization shall be ______ (hereinafter called the ALLIANCE)

SECTION 1.2 The designated service area of the ALLIANCE shall be the ______ County(s), Florida

SECTION 1.3 The principal office and place of business of the ALLIANCE shall be located as so designated by the ALLIANCE.

ARTICLE II. MISSION

SECTION 2.1 The mission of the ALLIANCE is ____

ARTICLE III. PURPOSE

SECTION 3.1 The purpose of the ALLIANCE shall be, but not limited to the following;

3.1.1 Joint planning for local resource utilization in the community.
3.1.2 Needs assessment and establishment of community priorities for service delivery.

3.1.3 Determining and evaluating community outcome goals.

3.1.4 Serving as a catalyst for community resource development.

3.1.5 Providing for community education and advocacy on issues related to delivery of services.

3.1.6 Promoting prevention and early intervention services.

3.1.7 Facilitating interagency communication.

SECTION 3.2

The ALLIANCE is a forum through which services for children mandated and funded by state and federal government are planned, organized and coordinated.

SECTION 3.3

The ALLIANCE shall use shared services and resources to achieve its mission and purpose.

ARTICLE IV. ALLIANCE GOVERNANCE

Section 4.1 AUTHORITY The governing authority of the ALLIANCE shall be invested in the ALLIANCE who shall have and exercise any and all powers in the management of the business and affairs of the ALLIANCE.

Section 4.2 COMPOSITION: Membership, governance and committees shall insure equal representation from each of the counties participation. The county representative shall be the Chairman of the Board or
Executive Director (CEO) of a corporate entity that designates funding for children’s issues or the Chairman of the Board or Executive Director (CEO) of an agency with statutory requirement to deal with children’s issues.

Membership: the alliance shall consist of the following members:

1. District DCF administrator
2. Representative of the Circuit Court
3. 
4. 
5. 
6. 
7. 

SECTION 4.3 TERM OF SERVICE: Each ALLIANCE member shall serve a term of service, according to the following:

4.3.1 Districtwide Mandated Positions ALLIANCE members shall serve without limit of term coincident to eligibility.

4.3.2 Additional Representatives

SECTION 4.4 VACANCY If a vacancy shall occur among the ALLIANCE's membership, the appointing/electing authority at its earliest convenience shall fill such vacancy. A member so appointed/elected shall serve for the unexpired position of that term of service.

SECTION 4.5 MEETINGS The ALLIANCE shall meet at least 12 months of the first calendar year and ______thereafter.

SECTION 4.6 QUORUM A majority of the ALLAINCE membership shall constitute a quorum necessary for official conduct of meetings of the ALLIANCE.
When a quorum is present, a majority vote of those members present and voting shall prevail in the decision of any matters brought before the meeting of the ALLIANCE, except where prescribed by these Bylaws.

SECTION 4.7 OFFICIAL FUNCTIONING The ALLIANCE shall operate as a public body, covered under provisions of the section 286.011 and the public records provision of section 119.07(1).

4.7.1 All meetings of the ALLIANCE shall be open to the public.

4.7.2 Members of the ALLIANCE are subject to the provisions of part III of chapter 112, the Code of Ethics for Public Officers and Employees.

SECTION 4.8 COMPENSATION Members of the ALLIANCE shall serve without compensation.

Members of the ALLIANCE may be reimbursed for actual and necessary expenses incurred in the performance of their official duties, subject to ALLIANCE approval.

ARTICLE V. OFFICERS

SECTION 5.1 COMPOSITION The Officers shall be Chair, Vice Chair and Secretary.

SECTION 5.2 ELECTION/TENURE/VACANCY All officers shall be elected by the ALLIANCE from among its members.

5.2.1 Each Officer shall serve for a one (1) year term. However, no Officer shall serve for more than two (2) consecutive terms in the same office.
5.2.2 The Nominating Committee shall present a slate of officers to the ALLIANCE at the October ALLIANCE meeting of each year.

5.2.3 Officer elections shall take place in November of each year.

5.2.4 The term of office for all Officers shall begin on January 1st of each year.

5.2.5 Officer vacancies may be filled by the ALLIANCE at any regular meeting of the ALLIANCE, or at a special meeting called for that purpose.

5.2.6 No two (2) officers shall be from the same county. Districtwide positions shall not constitute representation of any one (1) county.

SECTION 5.3 POWERS AND DUTIES  The Officers shall have such powers and duties as generally ascribed to their respective offices, and such further powers and duties as from time to time may be conferred by the ALLIANCE, including but not limited to the following:

5.3.1 Chair - preside at all meetings of the ALLIANCE; appoint the chair of ALLIANCE committees, serve as an ex-officio member of all ALLIANCE committees; represent and act on behalf of the ALLIANCE as authorized by the ALLIANCE; and exercise such other duties as may of right appertain to the office.

5.3.2 Vice Chair - exercise the authority and fulfill the duties of the Chair in the absence of that Office; and exercise such other duties as may be assigned by the Chair.
5.3.3 Secretary - maintain a current roster of the membership of the ALLIANCE; prepare a Record of Proceedings of all meetings of the ALLIANCE; serve as chair of the ALLIANCE's Nominating Committee; and exercise such other duties as may be assigned by the Chair.

ARTICLE VI. COMMITTEES

SECTION 6.1 EXECUTIVE COMMITTEE The ALLIANCE shall empower an Executive Committee whose membership shall be:

1. Chair
2. Vice-Chair
3. Secretary
4. 

SECTION 6.2 COMMITTEES Will be appointed as deemed necessary and appropriate.

ARTICLE VII. RULES OF ORDER

SECTION 7.1 MEETING PROCEDURES All meetings of the ALLIANCE will be conducted according to generally accepted procedures for the conduct of meetings.

7.1.1 Should a procedural dispute arise, the official presiding will seek consensus on dispute resolution among the members present.

7.1.2 If the procedural dispute cannot be resolved in a reasonable amount of time, the most recently published version of
Robert's Rules of Order will be used to resolve the disputed procedure.

ARTICLE VIII. AMENDMENTS

SECTION 8.1 PROPOSED AMENDMENTS  These Bylaws may be altered, amended, or repealed, either in part or in entirety, upon written notice of the proposed changes to the duly appointed/elected membership of the ALLIANCE at least 30 (30) days prior to the date of the ALLIANCE meeting at which the proposed changes will be considered and acted upon.

SECTION 8.2 AMENDMENT APPROVAL  These Bylaws (and any future alteration, amendment, or repeal to these Bylaws) shall require approval by an affirmative vote of two-thirds (2/3) of the duly appointed/elected membership of the ALLIANCE.
INVolVING REPRESENTATIVES
OF THE
FOSTER PARENT ASSOCIATION

This document gives ideas on how representatives from the foster parent association can become involved in community planning for services to children and their families.
HELPFUL HINTS

HOW CAN FOSTER PARENTS BECOME INVOLVED IN COMMUNITY-BASED CARE?

Planning and System Design Phase

Call your District Administrator or CBC coordinator and ask to be on a mailing list for meeting announcements, newsletters, Community workshops and training seminars.

Make a commitment to have a representative on the Community Alliance.

Be involved in shaping and designing a system of care for children and families.

Ask to be put on the agenda for Community Alliance, School Board, School Readiness, civic and faith community meetings. Talk about Foster Care in your community.

Decide which foster Parent from your Community can be the spokesperson for the Foster Parent Association. That person should inform other foster parents.

Foster parents should plan to meet regularly to keep each other informed and represented in all Community planning activities.

Each actively involved foster parent should partner with one who cannot devote the time. This helps foster parents stay informed and involved.
Write a letter to the Editor of the newspaper and voice opinions on how to build a better system of care for children.

SHARE THE NEWS! Establish an info-chain, a phone notification tree or an Email information loop.

**Procurement Phase**

Stay in contact with the Community Alliance; contact a member or DCF for updates.

Contact local providers about how to involve Foster Parents in obtaining better outcomes for children.

Continue encouraging local providers to contact the Foster Parents for their input, suggestions and support.

If you aren’t already participating in Community Alliance activities, the local spokesperson should keep in contact with the Alliance.

Ask to be a speaker at local civic groups, Alliance meetings, provider workshops, etc. Talk about what Foster parents do, educate your community about the important work you perform.

**Transition Phase**

Meet with the Lead Agency (LA). Learn about the mission, philosophy and what they value in a system of care.

Ask the Lead Agency to explain their licensing standards and hiring practices for Foster Parents.

**Ask:**

- How will the LA train, guide, nurture and support Foster Parents?
- How and when will the Foster Parents be paid?
- How will the LA involve Foster Parents in the case planning and service delivery phase?
- Who will be the back-up contact for the Counselor or CaseWorker?
- How much notice will Foster Parents and the children receive if there is a placement change?
- Will transition counseling be offered?
Who will handle “special orders:” extra clothes, camps, tutors, vacation funds, local community involvement to help support Foster Parents?

What forum will be used so Foster parents can contribute to a child’s progress report and future plans for other placements including case closure?

Offer ideas to the Lead Agency on how to get regular feedback from Foster Parent on child’s progress and improvements to the system.

**Lead Agency - Phase-in of Child Protective Services**

**Ask:**

- Will the Lead Agency be involved in local Foster Parents’ Association meetings and other functions?
- What is the Lead Agency’s commitment to keeping Foster Parents informed?
- How often will the Lead Agency meet with Foster Parents?
- Who can a Foster Parent call directly to discuss other issues not appropriate for the case manager?

**Ask:**
Will the Lead support community fundraisers and / or other methods of obtaining support to assist Foster Parents with birthdays, holidays, additional school clothes, athletic fees, etc.?

**Ask:**
Will there be regular appointments with the caseworker to discuss your foster child’s adjustment and other issues?

**Ask:**
How will the Foster Parents be notified of staffings, case planning activities, changes, visits with parents, relatives, and potential adoptive parents?
FLORIDA’S GOVERNMENT IN THE
SUNSHINE LAW,
MOST FREQUENTLY ASKED QUESTIONS ON
FLORIDA’S OPEN GOVERNMENT LAWS, and
WEB SITE ADDRESS FOR MORE
INFORMATION
Florida's Government in the Sunshine Law

To assist the public and governmental agencies in understanding the requirements and exemptions to Florida's open government laws, the Attorney General's Office compiles a comprehensive guide known as the Government-in-the-Sunshine manual. The manual is published each year at no taxpayer expense by the First Amendment Foundation in Tallahassee.

- Florida is renowned for putting a high priority on the public's right of access to governmental meetings and records. In fact, the principles of open government are embodied not only in Florida statutes, but also guaranteed in the state Constitution.

- Florida began its tradition of openness back in 1909 with the passage of what has come to be known as the "Public Records Law," Chapter 119 of the Florida Statutes. This law provides that any records made or received by any public agency in the course of its official business are available for inspection, unless specifically exempted by the Legislature. Over the years, the definition of what constitutes 'public records' has come to include not just traditional written documents such as papers, maps and books, but also tapes, photographs, film, sound recordings and records stored in computers.

- It was in 1967 that Florida's Government-in-the-Sunshine Law was enacted. Today, the Sunshine Law can be found in Chapter 286 of the Florida Statutes. The Sunshine Law establishes a basic right of access to most meetings of boards, commissions and other governing bodies of state and local governmental agencies or authorities.

- Throughout the history of Florida's open government, its courts have consistently supported the public's right of access to governmental meetings and records. As such, they also have been defining and redefining what a public record is and who is
covered under the open meetings law. One area of public concern was whether or not the Legislature was covered under the open meetings requirements. To address that concerns, a Constitutional amendment was passed overwhelmingly by the voters in 1990 providing for open meetings in the legislative branch of government.

- The Attorney General's Office has consistently sought to safeguard Florida's pioneering Government-in-the-Sunshine laws. Our attorneys have worked, both in the courtroom and out, to halt public records violations. In 1991, however, a Florida Supreme Court decision threatened the people's right to know. The questions raised by this decision made it clear that the best way to ensure the public's right of access to all three branches of government was to secure that right through the Florida Constitution. The Attorney General's Office then drafted a definitive constitutional amendment, the successful passage of which in 1992 not only guaranteed continued openness in the state's government, but also in effect reaffirmed the application of open government to the legislative branch and expanded it to the judiciary.

- Florida voters have overwhelmingly showed their support for government in the sunshine at all levels of government. They have made it clear they believe that open government provides the best assurance of government that is responsive and responsible to the needs of the people.
MOST FREQUENTLY ASKED QUESTIONS ON FLORIDA'S OPEN GOVERNMENT LAWS

The following questions and answers are intended to be used as a reference only -- interested parties should refer to the Florida Statutes and applicable case law before drawing legal conclusions.

Q. What is the Sunshine Law?
A. Florida's Government-in-the-Sunshine law provides a right of access to governmental proceedings at both the state and local levels. It applies to elected and appointed boards and applies to any gathering of two or more members of the same board to discuss some matter which will foreseeably come before that board for action. There is also a constitutionally guaranteed right of access.

Q. What are the requirements of the Sunshine law?
A. The Sunshine law requires that 1) meetings of boards or commissions must be open to the public; 2) reasonable notice of such meetings must be given, and 3) minutes of the meeting must be taken.

Q. What agencies are covered under the Sunshine Law?
A. The Government-in-the-Sunshine Law applies to "any board or commission of any state agency or authority or of any agency or authority of any county, municipal corporation or political subdivision." Thus, it applies to public collegial bodies within the state at both the local as well as state level. It applies equally to elected or appointed boards or commissions.

Q. Are federal agencies covered by the Sunshine Law?
A. Federal agencies operating in the state do not come under Florida's Sunshine law.

Q. Does the Sunshine Law apply to the Legislature?
A. Florida's Constitution provides that meetings of the Legislature be open and noticed except those specifically exempted by the Legislature or specifically closed by the Constitution. Each house is responsible through its rules of procedures for interpreting, implementing and enforcing these provisions. Information on the rules governing openness in the Legislature can be obtained from the respective houses.

Q. Does the Sunshine Law applies to members-elect?
A. Members-elect of public boards or commissions are covered by the Sunshine law immediately upon their election to public office.

Q. What qualifies as a meeting?
A. The Sunshine law applies to all discussions or deliberations as well as the formal action taken by a board or commission. The law, in essence, is applicable to any gathering, whether formal or casual, of two or more members of the same board or commission to discuss some matter on which foreseeable action will be taken by the public board or commission. There is no requirement that a quorum be present for a meeting to be covered under the law.

Q. Can a public agency hold closed meetings?
A. There are a limited number of exemptions which would allow a public agency to close a meeting. These include, but are not limited to, certain discussions with the board's attorney over pending litigation and portions of collective bargaining sessions. In addition, specific portions of meetings of some agencies (usually state agencies) may be closed when those agencies are making probable cause determinations or considering confidential records.

Q. Does the law require that a public meeting be audio taped?
A. There is no requirement under the Sunshine law that tape recordings be made by a public board or commission, but if they are made, they become public records.

Q. Can a city restrict a citizen's right to speak at a meeting?
A. Public agencies are allowed to adopt reasonable rules and regulations which ensure the orderly conduct of a public meeting and which require orderly behavior on the part of the public attending.
This includes limiting the amount of time an individual can speak and, when a large number of people attend and wish to speak, requesting that a representative of each side of the issue speak rather than every one present.

Q. As a private citizen, can I videotape a public meeting?  
A. A public board may not prohibit a citizen from videotaping a public meeting through the use of nondisruptive video recording devices.

Q. Can a board vote by secret ballot?  
A. The Sunshine law requires that meetings of public boards or commissions be "open to the public at all times." Thus, use of preassigned numbers, codes or secret ballots would violate the law.

Q. Can two members of a public board attend social functions together?  
A. Members of a public board are not prohibited under the Sunshine law from meeting together socially, provided that matters which may come before the board are not discussed at such gatherings.

Q. What is a public record?  
A. The Florida Supreme Court has determined that public records are all materials made or received by an agency in connection with official business which are used to perpetuate, communicate or formalize knowledge. They are not limited to traditional written documents. Tapes, photographs, films and sound recordings are also considered public records subject to inspection unless a statutory exemption exists.

Q. Can I request public documents over the telephone and do I have to tell why I want them?  
A. Nothing in the public records law requires that a request for public records be in writing or in person, although individuals may wish to make their request in writing to ensure they have an accurate record of what they requested. Unless otherwise exempted, a custodian of public records must honor a request for records, whether it is made in person, over the telephone, or in writing, provided the required fees
are paid. In addition, nothing in the law requires the requestor to disclose the reason for the request.

Q. How much can an agency charge for public documents?
A. The law provides that the custodian shall furnish a copy of public records upon payment of the fee prescribed by law. If no fee is prescribed, an agency is normally allowed to charge up to 15 cents per one-sided copy for copies that are 14" x 8 1/2" or less. A charge of up to $1 per copy may be assessed for a certified copy of a public record. If the nature and volume of the records to be copied requires extensive use of information technology resources or extensive clerical or supervisory assistance, or both, the agency may charge a reasonable service charge based on the actual cost incurred.

Q. Does an agency have to explain why it denies access to public records?
A. A custodian of a public record who contends that the record or part of a record is exempt from inspection must state the basis for that exemption, including the statutory citation. Additionally, when asked, the custodian must state in writing the reasons for concluding the record is exempt.

Q. When does a document sent to a public agency become a public document?
A. As soon as a document is received by a public agency, it becomes a public record, unless there is a legislatively created exemption which makes it confidential and not subject to disclosure.

Q. Are public employee personnel records considered public records?
A. The rule on personnel records is the same as for other public documents ... unless the Legislature has specifically exempted an agency's personnel records or authorized the agency to adopt rules limiting public access to the records, personnel records are open to public inspection. There are, however, numerous statutory exemptions that apply to personnel records.
Q. Can an agency refuse to allow public records to be inspected or copied if requested to do so by the maker or sender of the documents?
A. No. To allow the maker or sender of documents to dictate the circumstances under which documents are deemed confidential would permit private parties instead of the Legislature to determine which public records are public and which are not.

Q. Are arrest records public documents?
A. Arrest reports prepared by a law enforcement agency after the arrest of a subject are generally considered to be open for public inspection. At the same time, however, certain information such as the identity of a sexual battery victim is exempt.

Q. Is an agency required to give out information from public records or produce public records in a particular form as requested by an individual?
A. The Sunshine Law provides for a right of access to inspect and copy existing public records. It does not mandate that the custodian give out information from the records nor does it mandate that an agency create new records to accommodate a request for information.

Q. What agency can prosecute violators?
A. The local state attorney has the statutory authority to prosecute alleged criminal violations of the open meetings and public records law. Certain civil remedies are also available.

Q. What is the difference between the Sunshine Amendment and the Sunshine Law?
A. The Sunshine Amendment was added to Florida's Constitution in 1976 and provides for full and public disclosure of the financial interests of all public officers, candidates and employees. The Sunshine Law provides for open meetings and open records for all governmental agencies.

Q. How can I find out more about the open meetings and public records law?
A. Probably the most comprehensive guide to understanding the requirements and exemptions to Florida's open government laws is the Government-in-the-Sunshine manual compiled by the Attorney General's Office. The manual is updated each year and is available for purchase through the First Amendment Foundation in Tallahassee. For information on obtaining a copy, contact the First Amendment Foundation at (850) 222-3518.
How to Obtain a Published Copy of Florida's Government-In-The-Sunshine Manual

The Attorney General, in cooperation with the First Amendment Foundation, has prepared the Government in the Sunshine Manual which explains the law under which Florida ensures public access to the meetings and records of state and local government. Bound, unabridged copies of this manual can be obtained through the First Amendment Foundation at 850-222-3518.

The Foundation's address is:

First Amendment Foundation
336 E. College Avenue, Suite 300,
Tallahassee, FL 32301
DEPARTMENT OF CHILDREN AND FAMILIES
PREVENTION STRATEGIC PLAN FOR
CHILDREN AT RISK
Strategic Issue

Family Safety Strategic Issue 00-01/01-02: Develop and begin implementation of a prevention strategy for children at risk

1. What is the issue?
   • The department has not broadly implemented strategies that are sufficient to increase community capacity to prevent child abuse.

2. Why is this an issue?
   • Over 75,000 children were abused or neglected in Florida in 1998-1999. Additional state data indicate that:
     ➢ Up to 52 percent of these families have substance abuse problems
     ➢ Nearly 50 percent of all families with incidents of domestic violence are also seen by the child protective system for abuse and neglect
     ➢ Approximately 50 percent of investigated child abuse cases have no findings of abuse or neglect but most have some risk factors for abuse. In addition, 34 percent of the families referred for child abuse investigations have been previously referred.
   • Although there are effective prevention strategies, they are not widely available to our most vulnerable populations throughout the state. For example:
     ➢ Healthy Families Florida is only available in targeted zip codes
     ➢ Partnership initiatives only exist or are beginning in 12 targeted areas
     ➢ Only 20 percent of the substance abuse prevention need is currently met
     ➢ There are only 70 parent’s support groups throughout the state
     ➢ There are many locally funded prevention strategies that are not well coordinated or integrated with agency funded activities
   • The department is mandated to improve community’s capacity to make families stronger and keep children safe.
   • The Governor has placed a strong emphasis on prevention

3. What are the consequences of not addressing this issue?
   • Children will be exposed to greater risks.
   • There will be a breakdown of the child protective services system.
   • Communities will be less likely to assume leadership for keeping children safe.
   • There will be less effective use of limited resources.

4. What should our goals be in addressing this issue?
   • Prevent child abuse by:
Identifying and targeting interventions to known risk factors
Increasing community capacity to support families and promote protective factors
Increasing the availability of proven prevention strategies.

Strategy Statement
Worksheet
#1

Mandate: Develop and begin implementation of a prevention strategy for children at risk

Strategic issue (From Strategic Issue Worksheet approved by the Secretary)

- The department has not broadly implemented strategies that are sufficient to increase community capacity to prevent child abuse.

Goals (From Strategic Issue Worksheet approved by the Secretary)

- Prevent child abuse by:
  - Identifying and targeting interventions to known risk factors

1. What is the purpose of the strategy?

- To ensure policy makers have the essential data needed to guide ongoing planning and decision making and assess program effectiveness in order to implement targeted prevention strategies.

2. What are the strategy’s key elements?

- Collect and analyze data at county (and where available zip code levels) to better understand the issues and needs of those at highest risk, including
  - Unfounded and repeat complaints to the hotline
  - Healthy Families Florida participant profiles
  - Florida Youth Substance Abuse Survey
  - Information from asset mapping/needs assessment of prevention services
  - Other data sources as appropriate and available.

- Use these data to
  - Complete county prevention profiles/report cards
  - Identify and target appropriate research-based prevention services to communities and individuals with documented risk factors that lead to child abuse and neglect
  - Establish opportunities to electronically transfer selected calls to community based information and referral programs.
  - Establish baseline measures by county/zip code for child abuse rates

3. How does the strategy address the issue and achieve issue-specific goals?

- This strategy provides the information needed to accurately select and target the correct interventions to families and to maximize the use of limited resources.

4. What are the key actions that must be taken during FY 00 / 01 and FY 01 / 02 to implement the major initiatives or projects, and who is responsible for them?

Attachment O-3
Actions may include policies, programs, projects, actions, decisions, and resource allocations.

**FY00-01**

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify an interdepartmental group to work with mission support to draft a community prevention report card and accountability measures</td>
<td>Central Office (CO), District (D), FMHI</td>
</tr>
<tr>
<td>Produce an initial (limited) profile of at-risk families</td>
<td>CO, D, FMHI</td>
</tr>
<tr>
<td>Collaborate with information systems (EIM/ICB) to ensure system resources are available</td>
<td>CO</td>
</tr>
<tr>
<td>Expand contract with FMHI for the collection and analysis of these data</td>
<td>CO, FMHI</td>
</tr>
</tbody>
</table>

**FY01-02**

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disseminate complete profiles</td>
<td>CO/FMHI</td>
</tr>
<tr>
<td>Use profiles in communities to target needs based on comprehensive framework for a continuum of prevention services.</td>
<td>D</td>
</tr>
<tr>
<td>Continue data collection and analysis activities for ongoing updates</td>
<td>CO, D, FMHI</td>
</tr>
</tbody>
</table>

5. **What parts of the department are required to implement the strategy?**

- Whole department
- Adult Service Program Office
- Child Care Program Office
- Developmental Disabilities Program Office
- Economic Self-Sufficiency Program Office
- Family Safety Program Office
- Substance Abuse Program Office
- Mental Health Program Office
- Mission Support and Performance Team
- Human Resources Office
- Information Systems Office
- Training Office
- Budget Office
- Legislative Planning Office
- Communications Office
Strategy Statement
Worksheet
#2

Mandate Develop and begin implementation of a prevention strategy for children at risk

Strategic issue (From Strategic Issue Worksheet approved by the Secretary)

- The department has not broadly implemented strategies that are sufficient to increase community capacity to prevent child abuse.

Goals (From Strategic Issue Worksheet approved by the Secretary)

- Prevent child abuse by:
  - Increasing community capacity to support families and promote protective factors

1. What is the purpose of the strategy?
- Improve the department’s clinical practice efforts to address family issues in a preventative manner
- Ensure the department takes a proactive role in promoting, advocating for prevention, supporting and implementing best practices, and documenting community activities to prevent child abuse and neglect.

2. What are the strategy’s key elements?
- Improvement in case management strategies includes the following key elements
  - Expand cross training/field exposure opportunities between child abuse, substance abuse and domestic violence staff.
  - Improve staff efforts to link families to other community resources when child protection services system involvement is not needed.
  - Educate internal staff to the importance of improving department efforts to identify/access the most appropriate resources and to link families to extended families and the community resources through case planning processes.

- Each district needs a dedicated visible community focused prevention leader to:
  - Assist the department in taking a leadership role to promote prevention within the department and through local alliances, readiness coalitions, and other partnerships.
  - Educate and recruit non-traditional partners to assist in child abuse prevention efforts (e.g. housing authority, faith community)
  - Improve department efforts to share its child protective services expertise with community partners through involvement in joint consultations and case planning activities.
  - Encourage media efforts to highlight family strengths and community resources
  - Improve the coordination and referral mechanisms between and among services and existing prevention initiatives to meet family and community needs.
  - Identify “best practice” community efforts in child abuse prevention, substance abuse prevention, and domestic violence prevention and share information statewide.
3. **How does the strategy address the issue and achieve issue-specific goals?**
   - Historically, the department has not held the view that prevention is part of its core mission. This effort will ensure the department has an internal focus to support prevention and that the department assumes a leadership role in the community to advocate for and build partnership efforts for child abuse prevention activities.

4. **What are the key actions that must be taken during FY 00/01 and FY 01/02 to implement the major initiatives or projects, and who is responsible for them?**
   *Actions may include policies, programs, projects, actions, decisions, and resource allocations.*

**FY00-01**

<table>
<thead>
<tr>
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<th>Responsible Parties</th>
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<td></td>
</tr>
<tr>
<td>Require districts to develop mechanisms that ensure local FS field staff and other service program’s (e.g. substance abuse, Domestic Violence, Healthy Families) to improve understanding and awareness of resources and available services, and to develop contacts to improve referrals and communications.</td>
<td>D</td>
</tr>
<tr>
<td>Establish a pilot to identify standard practice for staffing/completing exit interviews with families with unfounded cases, prior to closure</td>
<td>CO, D8</td>
</tr>
<tr>
<td>Incorporate the number of children with repeat allegations into the sit report.</td>
<td>CO</td>
</tr>
<tr>
<td>Pilot implementation of family group conferencing as a case planning process</td>
<td>CO, PDC, Partnership sites</td>
</tr>
<tr>
<td>Ensure substance abuse providers give priority considerations to parents in the FS system for admissions and related services.</td>
<td>CO, D, Contracts</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td></td>
</tr>
<tr>
<td>Expand the department’s internal materials to include prevention considerations/educate own leadership on prevention (e.g. orientation video)</td>
<td>CO</td>
</tr>
<tr>
<td>Ask the districts and central office to form internal cross program teams to identify points of coordination for prevention initiatives in each district.</td>
<td>CO/D</td>
</tr>
<tr>
<td>Define how to best use a prevention coordinator position and integrate with other planning activities</td>
<td>CO/D</td>
</tr>
<tr>
<td>Develop an LBR to secure funds and positions for 16 inter program prevention coordinators (districts and central office)</td>
<td>CO</td>
</tr>
<tr>
<td>Develop/Implement a communication strategy about prevention for staff, policy makers and legislators</td>
<td>CO/D</td>
</tr>
</tbody>
</table>

**FY01-02**

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Practice</strong></td>
<td></td>
</tr>
<tr>
<td>Incorporate performance expectations for districts to reduce the number of children who are re-referred for investigation.</td>
<td>CO</td>
</tr>
<tr>
<td>Expand use of family group conferencing case planning activities</td>
<td>CO, PDC, Partnership Sites, D</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td></td>
</tr>
</tbody>
</table>

Attachment O-6
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Require district staff to participate in existing community efforts regarding prevention.</td>
<td>D</td>
</tr>
<tr>
<td>Hire prevention coordinators to work with communities, child welfare boards, prevention agencies, etc. to facilitate the development of prevention efforts.</td>
<td>D</td>
</tr>
<tr>
<td>Develop and implement communication strategies about prevention for communities, partner organizations and the general public</td>
<td>CO,D</td>
</tr>
<tr>
<td>Increase the coordination and focus of existing community prevention strategies</td>
<td>D</td>
</tr>
<tr>
<td>Increase community awareness to facilitate local development of additional prevention efforts and resources.</td>
<td>D</td>
</tr>
</tbody>
</table>

5. **What parts of the department are required to implement the strategy?**

- Whole department
- Adult Service Program Office
- Child Care Program Office
- Developmental Disabilities Program Office
- Economic Self-Sufficiency Program Office
- Family Safety Program Office
- Substance Abuse Program Office
- Mental Health Program Office
- Mission Support and Performance Team
- Human Resources Office
- Information Systems Office
- Training Office
- Budget Office
- Legislative Planning Office
- Communications Office
Mandate: Develop and begin implementation of a prevention strategy for children at risk.

**Strategic Issue** (From Strategic Issue Worksheet approved by the Secretary)

- The department has not broadly implemented strategies that are sufficient to increase community capacity to prevent child abuse.

**Goals** (From Strategic Issue Worksheet approved by the Secretary)

- Prevent child abuse by:
  - Increasing the availability of proven prevention strategies.

1. **What is the purpose of the strategy?**
   - To continue and expand Florida’s implementation of prevention efforts in accordance with the continuum of system wide activities recommended by Prevent Child Abuse America.

2. **What are the strategy’s key elements?**
   - Prevent Child Abuse America recommends that each state implement a continuum of services and activities. Examples (not a complete listing) of Florida’s programs related to each activity are listed in parentheses.
     - Support programs for new parents (e.g. Healthy Families Florida, Healthy Start)
     - Education for parents (e.g. parent support groups, structured parent education efforts)
     - Early and regular child and family screening and treatment (e.g. Kidcare)
     - Child care opportunities (e.g. child care, school readiness)
     - Programs for abused children (e.g. mental health services)
     - Life skills training for children and young adults (DOH, substance abuse prevention, DOH)
     - Public information and education (Family Source, Ounce, Child Watch)
     - Family support services (Family Source, Respite Care, Partnerships)

3. **How does the strategy address the issue and achieve issue-specific goals?**
   - Continued and expanded use of this prevention continuum, through the implementation of the associated programs, is the most comprehensive way to keep children safe from child abuse and neglect.

4. **What are the key actions that must be taken during FY 00 / 01 and FY 01 / 02 to implement the major initiatives or projects, and who is responsible for them?**

   *Actions may include policies, programs, projects, actions, decisions, and resource allocations.*

<table>
<thead>
<tr>
<th>FY00-01</th>
<th>Action</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Request the Judge lead other agency and organizations that contribute</td>
<td>CO</td>
</tr>
<tr>
<td></td>
<td>to this continuum of prevention to reaffirm their commitment and priority for prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implement partnership initiative in 11 new sites</td>
<td>CO, selected Ds</td>
</tr>
</tbody>
</table>
Develop a budget request for Healthy Families Florida to replace non-recurring funds and to address capacity considerations.  

Discuss/plan with universities (e.g. USF-FMHI/Chiles Center, FSU) for ability to develop, coordinate and maintain repository or warehouse of information and best practices, including information dissemination.

<table>
<thead>
<tr>
<th>FY01-02</th>
<th>Action</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Based on completed mapping, needs assessment and data analyses, develop additional budget issue to enhance/expand the system of prevention.</td>
<td>CO,D</td>
</tr>
<tr>
<td></td>
<td>Continue and expand measures of effectiveness of prevention initiatives</td>
<td>CO</td>
</tr>
<tr>
<td></td>
<td>Develop budget issue for prevention information and best practices warehouse.</td>
<td>CO</td>
</tr>
</tbody>
</table>

5. What parts of the department are required to implement the strategy?

- Whole department
- Adult Service Program Office
- Child Care Program Office
- Developmental Disabilities Program Office
- Economic Self-Sufficiency Program Office
- Family Safety Program Office
- Substance Abuse Program Office
- Mental Health Program Office
- Mission Support and Performance Team
- Human Resources Office
- Information Systems Office
- Training Office
- Budget Office
- Legislative Planning Office
- Communications Office
EXAMPLES OF ORIENTATION MATERIALS

District 13’s Orientation Paper
Funding a Family’s Journey through Child Protection
A Walk Through the Foster Care System.
This paper was developed in September 2000 by District 13 as an orientation to Community Based Care and Community Alliances. Please feel free to adapt it for your use in your District.

I. THE DEPARTMENT’S MISSION AND VISION FOR COMMUNITY-BASED CARE

The department has articulated a new mission statement and vision for how the child protection system needs to operate in the new millennium. Governor Bush and the department’s new Secretary, Judge Kathleen Kearney, are strongly committed to better, more effective interventions of behalf of abused and neglected children. The department’s new mission statement reflects this.

“The Department of Children and Families is committed to working in partnership with local communities to ensure safety, well-being and self-sufficiency for the people we serve.”

The department’s new leadership is committed to the following vision of Florida’s future child protection system:

- The safety of children at all times will be a foremost concern, and permanency resolution in accordance with a child’s sense of time will be the system’s standard;
- Services will be provided by comprehensive, community-based networks of providers who are equipped to manage and deliver all needed services and supports to meet the needs of child abuse and neglect victims and at-risk children and their families;
- Resources will be efficiently and effectively managed to achieve better outcomes for children, with the ultimate goal being child safety and permanency within a twelve-month timeframe;
- Services will be coordinated across systems to maximize limited resources and ensure a single, unified case plan, managed by a primary case manager;
- Financial support will be available from diverse federal, state, and local sources, flexibly managed at the local level, to meet child and family needs;
- There will be financial incentives to stimulate continuous improvement in child safety and permanency outcomes;
- There will be a coherent allocation model that equitably distributes resources across all jurisdictions based on actual child and family needs, costs, and standardized performance expectations; and,
- The system will be able to collect and use data to accurately forecast what services and supports are needed, gauge level of intensity and duration and at what cost, to achieve desired outcomes for each child and family in need.
II. COMPONENTS OF THE CHILD PROTECTION SYSTEM

The following is a description of the key components of the current child protection system.

**Child Protective Investigations** – The investigation of suspected abuse, neglect, and abandonment allegations received by the Florida Abuse Hotline will continue to be provided by the department unless transferred to the local sheriff’s office per local agreement.

**Child Protection Teams** – Medical, psychological, and multi-disciplinary staffings provided by the Department of Health in child abuse and neglect cases to develop a comprehensive treatment plan.

**Services to Child Abuse Victims, Child-In-Home** – If a child can be maintained without risk in their own home, a variety of services may be provided to address the problems that led to the abuse or neglect. A case plan will be established with the family, and will be either court-ordered or voluntary.

**Out-Of-Home Services** – If a child cannot be maintained without risk in their own home, they will be placed with relatives, in a foster home, residential group care, or treatment setting until permanency is achieved. Permanency may be achieved through reunification with family, adoption or independent living for older youth. Florida law, Chapter 39, requires that permanency be achieved in all but exceptional cases within twelve months.

**Adoption Services** – When a child cannot be reunified, termination of parental rights is pursued in order for the child to be adopted. Most adoptive families are provided with a monthly subsidy to assist with the adopted child's special needs.

**Child Welfare Legal Services** – Florida law defines when an abused or neglected child should be adjudicated dependent, meaning that protective services, interventions and possibly placement out of the home are critical in order to assure the child's safety and well-being. When a child is adjudicated dependent, all services subsequently provided are under the approval and supervision of the court. Legal representation is required to process dependency cases in the judicial system. The department, local state attorney, or office of attorney general provides these legal services.
III. GUIDING PRINCIPLES FOR DEVELOPING COMMUNITY BASED CARE

These guiding principles were developed at the statewide forum sponsored by the Children’s Home Society. These principles were adopted as the guide for participants working together during all of the subsequent regional and local forums. The principles are:

1. The care of dependent children and assistance to their families must be a community responsibility involving critical partners such as the child and family, the State of Florida, foster parents, the school system, the courts, law enforcement, the faith community and other community organizations.

2. The system of care will be child safety focused, family-centered, respectful of individual needs, outcome-based, and directed toward the achievement of timely permanency.

3. Families and children in the system of care will experience responsive, flexible, relationship-based services from competent staff who maintain frequent contact to assist the family toward the timely achievement of self-sufficiency.

4. The system of care must be designed using an inclusive and participatory planning process. System changes will be appropriately phased-in and targeted to produce improved client outcomes though efficient resource management.

5. The local provider network is indispensable as the foundation for an orderly transition of child welfare services from the public to private sector.

6. Integrity is the core value of the privatized system creating a sense of normalcy for children through communication and developing trust relationships with the various stakeholders in the child welfare system.

7. Relationships within and between the users and providers of services are paramount in fostering a cooperative community voice regarding the protection of children.

8. Adequate resources will be required to address the myriad of issues in child protection and each community must participate in the mobilization of these resources.

9. Accountability will be required at all levels to assure equality of treatment through standard approach to develop a system that is outcome-based and data driven.

10. All stakeholders will be brought together with the intention of developing a common language and planning for the implementation of privatization.

IV. COMMUNITY ALLIANCE

With the support of statute, the department shall establish a community alliance of stakeholders, community leaders, client representatives, and funders of human services. An alliance may cover one or more counties, as determined locally. Duties of the alliance shall include, but not be limited to:

1. Joint planning for resource utilization, in the community, including resources appropriated to the department and any funds that local funding sources choose to provide.


3. Determining outcome goals to supplement state required outcomes.
4. Serving as a catalyst for community resource development.
5. Providing community education and advocacy.
6. Promoting prevention and early intervention services.

Alliance membership, at a minimum, is to include
- A representative of county government
- A representative from the school district
- A representative from the United Way
- A representative from the sheriff’s office
- A representative from the circuit court
- Where present, a representative from the local children’s board
- The district administrator

Additional members and specific activities will be described in the by-laws.

### Family Safety in District 13

<table>
<thead>
<tr>
<th></th>
<th>Citrus</th>
<th>Hernando</th>
<th>Lake</th>
<th>Marion</th>
<th>Sumter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>18,981</td>
<td>23,034</td>
<td>39,408</td>
<td>53,029</td>
<td>10,072</td>
</tr>
<tr>
<td>Reports '99-00</td>
<td>1,259</td>
<td>1,282</td>
<td>3,248</td>
<td>3,874</td>
<td>626</td>
</tr>
<tr>
<td>Rate per 1,000*</td>
<td>4.90</td>
<td>4.15</td>
<td>6.11</td>
<td>5.11</td>
<td>4.68</td>
</tr>
<tr>
<td>For the month</td>
<td>June, 2000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protective Services</td>
<td>194</td>
<td>240</td>
<td>701</td>
<td>542</td>
<td>205</td>
</tr>
<tr>
<td>Foster Care</td>
<td>58</td>
<td>50</td>
<td>306</td>
<td>180</td>
<td>65</td>
</tr>
<tr>
<td>Adoption</td>
<td>11</td>
<td>5</td>
<td>22</td>
<td>41</td>
<td>14</td>
</tr>
</tbody>
</table>

* State average rate of child abuse reports per 1,000 children: 3.95

### Operating Budget for Family Safety, FY 99-00

<table>
<thead>
<tr>
<th></th>
<th>Department</th>
<th>District 13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,146,831,706</td>
<td>$42,818,376</td>
</tr>
</tbody>
</table>
EXAMPLES OF ORIENTATION MATERIALS

Funding a Family's Journey through Child Protection
### STAGE 1 ~ ATTACHMENT Q

#### Child Protection Action Taken

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Revenue Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Relative calls hotline with concerns about Jason</td>
<td>Child Abuse Prevention and Treatment, Community Based Family Resources, Promoting Safe and Stable Families</td>
</tr>
<tr>
<td>2.</td>
<td>Hotline receives call, referrals for services are provided</td>
<td>Temporary Assistance for Needy, Child Abuse Prevention and Treatment Act, Community Based Family Resource Grants, Promoting Safe and Stable Families (Family Support)</td>
</tr>
<tr>
<td>3.</td>
<td>Hotline receives a second call, and a report is initiated</td>
<td>Temporary Assistance for Needy, Child Abuse Prevention and Treatment Act, Community Based Family Resource Grants, Promoting Safe and Stable Families (Family Support)</td>
</tr>
<tr>
<td>4.</td>
<td>Report goes to the district and is investigated</td>
<td>Funded and allocated to all sources by Random Moment Sampling or time study methodology, Temporary Assistance for Needy</td>
</tr>
<tr>
<td>5.</td>
<td>Intensive in-home intervention is initiated and attempted with the family.</td>
<td>Social Services Block Grant, General Revenue-Maintenance of Effort, General Revenue, Tobacco Settlement, Promoting Safe and Stable Families (Family Preservation)</td>
</tr>
<tr>
<td>6.</td>
<td>Jason is removed and placed in emergency shelter</td>
<td>Title IV-E, Title IV-B, subpart 1, and Title IV-A/Emergency Assistance (the fund source driven by child’s eligibility)</td>
</tr>
<tr>
<td></td>
<td>- Board Payments</td>
<td>Funded and allocated to all sources by Random Moment Sampling or time study methodology, Title IV-E, General Revenue, Tobacco Settlement and Social Services Block Grant</td>
</tr>
<tr>
<td></td>
<td>- Protective investigator and services counselor working the case</td>
<td>Title IV-E, General Revenue, Tobacco Settlement and Social Services Block Grant</td>
</tr>
<tr>
<td></td>
<td>- Child Welfare Legal Services</td>
<td>TANF funding through Alcohol, Tobacco Settlement and Social Services Block Grant, General Revenue, Tobacco Settlement and Social Services Block Grant, Substance Abuse Block Grant, Medicaid, Promoting Safe and Stable Families (Time-limited reunification)</td>
</tr>
<tr>
<td>7.</td>
<td>Parent referred for substance abuse treatment and mental health services</td>
<td>TANF funding through Alcohol, Tobacco Settlement and Social Services Block Grant, General Revenue, Tobacco Settlement and Social Services Block Grant, Substance Abuse Block Grant, Medicaid, Promoting Safe and Stable Families (Time-limited reunification)</td>
</tr>
<tr>
<td>Child Protection Action Taken</td>
<td>Revenue Source</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>8. Jason and family receive special Comprehensive Assessment</td>
<td>Medicaid</td>
<td></td>
</tr>
<tr>
<td>9. Jason placed in foster care, and receives ongoing counseling services</td>
<td>Funded and allocated to all sources by Random Moment Sampling or time study methodology</td>
<td></td>
</tr>
<tr>
<td>- Foster care counselor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Licensure activities</td>
<td>Funded and allocated to all sources by Random Moment Sampling or time study methodology</td>
<td></td>
</tr>
<tr>
<td>- Board and care payments to the foster parent</td>
<td>Title IV-E, IV-B, subpart 1, General Revenue, Tobacco Settlement, Social Services Block Grant</td>
<td></td>
</tr>
<tr>
<td>- Child Welfare Legal Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Termination of parental rights proceed</td>
<td>Funded and allocated to all sources by Random Moment Sampling or time study methodology</td>
<td></td>
</tr>
<tr>
<td>- Adoption counselor</td>
<td>Title IV-E, General Revenue, Tobacco Settlement and Social Services Block Grant</td>
<td></td>
</tr>
<tr>
<td>- Child Welfare Legal Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
STAGE 1 ~ ATTACHEMENT Q

<table>
<thead>
<tr>
<th>Child Protection Action Taken</th>
<th>Revenue $</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Placement and supervision of Jason in an adoptive home</td>
<td></td>
</tr>
<tr>
<td>- Adoption Counselor</td>
<td>Funded and allocated to all sources</td>
</tr>
<tr>
<td>- Supportive services to the adoptive placement</td>
<td>Promoting Safe and Stable Families</td>
</tr>
<tr>
<td>- Maintenance Adoption Subsidy</td>
<td>Title IV-E, General Revenue</td>
</tr>
<tr>
<td>12. Adoption Finalized</td>
<td></td>
</tr>
<tr>
<td>- Maintenance Adoption subsidy ongoing</td>
<td>Title IV-E, General Revenue</td>
</tr>
</tbody>
</table>

* Department staff are sampled through a statewide system. The Random Moment Sampling statistics are calculated on the IV-E eligible population, the percent of time spent on eligible activities and the total of administrative expenditures. These statistics are applied to the following fund sources: General Revenue, Tobacco Settlement, Title IV-E Foster Care, Title IV-B, part 1, Social Services Block Grant, Temporary Assistance for Needy Families, and other sources.

** Contracted positions performing case management functions for the Family Safety population will complete a time study methodology to distribute cost to federal fund sources. The results of the time study methodology will be applied to the Title IV-E/non IV-E population and the cost of administrative activities and will be distributed to the following fund sources: Tobacco Settlement, Title IV-E Foster Care, Title IV-E Adoption Assistance, Title XIX Medicaid Administration, Temporary Assistance for Needy Families.
CONSENSUS MODEL OF DECISION MAKING
This excerpt is taken from a larger interagency collaboration agreement; System Of Care Teamwork Protocol, Buncombe County, North Carolina, October 1999.

DECISION MAKING

IMPORTANT VALUES IN EFFECTIVE DECISION MAKING:

1. All opinions are valuable.
2. Team members actively participate and share their viewpoints and strategies.
3. Team members actively listen to each other.
4. Team members speak honestly and openly.
5. Respect for knowledge of individual team members.
6. Open-mindedness.

CONSENSUS MODEL OF DECISION MAKING

1. I can say an unqualified "yes" to the decision. I am satisfied that the decision is an expression of the wisdom of the group.

2. I find the decision perfectly acceptable.

3. I can live with the decision; I'm not especially enthusiastic about it.

4. I do not fully agree with the decision and need to register my view about it. However, I do not choose to block the decision. I am willing to support the decision because I trust the wisdom of the group.

5. I do not agree with the decision and feel the need to stand in the way of this decision being accepted.
COMMUNITY-BASED CARE DEFINITIONS
COMMUNITY-BASED CARE DEFINITIONS

A. Applicant. A prospective not-for-profit agency or government entity which applies to become a lead agency for the Department.

B. Application. A proposal by a not-for-profit agency or government entity to become the lead agency for the department.

C. Contract Period. The period between the effective date of the contract and the ending date.

D. Contract Manager. The individual designated by the department to negotiate and manage and monitor the contract, the individual to whom the lead agency must send all required reports.

E. District. The department’s organizational unit responsible for the management of this contract.

F. Earned Federal Trust Funds. Dollars in the contract that must be earned from the federal government by conducting activities allowable by federal funding sources. These funds are a significant amount of the total budget for every child protection contract and these funds cannot be replaced by state general revenue. Federal earnings are based on the total cost for an allowable activity multiplied by the federal financial participation (FFP) rate up to any contracted cap on the amount of funding available or the allowable cost of a reimbursable activity.

G. General Revenue. State funds, supported by taxes, certain designated fees, licenses, interest on investments, and certain other designated miscellaneous sources, appropriated by the Legislature of the State of Florida for the financing of a range of services and activities.

H. Lead Agency. The licensed non profit community-based provider or government entity responsible for coordinating, integrating and managing a local system of supports and services for child abuse, abandon and neglect victims and their families. The lead agency is also referred in this contract as the “Provider.”

I. Network Providers. Agencies or entities in the community with which the lead agency contracts to provide services to child victims or their families served under this contract. Network providers includes agencies or individuals.
J. Master Trust Fund. Either the department's Master Trust Declaration or the designated client trust accounts or sub-accounts created within the Master Trust, as the context requires. The money or property placed in the trust account, or any sub-account for the client is not available to the client's family or assistance group for their current needs. Funds for the client's needs will be disbursed by the department, as Trustee, in accordance with sections 402.17 and 402.33, Florida Statutes.

K. State Fiscal Year. The period from July 1 through June 30.

L. State Trust Funds. Monies from trust funds appropriated by the Legislature of the State of Florida supported by collections of statutorily designated revenues, fees and other responsible third party sources.

M. Adoption and Related Services. Programs that recruit adoptive families and place in permanent placement special needs children whose parental rights have been terminated.

N. Adoption Exchange System. The state automated reporting system used to collect data and to register children legally freed for adoption and who have been permanently placed with the department or lead agency.

O. Amended Home Study. A foster care home study that was done as an evaluation and assessment tool in licensing foster parents in accordance with rule 65C-15.024, Florida Administrative Code which has been revised to meet the requirements of an adoptive home study in accordance with rule 65C-15.028, Florida Administrative Code.

P. Case Manager. The person who coordinates all services rendered to the child or family and who serves as the single and continuous point of contact for the child and family from entry into services until exit from services.

Q. Case Plan. A plan of intervention which is negotiated with the family and other parties and specifies the reasonable efforts of all parties to achieve the child's permanency goal and to ensure the child's safety and well-being and which follows the child from the beginning of service provision until services are terminated. It includes a concurrent case plan which describes efforts to place the child for adoption or with a legal guardian and efforts at the same time to preserve the child's in-home placement or reunify the child with the parent(s).

R. Child Health Check-Up. A comprehensive, preventive health screening for Medicaid eligible children from birth through age 20. Children who are removed from their home must receive this exam within 72 hours.
S. Child-Placing Agency. Any person, corporation, agency, public or private, or other business entity other than the parent or legal guardian of the child or an intermediary acting pursuant to Chapter 63, Florida Statutes, and Chapter 65C-15, F.A.C., that receives a child for placement and places or arranges for the placement of a child in a family foster home, residential child-caring agency, or adoptive home.

T. Child Well-Being Scale. A quantitative system designed by the department to evaluate changes in parenting skills related to child safety. The child well-being scales are a set of standardized client outcome measures specifically designed to meet the needs of a program evaluation in child protection services.

U. Early Service Intervention. Implementation of services prior to court or child protective investigations disposition.

V. Emergency Shelter Care. A facility or agency licensed by the department for the temporary care of a child that is alleged to be or found to be dependent, pending a court disposition before or after adjudication, or awaiting placement after court disposition.

W. Family Builders Program. A time-limited program of no more than four months that provides intensive in-home services to families to prevent the recurrence of abuse and neglect.

X. Family Foster Home. A private residence in which children who are unattended by a parent or legal guardian are provided 24-hour care such as emergency shelter family homes, foster homes, family foster group homes, and specialized foster homes for children with special needs.

Y. Foster Care. A voluntary or court ordered, temporary, out-of-home care placement for a planned period of time for children whose own families are unable to care for them.

Z. Home Study. The process of preparing, evaluating and assessing applicants for adoptive parenthood or foster care and completing a written report of the entire process. The written report must include a recommendation for approval of the application to adopt in accordance with rule 65C-15.028, Florida Administrative Code when used for the purposes of evaluating a family for adoptive placement. The written report used for the purposes of a home study for prospective Foster Care Licensing requirements must be in accordance with rule 65C-15.024.

AA. Independent Living Program. A program which provides an array of services to youth in foster care from 13 – 21 years of age to prepare them to live on their own and which may provide a subsidy for some youth.
BB. **Intensive Crisis Counseling Program.** A program of up to six weeks of in-home counseling to provide immediate short-term stabilization to families in crisis.

CC. **Interstate Compact.** A law, effective in all states and the District of Columbia and the U.S. Virgin Islands, which establishes a contract among the states and jurisdictions to ensure orderly procedures and licensing requirements for the interstate placement and post-placement supervision of children and which defines responsibilities for those involved in placing children.

DD. **Medical Foster Care.** A multi-agency supported program to provide family-based care for medically complex children (ages birth through 21) who cannot safely receive care in their own homes.

EE. **Permanency.** That condition under which a child can remain in a setting for the remaining years of the child’s minority. Permanency can include, but is not limited to, reunification with parent(s), long term foster care, as defined in Chapter 39., Florida Statutes, guardianship, adoption, independent living, or long term relative/non-relative custody.

FF. **Provisional License.** A license issued by the department when an applicant is unable to conform to the license requirements at the time of the study but who is believed able to meet the licensing requirements within the time allowed by the provisional license. A provisional license may also be issued when the applicant fails to meet the licensing requirements in matters that are not of immediate danger to the children and the agency has submitted a corrective action plan which is approved by the department.

GG. **Recruitment.** The process of finding adoptive parent resources for waiting children, using either formal media-based campaigns or informal procedures recognized as effective by the adoption agency. The registration of families approved by the department or one of its community-based child welfare providers for adopting Florida Special Needs Children registered on the Florida Adoption Exchange System is a form of recruitment.

HH. **Relative Caregiver Program.** A program which provides additional placement options and incentives that will achieve permanency and stability for many children who are at risk of foster care placement because of abuse, abandonment or neglect but are instead placed by the dependency court in the care of relatives.

II. **Residential Child-Caring Agency.** Any person, corporation, or agency, public or private, other than the child’s parent or legal guardian, that provides staffed 24-hour care for children in facilities maintained for that purpose, regardless of whether operated for profit or whether a fee is charged.
JJ. Reunification. The process of returning a child to the parent(s) or caregiver from whom the child was removed following an out of home placement.

KK. Safety Plan. A plan developed to ensure that the child is safe while dependency is being determined and the case plan is being developed.

LL. Special Condition Cases from the Department. Cases which do not meet the legal definition of allegations of abuse, neglect, and abandonment but which require intervention services by the lead agency, such as parent incarceration, parent hospitalization, or concern of children’s supervision in foster homes. These include reports to the Florida Abuse Hotline that do not meet the legal criteria of abuse and neglect, but which warrant possible intervention by Protective Investigators.

MM. Special Needs Child. As described in section 409.166(2)(a), Florida Statutes, a child whose permanent custody has been awarded to the department, and:
   a) who has established significant emotional ties with his foster parents, or
   b) is not likely to be adopted because he is
      1) eight years of age or older;
      2) mentally retarded;
      3) physically or emotionally handicapped;
      4) of black or racially mixed parentage; or
      5) a member of a sibling group of any age, provided two or more of the group remain together for purposes of adoption.

NN. Technical Assistance. The department providing information related to any part of this contract’s budget, training events and changes in state or federal laws, regulations, administrative rules of departmental policies.
STAGE 2

In this stage, the Alliance will build a baseline of information and decide upon primary outcomes related to their mission / vision.

~ MAJOR FUNCTIONS OF A COMMUNITY ALLIANCE ~

- Provide for community education and advocacy on issues related to delivery of services (Stages 1-4 and ongoing)

- Needs assessment and establishment of priorities for service delivery (Stage 2)

- Determining community outcome goals (Stage 2)

- Promote prevention and early intervention services (Stage 3)
- Joint planning for resource utilization in the community (Stage 3)
- Serve as a catalyst for community resource development (Stage 4)

*Citation from Florida Statute 20.19 (6) describing duties of Community Alliances*

A strong recommendation is that at least one of the community outcomes for families will address prevention and early intervention.

Goals:
- Discover what services are / are not provided in the local community
- Decide on a few priority outcomes that the Alliance will commit to improving
- Develop the capacity to measure and track the outcomes

These goals will be met when the Benchmarks & Achievements are completed.
STAGE 2

~ BENCHMARKS and ACHIEVEMENTS ~

1. Agreement on outcomes that are tied to the target population and relate to the mission / vision goals established by the Alliance.

- The Alliance will be most interested in outcomes that relate to their vision / mission
- The outcomes give shape to the planning and evaluations that follow this stage
- The outcomes must be measurable and achievable

- Outcomes may cover the following areas:
  - Child Protection outcomes
  - Outcomes related to prevention and early intervention
  - Child behavioral health outcomes
  - Child health outcomes
  - Vocational and transitional outcomes as children transition to adults
  - Child education outcomes
  - Child delinquency outcomes
  - Outcomes in other areas related to families

- As a first step, Community Alliances may begin their work with outcomes pertaining to Family Safety issues. Additional outcomes may be added at any time.

Example: Initial Family Safety outcomes:
- 95% of the children will have no findings of child maltreatment within one year of case closure from services.
- 97% of children not abused or neglected during services.
85% of children given exit interviews who were satisfied with foster care placement.

**Example: More community-involved outcomes:**
- Number and percent of individuals in protective supervision who have case plans requiring substance abuse treatment that are receiving treatment.
- Number and percent of children whose education is continued in the most appropriate setting with the least amount of disruption.

**Attachment A** at the end of this section gives the reader examples of outcomes from several different community-based systems of care including some from programs in other states. Deciding on community outcomes is an important first step for the Community Alliances.

**Example:** Hillsborough County in their newly released Community Plan lists more comprehensive suggested “Outcome domains” that cover System Outcomes as well as Child and Family Outcomes and will measure impact from a variety of stakeholders. A full description of their outcomes is found in **Attachment A** at the end of this section.

**Selecting Outcomes**
- Is the outcome important enough to commit time, energy, and funds for improvement?
- Is community diversity taken into consideration?
- Can the outcome be tracked accurately over time?
- Can improvement be achieved through coordinated efforts of the Alliance?

**Attachments B and C** found at the end of this section, are excerpts from two resources on how to develop outcomes. Information on how to procure both documents is found in the attachments. These excerpts are provided as a sample from each of two resource documents and are not intended to capture the full content of the book.

As the Community Alliance develops community-based outcomes it is critical to remember the emphasis placed on prevention and early intervention by the Legislature when outlining the duties of the Community Alliance. Listed below are two web sites that provide good information regarding prevention and early intervention strategies and are important
to Community Alliances for ideas of best practices and plans for new prevention programs:

- The web sites on prevention:
  - [http://www.preventchildabuse.org/fs15.html](http://www.preventchildabuse.org/fs15.html) provides a recommended continuum of prevention activities for a community
  - [http://www.preventioninflorida.org](http://www.preventioninflorida.org)

- Accomplishing the benchmarks and achievements in Stage 2 consists of a sizable investment of time and commitment, but the results are crucial to the ongoing planning and oversight activities of the Community Alliance.

2. Develop a baseline of information by analyzing existing outcomes of various programs and agencies serving families in the community.

- The Department of Children and Families can provide baseline data regarding Family Safety.

The key to “**Data as information**” is that the data must answer the questions inherent in determining outcomes such as:

- Is it consistent and reflective of the Alliance mission / vision?
- Does it answer questions about achievement of the outcome?
- Is it tied to the target population?
- What are the trends of this data?

**Attachment D** at the end of this section gives the reader an example of the data reports that are available from the department. Similar data should be available from other agencies in your community. Examples of different formats for presenting data in graph form are also included. There is a great deal of data available. The key is to ask staff and/or stakeholders to turn the data into information for Community Alliance.
members so that it answers specific questions concerning community outcomes.

3. **A collaborative process for measuring community outcomes on a regular basis.**

Community Alliance members should feel comfortable in requesting an analysis of the data obtained (to provide the information needed) to determine the achievement of outcomes. Technical Assistance is available when / if Alliances need help and guidance. Contact the local District Mission Support and Performance (MSPT) Coordinator, local District CBC Coordinator or Central Office CBC staff for assistance with outcome measures.

- The initial review of current available data by the Community Alliance should determine what additional data information is needed to better understand how the current system works and how it can be improved.

- This review also provides the baseline for future performance improvements.

- A simple matrix may be designed to capture the needed information and can be adapted to meet many measuring and tracking needs.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>Provided by</th>
<th>Funded by</th>
<th># Served</th>
<th>Data on Current Outcomes</th>
<th>Wait List</th>
<th>Quality Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Care</td>
<td>A1 Foster Services</td>
<td>ABC</td>
<td>XXX</td>
<td>Yes 150</td>
<td>Yes – see Remarks</td>
<td></td>
</tr>
</tbody>
</table>
Additional information on ways to review community services is provided in Attachment E, which gives the reader examples of three protocols. Each of the protocols, like the matrix above, can help the Community Alliance review the bottom line of what services are available for the community-based system of care, the adequacy of the services, and gaps in services.

- Each Community Alliance must decide which process meets their individual needs and will work best for their community.
- Community Alliances may want to take the best of each of the examples that most matches the way they want their stakeholder committees to approach this planning effort.
- The three protocols are:
  1. Hillsborough County planning protocol,
  2. The protocol used by two communities in Texas, one urban and one rural, in a nine-page excerpt from a larger paper on developing community-based systems of care in Texas including examples and findings in matrix form of their work, and
  3. Community Resource Mapping, a protocol used successfully in North Carolina by several.

Attachment F describes an instrument that many communities have used in conjunction with one of the above protocols to give further in-depth information about the children in the target population and the their needs and strengths. It is important as a tool to help a community decide what community-based services are needed to serve the children and their families.

- **Child & Adolescent Needs and Strengths (CANS) Methodology for Children and Adolescents with Special Needs: An Information Integration/Decision Support Tool for Planning and Monitoring Services in Home and Community Based Systems of Care for Children & Adolescents and their Families.** This information integration tool has been used in six states and one large urban county to gather information to plan for systems of care for children and their families.
4. A report detailing services and programs currently available within the community that assist children and families in meeting the outcomes established by the Alliance.

- The report is based on the community data collected and analyzed by the committees of the Alliance.
- It specifies the services and agencies that impact on the outcomes designated by the Community Alliance.
- Excessive service duplication and gaps in services, which hinder outcome attainment, will be highlighted in the report.

**HELPFUL HINTS**

Pick 3 - 4 outcomes for which data will be collected.

See what data and other information is available.

Combine the information and discuss:
- Can this outcome be improved?
- What additional data is needed?
- How can additional data and information be obtained?
COMMUNITY ALLIANCES

A Community Alliance provides for community ownership and oversight; provides a focal point for setting community priorities; and is a catalyst for community resource and development.

Stage II ~ To continue partnership building activities through an analysis of the desired outcomes of the children and their families in the community; an environmental scan of the community resources bearing on the outcomes to determine service duplication and gaps.

<table>
<thead>
<tr>
<th>ALLIANCE ACTIVITIES</th>
<th>ALLIANCE RESOURCE NEEDS</th>
<th>ALLIANCE BENCHMARKS &amp; ACHIEVEMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify what outcomes for children and their families that Alliance wants to see achieved</td>
<td>Access to current information from DCF and other data systems</td>
<td>List of desired outcomes for the communities’ children and families</td>
</tr>
<tr>
<td>Determine how well is the community currently meeting the outcomes</td>
<td>Technical assistance in analysis of current system of care and how Alliance agencies can work in partnership to improve outcomes</td>
<td>Strategies and opportunities to achieve improved outcomes</td>
</tr>
<tr>
<td>Isolate processes, linkages, supports currently impacting community outcomes</td>
<td>Existing Lead Agencies are an important resource</td>
<td>Environmental scan report of existing service array and gaps</td>
</tr>
<tr>
<td>Environmental scan of existing agencies, programs and initiatives in the community that may impact on the outcomes</td>
<td>Determine what additional information is needed to better understand how the current system works and how it can be improved</td>
<td></td>
</tr>
</tbody>
</table>
EXAMPLES OF OUTCOMES
SARASOTA COUNTY
MILWAUKEE, WISCONSIN, and
HILLSBOROUGH COUNTY

Examples of outcomes from several different community-based systems of care including a program in another state.
Outcomes

We believe that these outcome measures will establish a new level of accountability for foster care services. In those instances where historical data cannot establish a baseline, the measure will not have a specific performance attainment goal in the first year of measurement.

1. **97%** of the children served will not be abused or neglected during the provision of services

2. **95%** of the children served will have no findings of child maltreatment within one year of case closure from services.

3. **95%** of the clients will be satisfied with the services received. Client satisfaction will be measured based upon criteria and methods to be negotiated between the provider and district.

4. **90%** of the number of children who are legally available for adoption will be adopted within 12 months of availability for adoption.

5. Percent of children reunified with their family who return to foster care within one year of case closure.

6. Children in care will have four face-to-face contacts per month.

7. Caseload/children per case manager will not exceed 15.

8. Reduce the overall average length of stay in out of home care to 18 months overall for return home and adoption.
Surveys

An annual parent survey and community survey will be reported to build a baseline for future outcome measures. The Coalition, Stakeholders, and the Department of Children and Families will approve surveys.

Interviews will be conducted with foster children upon placement change in Foster Care and will be collated and reported annually.

A tool will be developed to survey foster parents annually.
WHAT ARE THE OUTCOMES?

✶ IS THERE IMPROVED CLINICAL FUNCTIONING—CAFAS SCORES?

✶ HAS THERE BEEN A REDUCTION IN RESTRICTIVENESS OF LIVING ENVIRONMENT?

✶ IS THERE REDUCTION IN JUVENILE JUSTICE CONTACTS?

✶ HAS SCHOOL ATTENDANCE IMPROVED?

✶ ARE THE WRAPAROUND COSTS COMPARABLE TO OR LESS THAN RESIDENTIAL TREATMENT COSTS?

✶ ARE FAMILIES SATISFIED WITH THE SERVICES?
Hillsborough Kids, Inc.

The following information is excerpted from Attachment 1 of the Building a Better Child Welfare System: A community Plan for Hillsborough County, 2000, funded by the Children’s Board of Hillsborough County. Call Beth Barrett @ (813) 414-0808 for more information.

Expected Outcomes

HKI is designed to provide comprehensive services and supports that are outcome oriented and that include measures to determine individual, geographic, and programmatic effectiveness across three broad areas:

- Child Safety
- Child and Family Well Being
- Permanency

Outcomes will include immediate, short-term, and long-term objectives. The following information will be used to determine HKI’s effectiveness in meeting its outcome goals:

- Program outcomes/status of the cases handled, including recidivism
- Individual outcomes such as development or demonstration of a skill
- Stakeholder satisfaction, including family and youth satisfaction
- Aspects of quality service linked to positive outcomes such as worker engagement of parents or children in services

As HKI is designed to maximize resources and eliminate duplication of services/supports, cost data will be collected to determine:

- Per child service cost
- Per family cost
- Cost effectiveness data: What works for which type of population?
- Benefit cost data

Suggested Outcome Domain Areas

I. System Outcomes
   A. Continuity of Care
      Indicators
      Length of stay
      Number of placements
II. Child and Family Functioning

Outcome Indicator

A. Child Safety Percentage of subsequent maltreatment
   • Of open cases
   • Within a period of time following close of services

B. Child Well Being School Achievement
   • School attendance
   • Extracurricular activities
   • Grade-level performance
   • School behavior, suspensions
   Emotional Functioning
   • Behavior at home, community
   • Cultural identity
   • Child-parent attachment
   • Mental health
   Physical Health
   • Medical, dental, vision and hearing functioning
   • Level of functioning regarding physical health

Number of Care Managers
Number of disruptions
Number of sibling groups separated
Distance from sibling group
Distance from birth parents

B. System Responsiveness Days to Comprehensive Assessment
   Days to Initial Service Plan
   Days to “long-term” living arrangement
   Percentage of youth placed:
   • Reunified
   • Permanently placed with relative
   • Adopted
   • Independent Living
• Drug and alcohol use
• Risk-taking behaviors

C. Parental Functioning
   Child Rearing Skills
   Housing Maintenance
   Nutrition
   Emotional Functioning
   Physical Health
   Employment/financial stability
Excerpt from the workbook, Turning Ideas Into Action Using Theory-Based Frameworks, Mario Hernandez, Ph.D. and Sharon Hodges, Ph.D. Department of Child and Family Studies Louis de la Parte Florida mental Health Institute at the University of South Florida
The following excerpt from the workbook, *Turning Ideas Into Action Using Theory-Based Frameworks*, by Mario Hernandez, Ph.D. and Sharon Hodges, Ph.D. at the Department of Child and Family Studies, University of South Florida, helps to think through what outcomes are most appropriate for the community. Their assumption is that outcomes should directly reflect issues and strengths for the population of focus and be tied to the chosen strategies.

“In a theory-based framework, outcomes refer to the expected or desired impact of services or strategies. Although there is no requisite number of outcomes to be identified, this frame should include both short and long term outcomes. It is important that the identified outcomes reflect the issues and strengths of the population of focus and that they be tied to identified strategies. In addition, they should be relevant and supportive of the stated principles of the system or program. In selecting outcomes, systems and programs need to ensure that they are useful to managers and administrators as well as front-line workers, children and families, and other significant stakeholders. Identified outcomes and their indicators should provide information that will be timely and relevant in implementing corrective action. Participants need to be realistic about the programs’ ability to influence certain outcomes, by identifying other potential influences.”

Criteria for Selecting Outcomes:

- Is the outcome information useful to managers and administrators?
- Is the outcome information useful to front-line workers?
- Is the outcome information relevant to children and families?
- Is the outcome information relevant to other significant stakeholders?
Stage 2 ~ ATTACHMENT B

- Does the process provide the opportunity for corrective action?
- Does the information support the achievement of cultural competence?


For further information on developing outcomes or to obtain a copy of this workbook contact Dr., Marion Hernandez or Dr. Sharon Hodges at (813) 974-4651.
EXEMPLARY FROM MEASURING PROGRAM
OUTCOMES: A PRACTICAL APPROACH,

A publication of the United Way of America, 1996
A practical guide to developing outcomes for communities and agencies.
Measuring Program Outcomes: A Practical approach.  
(An excerpt)

“In growing numbers, service providers, governments, other funders and the public are calling for clearer evidence that the resources they expend actually produce benefits for people. Consumers of services and volunteers who provide services want to know that programs to which they devote their time really make a difference. That is, they want better accountability for the use of resources. One clear and compelling answer to the questions of “Why measure outcomes?” is:

To see if programs really make a difference in the lives of people.

Although improved accountability has been a major force behind the move to outcome measurement, there is an even more important reason:

To help programs improve services.

Outcomes measurement provides a learning loop that feeds information back into programs on how well they are doing. It offers findings they can use to adapt, improve, and become more effective.

Measuring Program Outcomes provides a step-by-step approach to developing a system for measuring program outcomes and using the results. The approach, based on methods implemented successfully by agencies across the country, is presented in eight steps, although presented as sequential, this is actually a dynamic process with a good deal of interplay among stages. The eight steps are:

1. Get ready
2. Choose the outcomes you want to measure
3. Specify indicators for the outcomes
4. Prepare to collect data on the indicators
5. Try out the outcome measurement system
6. Analyze and report findings
7. Improve the system
8. Use the findings”

There are specific tasks outlined for each step with examples and worksheets. This 170-page spiral bound book includes a Glossary of Selected Outcome Measurement Terms and a Bibliography of related readings on Performance Measurement, Data Collection, and Performance Indicators.


For more information or to order a copy of the workbook call Sales Service/America (800) 772-0008 or write to: United Way of America, Effective Practices and Measuring Impact, 701 North Fairfax Street, Alexandria, VA 22314-2045, (703) 836-7100.
EXAMPLES OF DATA AVAILABLE
FROM THE DEPARTMENT OF
CHILDREN & FAMILIES

EXAMPLES OF DATA AS INFORMATION

These examples show the use of graphs to portray data as infor
Data Reports

There are several existing quarterly and monthly reports that can be utilized as orientation package and/or ongoing relevant information for the Community Alliance accompanied with a brief explanation, these reports provide a description of the type clients being served in all levels of the Department’s programs. Examples of these reports include:

- ARS0001.xls - Adoptions statistics by district included numbers of TPR’d children
- Rent9900.xls - This report lists the percent of clients in each district that have re-entered into Foster Care Substitute Care for post placement completion during the previous fiscal year.
- Read9900.xls - This report lists the percent and number of clients in which re-abuse results in the child returning to services for cases terminated during the previous fiscal year occurred within one year after.
- Reac9900.xls - This report lists by program the number and percents of children Abused/Neglected/Threatened Harm DURING service provision.
- Actv0001.xls - This report lists the number of active clients for In-Home and Out-...
- Fcout900.xls - This report lists the status of the children who entered foster care June 1999 at 12 months after entry.
• Alos9900.xls - This report lists the length of stay (months) for Foster Care - Subs for clients that are currently ACTIVE in Care. This information is broken down and plan goals.

• Reab9900.xls - This report lists by district the number of cases closed that have been Re-Abuse / Neglect / Threatened within 1 year.

• Sc-0001.xls, Sc-9900.xls, Sc-9899.xls - This report lists by district and month cases, new cases and cases closed by budget categories and placement status of Foster Care, Residential Group Care and Emergency Shelter.

• Srv9899.xls, Srv9900.xls - This report lists by district the number of children and families receiving specific In-Home services.

• Vict0001.xls, Vict9900.pdf - Number of children identified as victims in reports listed by district.

• T-supr~1.xls - Graph of number of children receiving foster care supervision (not relative placements). Compared against projections.

• T-proj.xls - Actual and projected number of investigations per district. Listed by child population, % identified as victims in locked reports.

• T-fcdist.xls - Foster care admissions per 1,000 reports, % of children exiting foster care reunited with their families, and monthly admissions and releases by district.
Stage 2 ~ ATTACHMENT D

- **T-ars.xls** - Charts of # adoptive placements by district, age, race.
- **Survive combined.xls** - Breakout of lengths of stay expressed by ‘Survival Curve’ method for 96/97-99/00.
- **Reun0001.xls** - Percent of children exiting foster care whom are reunited with their families.
- **Psnew.xls** - Unduplicated # of children newly admitted into protective services and living arrangements.
- **Prab0001.xls** - Alleged victims in reports by whether any prior reports were received for the same victim in the previous two years.
- **P-fcpaid.xls** - Graph of foster care board payments by month, estimated and actual.
- **Msf0001.xls** - Report of initial child abuse/neglect/threatened harm/special condition reports locked listed by most serious finding for any victim in report – listed by district.
- **Fc-los.xls** - Foster care lengths of stay by district using currently active client entry cohorts from 98/99 and 97/98, and exit cohorts.
- **Fahc0001.xls, fahc9900.xls** - Florida Abuse hotline calls by district and county population. Listed by month and cumulative.
• Es-tre`1.xls- Emergency shelter counts by district and admissions/releases. A admission per 1,000 investigations.

• Es-pro~3.xls- Emergency shelter population projections and actual growth.

• Ccm0001.xls- Amount of time (hours and days) by district for investigations to b to be seen and until investigations were complete

• Cbl0001.xls- Child backlog reports open by length of time open, listed by distri

• Callsum.xls- Graph of hotline activities including calls answered, abandoned, 1 calls/counselor. Also shows distribution by child and adult

• Alostr~1.xls- Charts of average length of stays displayed by goal, legal status,

• 60days.xls- Graphs of open cases and backlog cases by days open and distri

• fccohorts.doc- Definitions for determining entry cohorts for LOS.

• cbcunits.doc- Current units identified as CBC.

• Pivot.xls- Charts of client data receiving In-Home supervision
Useful Web Pages:

http://www.state.fl.us/cf_web/news/mspt/

http://quickfacts.census.gov/qfd/index.html

http://eww.dcf.state.fl.us/~fsp/PAGES/dreports.htm (inTRAnet only)

Additional reports regarding behavioral healthcare can be obtained through the ADM data warehouse. This information can be used to provide numbers of children receiving Mental Health or Substance Abuse services funded through the Department or Medicaid. The data can be analyzed to show types and frequency of services provided. The data can also be matched against the district Family Safety client list to provide more specific information regarding services to Family Safety clients.
STATEWIDE
% OF FOSTER CARE POPULATION
GOAL OF ADOPTION

20.0%
21.0%
22.0%
23.0%
24.0%
25.0%
26.0%
27.0%
28.0%
29.0%
30.0%

Jul-99
Aug-99
Sep-99
Oct-99
Nov-99
Dec-99
Jan-00
Feb-00
Mar-00
Apr-00
May-00
Jun-00
Jul-00
Aug-00
Sep-00
Oct-00
Nov-00
Dec-00
Jan-01
Stage 2 ~ ATTACHMENT D
THREE EXAMPLES OF PLANNING PROTOCOLS

- HILLISBOROUGH COUNTY
- TEXAS PROTOCOL TO DETERMINE COMMUNITY SERVICES AND FUNDING
- NORTH CAROLINA COMMUNITY RESOURCE MAPPING
The following information is excerpted from Attachment 1 of the Building a Better Child Welfare System: A community Plan for Hillsborough County, 2000, funded by the Children’s Board of Hillsborough County. Call Beth Barrett @ (813) 414-0808 for more information.

An example of a community effort to review their current community services is the planning document accomplished through community workgroups in Hillsborough County. The plan included strong participation from all stakeholders including provider agencies, child advocates, staff of the Department and the Children’s Board, the 13th Circuit Judicial Court, foster parents and the Child Protection Team. Participants were invited to join one of five work groups:

1. Prevention Services
2. Early Intervention
3. Put-of-Home Care
4. Specialized Therapeutic Services, and
5. Connecting Families to Community supports

Each group was asked to:

- Identify local best practice programs,
- List barriers to effective service delivery,
- Identify priorities for service expansion and new services
- Develop creative ideas for funding,
- Look for opportunities to improve service collaboration and integration, and
- Identify next steps for improving services to children and families.
The results were surprising for all involved.

☑ There were over 3000 entities identified by the work groups that provide some service to children and their families, many unknown to the service professionals.

☑ They found in their community a rich array of faith, neighborhood, county based and agency driven support services, but were also surprised at how poorly the service professionals connect families at risk to the neighborhood and natural supports they so desperately need.

☑ Of equal or greater surprise, the work groups outlined many improvements in their system of care for children and their families that can be accomplished with **no additional costs**!

☑ In the conclusion section, the authors picked the 25 “next action steps” that can be completed within one year at no additional cost.
The following protocol appears in a paper written by staff of the Texas Health and Human Services Commission and is intended to be used as an example of a community’s effort to determine the services and funding available to serve children and their families.

COMMUNITY-BASED OPTIONS REQUIRE FINANCE REFORM IN TEXAS

The Texas Children's Mental Health Plan has made a good start in developing community-based systems of care. But underlying this systems reform initiative is the realization that mental health, child welfare, education, and juvenile justice programs have too often failed to provide the appropriate array of services that children with serious emotional disturbance and their families need. One reason for the failure to meet families' needs is that financing structures have not changed and do not support an individualized approach.

Texas, like most states, is faced with the dilemma of serving children and families whose needs call for services provided by many different public programs, with a funding structure that is fragmented and categorical. Past efforts at collaboration between public agencies providing services have increased information sharing, but have done little to increase the notion of shared resources. In addition, the public programs serving children spend the majority of their mental health dollars on high cost residential and inpatient care, without the information necessary to determine the overall effectiveness of those interventions. Because of the mix of federal and state funds and the categorical nature of the funding streams, there is not an obvious financial incentive to serve children in the community.

Reform of the funding structure is essential to building community based systems of care for children with severe emotional disturbance and their families. Since contracting must occur across public systems, flexible financing and interagency pooled funding are necessary to promote changes in the financing structure. To develop the capacity to serve children with complex and multiple needs in the community, dollars must follow children from high cost residential and inpatient care back to the community. The goal is to deliver better and more flexible services designed to meet each family's needs rather than the needs of a system or program.

Principles

TIFI adhered to the following principles:

◊ Families are important and necessary partners in the development and implementation of an integrated service delivery system.
◊ Local control allows for better decision making and enhances community development.
◊ Managing funds and providers through a single local entity will produce better outcomes for children and families.

Attachment E-4
Strategies

The two pilot sites have used unique strategies to test new financial and system development approaches. Some of the strategies are:

◊ Pool funding across child serving agencies to provide flexible and individualized services;
◊ Create one point of entry into care to improve access;
◊ Utilize a wrap-around approach to ensure individual treatment plans and improved outcomes;
◊ Strengthen family partnerships to improve overall quality;
◊ Develop independent care coordination for seamless services;
◊ Utilize informal and formal supports to assure children remain in the community; and
◊ Support community and neighborhood based providers to strengthen cultural competence.

PROTOCOL

The protocol is as follows:

◊ Identify Target Population
◊ Collect data on target population
◊ Conduct a funds discovery for target population
◊ Collect historical cost information for targets
◊ Assess current delivery system for target population
◊ Develop a prototype of the future system, including
  • Governance
  • Financial structures and incentives
  • Administration
  • Service Delivery
◊ Establish an interagency case rate(s) for the target population
◊ Develop an interagency evaluation and outcome tracking system
◊ Begin service delivery

Developing the Projects

The protocol followed by the pilot communities is not a linear process; many of the activities occurred simultaneously and/or not in the order given here. However, the first work undertaken by both pilot sites was to identify the target population.
Identify Target Population

TIFI worked with each site to define a narrow target population for the pilot project. For both sites, target population selected was defined as children and youth with complex needs, who were in residential care and ready to return to the community or were at imminent risk of being placed in residential care. In Brown County, approximately 35 children per year are placed in residential care through DPRS Child Protective Services and the local juvenile probation department. In Travis County, the number of children in residential care was not known, so a study was conducted. The study found that almost 300 children are placed in residential care each year, at a cost of close to $12 million per year. This includes children placed through DPRS Child Protective Services, Austin/Travis County MHMR, the Travis County Juvenile Court, and the Travis County Health and Human Services Department.

<table>
<thead>
<tr>
<th>Children in Residential Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Results of Travis County Study</strong></td>
</tr>
<tr>
<td>Average Daily Census = 297</td>
</tr>
<tr>
<td>Average Cost Per Child = $110</td>
</tr>
<tr>
<td>Average Cost Per Day = $32,406</td>
</tr>
<tr>
<td>Total Cost Per Year = $11,828,000</td>
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</tbody>
</table>

Collect data on target population

To further define the target population, TIFI collected data on a sample of the youth identified, using a survey instrument that is designed to determine strengths and risks of children by interviewing their residential treatment providers. The instrument, titled the Childhood Severity of Psychiatric Illness (CSPI), was developed by Dr. John Lyons of Northwestern University Medical Center. Dr. Lyons provided technical assistance to the sites on the use of the instruments. The children in residential treatment were compared to a random sample of children receiving community-based services from Austin/Travis County MHMR. From that comparison it was noted that there were children being successfully treated in the community who were at the same level of risk as those in residential care. Thus the conclusion was that there was a group of children at both sites who had been placed in residential treatment, but who demonstrated a lower level of risk and could be successfully treated in the community.


**Funds Discovery**

State and local participants provided information on the type and amount of funds used with the target population. Once that was determined, an ongoing analysis was conducted to determine the flexibility inherent in particular funding streams.

**Historical cost information**

The next step was to determine the current cost of services provided to the subset of children who were at the lower end of risk, and the historical cost of services provided to them in the year prior to their placement in residential treatment. TIFI extrapolated this information from client records. The results of the investigation showed that because the service delivery system is not managed, some children received a continuum of services, others a smattering, while the majority received little to no service the year before placement.

### Cross Agency Behavioral Health Expenditure Comparison

<table>
<thead>
<tr>
<th>Services</th>
<th>Child Welfare</th>
<th>Mental Health</th>
<th>Juvenile Justice</th>
<th>Total</th>
<th>Average Expenditures</th>
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<td>Crisis</td>
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<td>$810</td>
<td>$400</td>
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<tr>
<td>Case Manage.</td>
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<td>Assess.</td>
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<td>Family Pres.</td>
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<td>Mentoring</td>
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<td>$27,178</td>
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<td>EXPENDITURES</td>
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<td>$9,798</td>
<td>$85,734</td>
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### Out of Home Costs and Services for Same 18 Youth

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<th>Service</th>
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<th>Shelter</th>
<th>Residential</th>
<th>EXPENDITURES</th>
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<td>$6,400</td>
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<td>$382,250</td>
<td>$495,175</td>
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**Assess current delivery system**

Pilot sites were encouraged to include families in all activities associated with the project. Both sites held focus groups with family members to discuss the needs of families seeking services.

In Brownwood, a group of families whose children were in residential care met with agency staff to discuss the kinds of services and supports that would be necessary to serve their children in the community. The need for flexible funds to meet the individual needs of the child and family was identified as the first priority.

The services that Brownwood families identified as necessary to serve their children in the community were:

◊ Respite care  
◊ Opportunities for mentoring or work study  
◊ After school activities  
◊ Tutoring  
◊ Someone to be in school with the child to help with behavior problems

In Travis County, focus groups consisting of a diverse group of parents were held in four neighborhoods. All the parents had been involved with public child serving agencies, some had children in residential care while others were receiving community based services. Parents discussed the need for culturally competent services, including case workers and counselors with experience and/or cultural backgrounds appropriate for the children receiving services.

Parents in Travis County identified a need for the following services:

◊ Support/advocacy services for parents  
◊ Family support groups  
◊ Child care  
◊ Youth advocacy training  
◊ Education on what services are available  
◊ Coordination of services  
◊ Foster parent support
◊ Respite Care - drop-in
◊ Transportation
◊ School services, including counseling
◊ Transition to adult living
◊ Education on mental health issues
◊ Care before a crisis
◊ Support on blended family issues
◊ Monitoring of children near school grounds to prevent drug use
◊ Evening and weekend services
◊ Parenting education

*Develop system of care infrastructure*

*Governance*

In keeping with the principle that local control will produce better outcomes on every level, the pilots were supported in creating governance structures that build on their current interagency infrastructures. In Travis County, rather than designate a lead agency to receive pooled funds, a new locally controlled non-profit was created. Known as the Travis County Children's Partnership, it is made up of representatives of DPRS, Austin/Travis County MHMR, the Travis County Juvenile Court, Travis County Health and Human Services, the Region 13 Educational Service Center, and five consumer family representatives. In Brownwood, the participating agencies developed a Memorandum of Understanding (MOU) that sets out the agreement to pool funds and deliver services. An already existing community board with broad representation provides the oversight for the project. The interagency governance in both sites has accomplished the following:

◊ Developed the structure for purchasing and/or arranging services;
◊ Determined the funding strategy including rate setting;
◊ Designated funds to the fund pool;
◊ Ensured family voice and representation;
◊ Established shared outcomes and; and
◊ Designated the target population.

*Finance*

The Travis County pilot is pooling funds through an equal contribution from each participating agency. The average cost of residential care for the target population was determined to be approximately $35,000 per year. Each agency has agreed to designate a minimum of $70,000 of current funding for the project. DPRS has committed $70,000 of federal Title IV B funding. TDMHMR allocated $147,000 of Temporary Assistance to Needy Families (TANF) funds; Educational Service Center Region 13 is contributing $70,000 of non-educational funds. Travis County Juvenile Board agreed to commit
$70,000 of local funds, as did the Travis County Health and Human Services. The total pooled funds for Travis County is $447,000 per year.

In Brownwood, Juvenile Justice, mental Health and DPRS are pooling nearly all contracted revenue. This includes approximately $15,000 of DPRS federal Title IV B funds, $400,000 of DPRS Family Preservation and support funds, $175,000 in MHMR general revenue and a projected $10,000 in Brownwood Juvenile Probation state revenue. The total amount of pooled funds in Brownwood is $600,000 per year.

Administration

In Brownwood, Central Counties MHMR is serving as the administrative agent for the pooled funds. Each of the participating agencies is contracting separately with Central Counties and the MOU directs the coordination of those funds. In Travis County, Austin Travis County MHMR is serving as the administrative service organization for the first eighteen months, and in August 1999, the Travis County Children's Partnership will request bids for another organization to perform the administrative service organization (ASO) function. As the ASO, both Central Counties MHMR and Austin Travis County MHMR are responsible for the following functions:

◊ Managing funds from each agency and funding source;
◊ Purchasing and monitoring all services provided to the target population;
◊ Providing unconditional care;
◊ Developing and enhancing the provider network;
◊ Authorizing individual treatment plans; and
◊ Serving the target population.

Establish case rate

Based on the data analysis for children meeting the target population, a cost for service was projected. For Travis County, a case rate was based on data from 180 youth. Service encounters were aggregated across service systems, including child welfare, juvenile justice, education, and mental health. The projected amount for community based services was determined to be $24,000 per child per year. This is $10,000 per year less than the cost of one year of level IV residential care. Residential care is part of the service mix paid for within the $24,000 per year case rate. It is being used less often and for a shorter length of stay.

For Brownwood, a case rate was established at $18,000 per year. However, for the first year, existing contracts with service providers will be maintained at current rates on a fee for service basis. Next year, a case rate will be used based on the new provider contracts.
Service Delivery

The infrastructure developed at each site, which allowed for pooled funds, shared governance, and dollars following families, also supported a significant shift in the way services are being delivered.

At both sites, services are being delivered using a "Wraparound" approach. Wraparound is a process designed to improve the lives of children and families with complex needs. The Wraparound approach helps communities develop individualized plans of care. This approach has been proven successful, and all states have at least one community actively piloting this method. Many states, like Michigan and Oregon, are providing and facilitating cross agency statewide training in Wraparound. Wraparound is a departure from the current methods and requires an adherence to a set of framing principles, which serve as the philosophical base for the process (Dennis, VanDenBerg, & Burchard, 1992). Those principles are:

◊ Wraparound efforts must be based in the community;
◊ Services and supports must be individualized to meet the needs of the children and families, and not designed to reflect the priorities of the service systems;
◊ The process must be culturally competent and build on the unique values, strengths, and social and racial make-up of children and families;
◊ Parents must be included in every level of development of the process;
◊ Agencies must have flexible, non-categorical funding;
◊ The process must be implemented on an interagency basis and owned by the larger community;
◊ Services must be unconditional. If the needs of the child and family are not to be rejected from services. Instead, the services must be changed;
◊ Outcomes must be measured. If they are not, the wraparound process is merely an interesting fad.

At both sites, care coordinators have been hired to facilitate the Wraparound process. Care coordinators act as generic case managers for the family, performing functions including:

◊ Identifying, with the family, key players to be on the child and family team;
◊ Performing a strengths discovery and assessment with the family;
◊ Helping the child and family team develop the individualized treatment plan;
◊ Creating and arranging services and supports, including non traditional services;
◊ Managing flexible dollars;
◊ Evaluating services and supports; and
◊ Promoting unconditional care.

Both sites are utilizing a software system that supports client tracking, fund management, and outcomes. The software, The Clinical Manager, was developed by Dane County Mental Health and Mental Retardation Center through a grant from the Robert Wood
Johnson Foundation. This state-of-the-art software is used by the care coordinators to document the individualized plan of care, track funds used for services, and track the goals and outcomes for each family. This software supports the Wraparound process by measuring both systems- and client-based outcomes.
BIBLIOGRAPHY


Boundaries between programs built up over the years by separate funding streams are a serious barrier to developing services that meet the real needs of children, youth and their families. *Funding shapes available services. Changing funding is a powerful tool that can be used to change services.* The delivery of more comprehensive, community-based services requires bringing funds together across programmatic lines, making them more flexible and more available to local Collaboratives.

States and communities across the country are engaged in changing the financing of child and family services to support the development of comprehensive, community-based services. Common features of these efforts include:

- collaboration across agency and department lines,
- funds from two or more traditionally separate programs blended together to broaden the service array, and
- pooled funds made available to local collaborative entities for flexible use.

Human services systems are shifted to assure that services and supports made available to families are driven by what the child, youth and family actually need, not by the funding streams available. This shift requires that public bureaucracies share authority with local Collaboratives to make decisions about services for children and families in their community. Participants in these reforms face numerous barriers, especially those related to turf issues, that make players reluctant to work together, along with separate and rigid funding streams that define the boundaries of programs (O’Brien, Mary M., 1996).

**What is a Collaborative?**

A Collaborative is a diverse governance team that brings together decision-makers and stakeholders to “drive”, manage, and monitor systems reform efforts. Participants in Collaboratives vary in each community, but generally include: administrators from local public schools, health, juvenile justice, social services, local mental health and substance abuse agencies, along with family representatives, family advocates, university/college faculty, nonprofit organizations, and other community representatives including members of local business.
The willingness of collaborative partners to share resources, ideas and power is a key component to systems reform – lasting positive change (sustainability) will not occur without this foundation of trust. Agencies and others will not willingly share money or other resources unless they believe that the benefits outweigh the risks. It takes time to build trust and is a process that cannot be ‘skipped’ in the developmental stages of a Community Collaborative. Successful implementation of every approach and strategy described in this document requires a foundation of trust and mutual benefit among participants, together with the full and active participation of family members of children and youth served by the service systems.

Enhanced funding – bringing more, or ‘new’ money into the community, such as grant funds or revenues previously inaccessible to a given agency now made accessible through a contract arrangement. For example, if an Area Program extends its Medicaid provider status to another child-serving agency via contract, that agency can draw down revenues that are new to its system, enhancing the total funds available for service in the community.

Pooled funding – the practice of merging funds that originate from separate funding streams into a common ‘pot’ which no longer belongs to any one individual entity. An example of pooled funding is Flexible Funds, where all participants combine dollars from more than one source for use. Flexible Funds are an effective strategy to promote the development and delivery of non-traditional services, supports, and wraparound approaches in a system of care.

'Rocks, Pebbles & Sand'
The director of the MISC Project in Santa Barbara, CA (Todd Sosna, Ph.D.) provides a good analogy regarding how to maximize blended and enhanced funding. Use categorical funds first when funding a service plan, as they are the most rigid. Use flexible funds last. Think of rocks, pebbles and sand – if you have a cup full of all three, empty the cup, and want to refill it with the same amount - in order to make all the items fit, you first put in the rocks (rigid categorical funding which is put in together, or blended), then put in the pebbles (enhanced or new funding which may still have mandated requirements, but is less rigid than the rocks/categorical); last the sand, or Flexible Funds that can fill in the gaps with non-traditional and wraparound approaches.
COMMUNITY RESOURCE MAPPING INVENTORY

As discussed previously, communities are required to document substantial state and local or other non-federal investment in the implementation and operation of the local system of care in order to meet federal matching requirements. Given the broad range of resources and depth of trust necessary between funding agencies to develop and sustain a comprehensive system of care, Community Collaborative governance structures offer the ideal venue for identifying resources, including match, for this purpose.

The first step in building a comprehensive sustainability and match structure is consensus among partners regarding their commitment to this effort. Once it is clear that all partners are on board, a Community Resource Mapping Inventory can be developed to assist the community in thinking about all the resources (services, staff, funds) currently being expended for children and youth that meet the target population criteria. This process yields more than the completion of the inventory - it forces a dialogue that assists communities to see how they can continue their collaborative system of care process after start-up federal funds expire. The mapping inventory involves several basic steps that may be adapted according to the needs of each Collaborative:

1 **Identify the geographic community.** What communities and counties will participate? Reach consensus about current and future geographic boundaries for the system of care effort and make sure everyone is clear on the agreement.

2 **Identify all currently participating organizations.** Is everyone ‘at the table’? It is important not to wait until every single entity is present to move forward, as long as there is consensus regarding critical mass - proceed. Discuss why other partners are not currently participating and whether/what
strategies will be employed to get them there. Bring others to the table as possible in the future.

3 **Discuss the description of the required target population.** Unbundle the diagnosis requirements and reframe them around need. For example, each partner should assess their own ‘population’ for children and youth a) who have significant challenges in home, school or community related to unmet or ‘under-met’ mental health needs, b) who are receiving or need to receive the services of more than one public agency. This process helps eliminate the problem of agencies believing that this is solely a mental health ‘program’ and increases the realization that there is a set of youngsters and families needing/accessing services across agencies who may or may not be formally diagnosed as Seriously Emotionally Disturbed, but nevertheless meet eligibility criteria and will benefit from a collaborative service approach. (The area program can ensure diagnosis later.)

4 **Identify services/programs being provided** by the participating organizations for these youngsters/families, and associated funding streams, e.g. Families for Kids, Special Education, Office of Juvenile Justice, etc. (Note – by now, duplication of services and programs should become more and more apparent.)

5 **Inventory each agency/organization’s expenditures.** How much money, from what funding streams, are devoted to the services for these children, youth, and their families in a given year? Define/agree upon fiscal year or years. (This will probably require the direct or indirect participation of each agency/organizations finance department to ensure complete information.)

---

1 This is **not** intended to promote a deficit-based approach, but to broaden understanding of unmet or undermet mental health needs. Strength-based approaches to serving children, youth and families are a cornerstone of the system of care, but are not the focus of this particular discussion.
6 Identify funds expended but not fully matched with, or necessary for match with federal funds. (This will probably require the direct or indirect participation of each agency/organization's finance department to ensure complete information.)

7 Discuss resources that could be better-spent if provided collaboratively (once areas of duplication have been identified), as well as the identification of federal fund maximization opportunities. For example, if a crisis-outreach service is needed, and more than one agency provides some level of crisis-intervention, can a portion of funds dedicated to crisis services be combined (blended or pooled) across funding streams to develop a more responsive/collaborative outreach service?

8 Assess the redundancy of separate case management within each agency. Family members can help agencies realize what it's like for them to maneuver between multiple case managers and plans. Discuss openly how each agency's mandates must/will be met regarding case management requirements and pilot a unified case management 'one family/one plan' approach.

9 Summarize the purpose and findings of the Resource Mapping Inventory and ensure endorsement by all Collaborative members.

10 Develop and implement a plan to systematically formalize and strategically implement the collaborative service and system approach:
   - How the new approach will be piloted, i.e., the number of youngsters/families who will be approached to participate, the geographic areas of initial participation?
   - How (and how often) will the Collaborative measure outcomes, address challenges? Brainstorm potential challenges/solutions in advance.
   - What are the implications for training, e.g., practice, record keeping?
Monitor and assess results, gradually expanding the effort.

1. **How will the Collaborative share information and results to ensure support?** What is the role of each member of the Collaborative in promoting the sustained success of the effort? What assistance is needed from/for family members? Evaluators? Policy-makers? to move the system forward?

*Regular publicizing of accomplishments is critical for success - create a sense of urgency, momentum and commitment to ensure that stakeholder view the effort as important and worthy of their support!!*

(See Appendix E for an example of a Community Resource Mapping Inventory template.)
## COMMUNITY MAPPING INVENTORY TEMPLATE

<table>
<thead>
<tr>
<th>Agency/Org.</th>
<th>Geographical Area &amp; Population Served</th>
<th>Primary Services Provided</th>
<th>Expenditures for Target Population</th>
<th>Funding Streams</th>
<th>Funds Available to Blend, Pool &amp;/or Match</th>
<th>Collaborative Services to be Developed or Augmented</th>
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</table>
Child & Adolescent Needs and Strengths (CANS) Methodology for Children and Adolescents with Special Needs:

An Information Integration/Decision Support Tool for Planning and Monitoring Services in Home and Community Based Systems of Care for Children & Adolescents and their Families.

This is an overview of the CANS information integration tool. It has been used successfully in several communities and six states.
CHILD & ADOLESCENT NEEDS AND STRENGTHS (CANS) METHODOLOGY

For Children and Adolescents with Special Needs

An Information Integration/Decision Support Tool for Planning and Monitoring Services in Home and Community Based Systems of Care for Children & Adolescents and their Families

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The copyright for the CANS information integration tool is held by the Buddin Praed foundation to ensure that it remains an open tool free for anyone to use. Information on guidelines for use and development can be obtained by contacting Melanie Lyons of the Foundation at 847-501-5113 or Mlewis422@aol.com
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<thead>
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INTRODUCTION AND METHODOLOGY

We have used a uniform methodological approach to develop information integration tools to guide service delivery for children and adolescents with mental, emotional and behavioral health needs, mental retardation/developmental disabilities, and child welfare and juvenile justice involvement. The basic approach allows for a series of locally constructed decision support/information integration tools that we refer to as the Child & Adolescent Needs and Strengths (CANS). It provides a communication framework so that different child serving partners can develop a common language on which to communicate about the characteristics, needs, and strengths of children and their families. While blended funding, system of care, and other service integration strategies offer significant potential for helping child serving agencies work more closely in the interest of the children they serve, communication represents a separate, independent challenge to these collaborations.

The background of the CANS comes from our prior work in modeling decision-making for psychiatric services. In order to assess appropriate use of psychiatric hospital and residential treatment services, Dr. Lyons and others developed the Childhood Severity of Psychiatric Illness (CSPI). This measure was developed to assess those dimensions crucial to good clinical decision-making for expensive mental health service interventions. We have demonstrated its utility in reforming decision making for residential treatment (Lyons, Mintzer, Kisiel, & Shallcross, 1998) and for quality improvement in crisis assessment services (Lyons, Kisiel, Dulcan, Chesler & Cohen, 1997; Leon, Uziel-Miller, Lyons, Tracy, 1998). The strength of this measurement approach has been that it is valid and easy-to-use, yet provides comprehensive information regarding the clinical status of the child or youth.

The CANS builds on the methodological approach of the CSPI but expands the tool to include a broader conceptualization of needs and the addition of an assessment of strengths of the child and the family (Lyons, Uziel-Miller, Reyes, Sokol, 2000). It is a tool developed to assist in the management and planning of services to children and adolescents and their families with the primary objectives of permanency, safety, and improved quality of life. The CANS is designed for use at two levels: 1) for the individual child and family and 2) for the system of care. The CANS provides a structured profile or “picture” of a child and family along a set of dimensions relevant to service planning and decision-making. Also, the CANS provides information regarding the child and family’s service needs for use during system planning and/or quality assurance monitoring. Due to its modular design the tool can be adapted for local applications without jeopardizing its psychometric properties. The goal of the measurement design is to ensure participation of representatives of all partners to begin building a common assessment language. The CANS measure is then seen predominantly as a communication strategy.

The CANS is designed to be used either as a prospective information integration tool for decision support during the process of planning services or as a retrospective decision support tool based on the review of existing information for use in the design of high quality systems of services. This flexibility allows for a variety of innovative applications.

As a prospective information integration tool, the CANS provides a structured profile of children along a set of dimensions relevant to case service decision-making. The CANS
provides information regarding the service needs of the child and their family for use during the development of the individual plan of care. The information integration tool helps to structure the staffing process in strengths-based terms for the care manager and the family.

As a retrospective decision support tool, the CANS provides an assessment of the children and adolescents currently in care and the functioning of the current system in relation to the needs and strengths of the child and family. It clearly points out "service gaps" in the current services system. This information can then be used to design and develop the community-based, family-focused system of care appropriate for the target population and the community. Retrospective review of prospectively completed CANS allows for a form of measurement audit to facilitate the reliability and accuracy of information (Lyons, Yeh, Leon, Uziel-Miller & Tracy, 1999).

In addition, care coordinators and supervisors can use the CANS as a quality assurance/monitoring device. A review of the case record in light of the CANS tool will provide information as to the appropriateness of the individual plan of care and whether individual goals and outcomes are achieved.

The dimensions and objective anchors used in the CANS were developed by focus groups with a variety of participants including families, family advocates, representatives of the provider community, case workers and state staff. The CANS was originally developed with support from the Texas Health and Human Services Commission and Christ’s Home for Children; additional support for the development of the CANS-DD was provided by the Texas Families Are Valued Project and Texana MH/MR. Testing of the reliability of the CANS in its applications for developmental disabilities and mental health indicate that this measurement approach can be used reliably by trained professionals and family advocates.

Following are a summary of the dimensions used in the CANS-MH, the CANS-DD and the CANS-JJ used in several states. Unless otherwise specified, each rating is based on the last 30 days. Each of the dimensions is rated on a 4-point scale after routine service contact or following review of case files.

Even though each dimension has a numerical ranking, the CANS information integration tool is designed to give a profile or picture of the needs and strengths of the child and family. It is not designed to "add up" all of the "scores" of the dimensions for an overall score rating. When used in a retrospective review of cases, it is designed to give an overall "profile" of the system of services and the gaps in the service system not an overall "score" of the current system. Used as a profile based information integration tool, it is reliable and gives the care coordinator, the family and the agency, valuable existing information for use in the development and/or review of the individual plan of care and case service decisions.

The basic design of the ratings is:
- ‘0’ reflects no evidence,
- a rating of ‘1’ reflects a mild degree of the dimension,
- a rating of ‘2’ reflects a moderate degree, and
- a rating of ‘3’ reflects a severe degree of the dimension.
Another way to conceptualize these ratings is:

- ‘0’ indicates no need for action,
- ‘1’ indicates a need for watchful waiting to see whether action is warranted (i.e., flag for monitoring and/or prevention)
- ‘2’ indicates a need for action, and
- ‘3’ indicates the need for either immediate or intensive action.

The rating of "U" for unknown should be considered a flag for a need to find this information for a complete profile or picture of the needs and strengths of the child and their family. The rating of “U” should be used only in those circumstances in which you are unable to get any further information. It is considered an item for immediate action to find the missing information in order to have a complete profile (picture) of the strengths and needs of the child and the family for a viable care coordination plan.

In order to maximize the ease of use and interpretation, please note that the last two clusters of dimensions, Caregiver Capacity and Strengths, are rated in the reverse logical manner to maintain consistency across the measure, i.e., a rating of “0” is seen as a positive strength. The following is the conceptualization that we use for the strengths based dimensions:

- '0' indicates a strength on which to build,
- '1' indicates an opportunity for strength development and use in planning,
- '2' indicates a need for strength development
- '3' indicates a need for significant strength identification and/or creation

Thus, in all cases in the strengths section, a low rating is positive.

The “comment section” is used to clarify information or to add to the information based on the child and/or family’s comments.

The CANS is an effective information integration tool for use in either the development of individual plans of care or for use in designing and planning community-based, family-focused systems of care for children and adolescents with serious mental, emotional and behavioral disorders and their families. To administer the CANS information integration tool, the care coordinator, family advocate or other service provider has several options. 1) The interviewer can read the anchor descriptions for each dimension and then record the appropriate rating on the assessment form or 2) they can use a semi-structured interview questions to generate a discussion with the family. One CANS form is completed for each case reviewed or for each individual child and family interviewed.

When the CANS is used in an initial interview process with the child and family, the person completing the CANS (parent advocate, care coordinator, etc., should be sufficiently familiar with the form to listen to the family’s “story” as they would like to tell it. The interviewer can then ask those questions needed to obtain the information needed to complete the CANS.
CHILD & ADOLESCENT NEEDS AND STRENGTHS
For Children and Adolescents with Mental Health Challenges
(CANS-MH)

<table>
<thead>
<tr>
<th>Problem Presentation</th>
<th>Risk Behaviors</th>
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</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>Danger to Self</td>
</tr>
<tr>
<td>Attention Deficit/Impulse Control</td>
<td>Danger to Others</td>
</tr>
<tr>
<td>Depression/Anxiety</td>
<td>Elopement</td>
</tr>
<tr>
<td>Oppositional Behavior</td>
<td>Sexually Abusive Behavior</td>
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<td>Social Behavior</td>
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<tr>
<td>Substance Abuse</td>
<td>Crime/Delinquency</td>
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<tr>
<td>Adjustment to Trauma</td>
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<tr>
<td>Situational Consistency of Problems</td>
<td></td>
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<tr>
<td>Temporal Consistency of Problems</td>
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<table>
<thead>
<tr>
<th>Functioning</th>
<th>Care Intensity &amp; Organization</th>
</tr>
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<tbody>
<tr>
<td>Intellectual/Developmental</td>
<td>Monitoring</td>
</tr>
<tr>
<td>Physical/Medical</td>
<td>Treatment</td>
</tr>
<tr>
<td>Family</td>
<td>Transportation</td>
</tr>
<tr>
<td>School/Day Care</td>
<td>Service Permanence</td>
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<tr>
<td>Sexual Development</td>
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<thead>
<tr>
<th>Family/Caregiver Needs and Strengths</th>
<th>Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Family</td>
</tr>
<tr>
<td>Supervision</td>
<td>Interpersonal</td>
</tr>
<tr>
<td>Involvement with Care</td>
<td>Relationship Permanence</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Education</td>
</tr>
<tr>
<td>Organization</td>
<td>Vocational</td>
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<tr>
<td>Resources</td>
<td>Well-being</td>
</tr>
<tr>
<td>Residential Stability</td>
<td>Spiritual/Religious</td>
</tr>
<tr>
<td>Safety</td>
<td>Talents/Interest</td>
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<tr>
<td></td>
<td>Inclusion</td>
</tr>
</tbody>
</table>

Attachment F-7
# CHILD & ADOLESCENT NEEDS AND STRENGTHS
For Children and Adolescents with Developmental Disabilities (CANS-DD)

## Functioning
- Motor
- Sensory
- Intellectual
- Communication
- Developmental
- Self Care
- Independent Living Skills
- Physical/Medical
- Family
- School/Day Care

## Risk Behaviors
- Danger to Self
- Danger to Others
- Agitation/Self Stimulation
- Runaway
- Social Behavior
- Crime/Delinquency

## Co-Existing Conditions
- Psychotic Symptoms
- Depression/Anxiety
- Impulse Control
- Oppositional
- Substance Abuse
- Adjustment to Trauma

## Care Intensity & Organization
- Monitoring
- Assistance
- Treatment
- Funding/Eligibility
- Transportation
- Service Permanence

## Caregiver Capacity
- Physical
- Supervision
- Involvement
- Knowledge
- Organization
- Home Adaptability
- Resources
- Safety

## Strengths
- Family
- Interpersonal
- Relationship Permanence
- Education
- Vocational
- Well-being
- Spiritual/Religious
- Talents/Interest
- Inclusion
## CHILD & ADOLESCENT NEEDS AND STRENGTHS

For Children and Adolescents in the Juvenile Justice System

(CANS-JJ)

<table>
<thead>
<tr>
<th><strong>Criminal and Delinquent Behavior</strong></th>
<th><strong>Functioning</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Seriousness of Criminal Behavior</td>
<td>Intellectual/Developmental</td>
</tr>
<tr>
<td>History of Criminal Behavior</td>
<td>Physical/Medical</td>
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<tr>
<td>Violence</td>
<td>Family</td>
</tr>
<tr>
<td>Sexually Abusive Behavior</td>
<td>School/Day Care</td>
</tr>
<tr>
<td>Peer Involvement</td>
<td></td>
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<tr>
<td>Parental Involvement</td>
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<thead>
<tr>
<th><strong>Mental Health Complications</strong></th>
<th><strong>Other Risk Behaviors</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>Danger to Self</td>
</tr>
<tr>
<td>Attention Deficit/Impulse Control</td>
<td>Social Behavior</td>
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<tr>
<td>Depression/Anxiety</td>
<td>Elopement</td>
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<td>Oppositional Behavior</td>
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<tr>
<td>Antisocial Behavior</td>
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<td>Substance Abuse</td>
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<tr>
<td>Temporal Consistency of Problems</td>
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<thead>
<tr>
<th><strong>Care Intensity &amp; Organization</strong></th>
<th><strong>Caregiver Capacity</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring</td>
<td>Physical</td>
</tr>
<tr>
<td>Treatment</td>
<td>Supervision</td>
</tr>
<tr>
<td>Transportation</td>
<td>Involvement with Care</td>
</tr>
<tr>
<td>Service Permanence</td>
<td>Knowledge</td>
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<tr>
<td></td>
<td>Organization</td>
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<td></td>
<td>Resources</td>
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<tr>
<td></td>
<td>Safety</td>
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<tr>
<th><strong>Strengths</strong></th>
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<tbody>
<tr>
<td>Family</td>
<td></td>
</tr>
<tr>
<td>Interpersonal</td>
<td></td>
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<tr>
<td>Relationship Permanence</td>
<td></td>
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<tr>
<td>Education</td>
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<tr>
<td>Vocational</td>
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<td>Well-being</td>
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<tr>
<td>Spiritual/Religious</td>
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<td>Inclusion</td>
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</tbody>
</table>
# CHILD & ADOLESCENT NEEDS AND STRENGTHS

For Children and Adolescents in the Child Welfare System
(CANS-CW)

<table>
<thead>
<tr>
<th>Functional Status &amp; Mental Health</th>
<th>Caregiver Needs and Strengths &amp; Care Management</th>
<th>Child Safety &amp; Child Risk Behaviors</th>
<th>Substance Abuse &amp; Criminal and Delinquent Behavior</th>
<th>Strengths</th>
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</thead>
<tbody>
<tr>
<td>Intellectual &amp; Serious mental Illness</td>
<td>Physical &amp; Urgency</td>
<td>Abuse &amp; Danger to Self</td>
<td>Severity of Substance Abuse &amp; Seriousness of Criminal Behavior</td>
<td>Family</td>
</tr>
<tr>
<td>Developmental &amp; Attention Deficit/Impulse Control</td>
<td>Developmental &amp; History of Criminal Behavior</td>
<td>Neglect &amp; Runaway</td>
<td>Duration of Substance Abuse &amp; Violence</td>
<td>Interpersonal</td>
</tr>
<tr>
<td>Physical/Medical &amp; Depression/Anxiety</td>
<td>Organization &amp; Sexually Abusive Behavior</td>
<td>Permanency &amp; Peer Involvement</td>
<td>State of Recovery &amp; Peer Involvement in Crime</td>
<td>Relationship Permanence</td>
</tr>
<tr>
<td>Family &amp; Antisocial Behavior</td>
<td>Resources &amp; Parental Criminal Behavior</td>
<td>Exploitation &amp; Parental Involvement</td>
<td>Peer Involvement &amp; Peer Involvement</td>
<td>Education</td>
</tr>
<tr>
<td>Attachment &amp; Adjustment to Trauma</td>
<td>Residential Stability &amp; Well-being</td>
<td>School/Day Care &amp; Well-being</td>
<td>State of Recovery &amp; Violence</td>
<td>Vocational</td>
</tr>
<tr>
<td>Sexual Development &amp; Situational Consistency of Problems</td>
<td>Urgency &amp; Service Permanence</td>
<td>Mental Health &amp; Temporal Consistency of Problems</td>
<td>Peer Involvement &amp; Sexually Abusive Behavior</td>
<td>Spiritual/Religious</td>
</tr>
<tr>
<td>School/Day Care &amp; Problems</td>
<td>Supervision &amp; Treatment</td>
<td>Child Safety &amp; Social Behavior</td>
<td>Parental Involvement &amp; Peer Involvement in Crime</td>
<td>Creative/Artistic</td>
</tr>
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<td></td>
<td>Involvement with Care &amp; Transportation</td>
<td>Strengths &amp; Inclusion</td>
<td>Parental Involvement &amp; Parental Criminal Behavior</td>
<td>Inclusion</td>
</tr>
</tbody>
</table>
| | Knowledge & Service Permanence | | | }
REFERENCES


In this stage, the Alliance will develop a plan for a community-based system of care for children and their families.

~ MAJOR FUNCTIONS OF A COMMUNITY ALLIANCE ~

- Provide for community education and advocacy on issues related to delivery of services (Stages 1-4 and ongoing)
- Needs assessment and establishment of priorities for service delivery (Stage 2)
- Determining community outcome goals (Stage 2)
- Promote prevention and early intervention services (Stage 3)
- Joint planning for resource utilization in the community (Stage 3)
- Serve as a catalyst for community resource development (Stage 4)

*Citation from Florida Statute 20.19 (6) describing duties of Community Alliances*

A community-based System of Care is coordinated seamless services for children and their families to achieve individual goals/outcomes.

Goals:
- To develop a plan for a community-based system of care for children and their families that reflects:
  - The community’s vision/mission, and
  - Designated outcomes.

This goal will be met when the Benchmarks & Achievements are completed.
STAGE 3

~ BENCHMARKS and ACHIEVEMENTS ~


- The System of Care design/plan will reflect the active partnership of the community members.

- The core values and guiding principles of a System of Care found in the seminal work of Stroul and Friedman are included in Attachment A.

- The community wide System of Care design/plan will include prevention and early intervention services.

- The System of Care design/plan will reflect the target population specified in the designated outcomes for children and their families.

- If there is an existing Lead Agency, a community based system of care plan already exists and should be reviewed with the lead Agency to tie the community together.

- The community providers will have the information needed for the basis of a community based system of care and their inclusion in this work is imperative.

- The community may find that a framework for a system of care already exists and only needs refinement and/or plans to fill in gaps in services.

- As a first step, Community Alliances may begin their work with a system of care design reflecting one or a few outcomes of a small target population. Additional services/target population may be added at a later date through an ongoing information feedback and planning process.
Example: The community planning group in Hillsborough County found that they already have the basic framework for a system of care in place and are targeting their efforts to planning for the gaps in services and/or additional services needed for their target population. Please see Attachment B at the end of this section describing their system of care.

Other communities have also moved forward with a description of their system of care. Attachment C describes the systems of care in Sarasota County, Sarasota YMCA, and District 15.

HELPFUL HINTS

A community based system of care is a collaborative system of support that:
- Emphasizes creative resource development,
- Links formal and informal service providers from diverse backgrounds,
- Maximizes effective use of limited resources, and
- Keeps the child and family at the center of operations.

- The System of Care design/plan will reflect a basic structure and the functions necessary for implementation.
- A fully operational home and community-based system of care for children and their families addresses the following components:
  - Families and children served – profiling the target population
  - Family involvement~ building family organizations through parent/professional partnerships ~ involving the families of the target population including grandparents raising their grandchildren and kinship care families
  - Community ownership/investment
  - Interagency collaboration
  - Cultural competence/sensitivity ~ mapping of the ethnic and cultural profiles of the target communities
1. **Service array development ~ strengths based resource development**

   Individual service plan design and coordination ~ parent and professional train other parents and professionals together in the care coordination (Wraparound) process

2. **Staff resources ~ including cultural competency**

3. **Funding, financial management, and sustainability planning**

4. **Evaluation and quality management ~ family involvement in evaluation design, data gathering and data analysis**

5. **Information management and communication ~ data as information to make decisions at all levels of the system**

A more detailed description of the critical indicators and questions to determine a community-based system of care are found in **Attachment D** at the end of this section. This system of care capability worksheet can also be used with individual agencies providing services in a system of care as a management-tracking tool.

2. **Identify opportunities/barriers in implementing the System of care.**

   - Review the services and linkages currently in place that serve children and their families.

   - The community may be in a posture of refining an existing community based system of care because they may already have the beginning structure of a community-based system of care in place.

   - Each child serving agency in the community must “own” the outcomes designated by the community for children and families and have a vested interest in the achievement of these outcomes.

   - An honest and open collaborative partnership across agency lines will result in true, shared accountability and community ownership of the outcomes for children and their families.
3. **A community resource development plan for the system of care.**

- One of the keys to defining a community-based system of care is to "think outside the box" when looking at the services needed to positively impact child and family outcomes.

- The information gathered from the review of community services completed in **Stage 2** will give the community an overview of the services that impact on the designated outcomes, duplication and gaps in services, effectiveness of the service and sufficiency of availability.

- This information organized to look at service availability, either through service duplication and/or gaps in service, will provide the basis for the resource development plan for the community based system of care.

- Think creatively when looking at the services needed or duplicated.

- Review non-traditional services and those services that can be provided in the community by faith-based organizations and other community and neighborhood organizations that can help in this creative planning process.

- As in the Hillsborough County example outlined in Stage 2, remind committee/work group members to look at ways to improve services **first through collaboration without additional funds**.

- Some areas of interagency collaboration may not take additional resources but will incorporate an objective of using current resources in a more effective, efficient, or creative collaborative manner.

- Committee/work group members should then present to the Alliance a resource development plan that is priority list of services that need to be funded to fill service gaps and will positively impact on the designated outcomes.
COMMUNITY ALLIANCES

A Community Alliance provides for community ownership and oversight; provides a focal point for setting community priorities; and is a catalyst for community resource and development.

Stage III ~ To develop the System of Care design/plan and resource development plan for the community.

<table>
<thead>
<tr>
<th>ALLIANCE ACTIVITIES</th>
<th>ALLIANCE RESOURCE NEEDS</th>
<th>ALLIANCE BENCHMARKS &amp; ACHIEVEMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop design/plan for Community based System of Care (SOC)</td>
<td>Identify critical elements of a System of Care design</td>
<td>A community based System of Care design/plan developed in partnership and specifically tailored to the community</td>
</tr>
<tr>
<td>Identify opportunities/barriers in implementing the System of Care design.</td>
<td>Research and review examples of seamless service SOC designs/plans</td>
<td>A resource development plan for the System of Care</td>
</tr>
</tbody>
</table>
CORE VALUES AND GUIDING PRINCIPLES
OF A SYSTEM OF CARE


This book is a very good reference book for community-based family-focused system of care development.
VALUES AND PRINCIPLES FOR THE SYSTEM OF CARE

CORE VALUES

1. The system of care should be child centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community based, with the locus of services as well as management and decision making responsibility resting at the community level.

3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the population.

GUIDING PRINCIPLES

1. Children with emotional disturbances should have access to a comprehensive array of services that address the child’s physical, emotional, social, and educational needs.

2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.

3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.

5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.

6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and youth with emotional disturbances should be promoted.

10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

HILLSBOROUGH KIDS, INC. CONCEPTUAL SYSTEM OF CARE
Hillsborough Kids, Inc. Conceptual System of Care

Hillsborough Kids, Inc. (HKI) has designed a comprehensive system of care that seeks to expand and strengthen the county’s community-based family support services. This system will assist families in need, and offer protection services for children who have been abused or neglected, or who sit at risk of abuse or neglect. The design includes an emphasis on and expansion of resources allocated to prevention/early intervention efforts. It also strengthens permanency initiatives for children who must be placed in out-of-home care.

**Mission**

*Our mission mandates that we oversee and coordinate a system of care assuring the safety and permanency of Hillsborough County children and families who are now, or have been, at risk of abuse or neglect.*

**Targeted Population**

As our mission states, HKI seeks to serve children and families who have experienced child abuse and/or neglect. We also work with those who, as defined in Chapter 39 of the Florida Statutes, are at risk of abuse or neglect. Our designed system includes multiple entry points for community members. These entry points seek to serve families; make referrals; and quickly access resources, services and supports.

**Guiding Principles**

Our guiding principles, as determined by numerous strategic planning activities in the community, seek to provide services that:

- **Focus on children and are family centered**
- **Offer seamless, cohesive and comprehensive delivery of services**
- **Are culturally competent, relevant and respectful in delivery**
- **Provide individualized and strength-based delivery**
- **Emphasize prevention and early intervention**
- **Involve consumers, family members, and all other stakeholders**
- **Offer an array of fully-integrated, coordinated, and non-duplicated services**
- **Maximize existing resources**
- **Create new resources**
• Develop non-specific, non-categorical funding
• Provides continuous quality assurance and improvement

**Intake**

A number of services refer children and families to HKI. Many of these families have been examined by the Department of Children and Families’ Protective Investigations division, after allegations of abuse or neglect. They may enter the HKI system at a number of points in the investigation process. For example, these families may enter HKI via:

• A Protective Investigator seeking immediate need for services or support.

• A Protective Investigator believing, during the investigation, that the child is in immediate danger. Such professionals contact HKI to shelter the child in an out-of-home placement, regardless of whether the family desires immediate help.

• A Protective Investigator believing, upon conclusion of the investigation, that the family has requested and received court ordered services for the safety of the child or children involved. HKI offers both in-home and out-of-home arrays of services and supports. The level of support depends on court order.

Children and families may also enter the HKI system through community referrals. Families may:

• Self-refer
• Enter the program via community service providers.
• Enter the program after school referrals directly to HKI

HKI intake staff, a group of trained professionals, will initially determine, with the referral source, the immediate action needed by the child/children and family in question. Initial screenings will seek to answer the following:

• Is this a referral for linkage and access to a community resource only?
• Is the child in need of temporary shelter? If so, what type of shelter placement appears most appropriate for the child and family?
• Is the child at risk of out-of-home placement if intensive family preservation is not accessed?
• Is there an immediate need to place the child out of his home, in foster, relative, or residential care?

Depending on the immediate need, children and families may come into the HKI system for a short or long period of time. Their length of placement is determined by whether these families simply need to access available resources in the community; or whether they need comprehensive services designed to facilitate long-term, safe, permanency.

**Team Approach to Care Management**

HKI has designed a system of care offering a team approach to working with families. Each team will consist of a Care Manager and two Resource Managers. Care Managers and Resource Managers have different but related responsibilities:

*Resource Coordinators each serve as a* member of the Care Management Team. Each coordinator will meet all of the current requirements for status as a child-protection worker. These requirements include:

- A Bachelor’s degree in a related field
- Two years’ direct experience working with children and families
- Completion of the state Child Protection Certification program

Anyone assuming the role of *Resource Coordinator* must also develop, expand, access, and link resources in the community to the needs of the children and families. *Resource Coordinators* will share a caseload with another *Resource Coordinator* and a *Care Manager* (Team caseload numbers have yet to be determined, but they will not exceed 45 children per three-member team). Children and families on a *Resource Coordinator* caseload will usually require short-term services or linkage with community resources. They will also work under a community case manager already assigned to the child and/or family. Such Resource Coordinators may also have judicial involvement.
Care Manager

The Care Manager is both member and leader of the Care Management Team. This person will meet all current child-protection staff requirements, but will also have a clinical degree and extended experience in working with children and families with multiple needs. This experience includes:

- A Master’s degree in a related field
- Two years’ experience working with children and families
- A Comprehensive Assessment Certificate
- Completion of the state Child Protection Certification Program

The Care Manager will provide clinical oversight and expertise to the team, and clinical intervention to children and families on their caseload. These interventions include: a comprehensive assessment that identifies the strengths, needs, and risk factors affecting the child and family in question; direction for service delivery; development of a service plan with parents; substitute care givers, and other stakeholders; oversight and support for all members of the child and family team on service plan implementation; reports to courts on progress towards permanency goal.

Flow of the System

1) Children and Families are referred to central intake within Hillsborough Kids, Inc. An initial screening process determines the immediate level of care and, within the first 24 hours, an assignment is made to a Resource Coordinator or Care Manager. HKI will ensure continuity of care by assigning a lead Resource Coordinator or Care Manager and a Care Management Team to take responsibility for the child and family from intake through discharge.

2) A strength and needs assessment process begins for families that require services beyond 30 days. Care Managers will complete and implement a comprehensive assessment for all children who have been sheltered or ordered into other out-of-home care. Assessments will be complete within the first 30 calendar days.

3) Resource Coordinators and Care Managers will develop a service plan for all children and families needing services beyond 30 days. Service
plans will be developed by the family service team – a team comprised of parents, alternative caretakers, significant others and other service providers. The service plan will include a realistic permanency goal that can be achieved within 12 months; measurable objectives relating to the permanency goal, and specific task assignments with timelines. The initial service plan will be completed within the **first 45 days**.

4) Within the first 60 days, **Care Managers** and **Resource Coordinators** will staff all children and families who have judicial involvement with the multi-disciplinary Integrated Service Network. The Integrated Service Network will meet one day a week for 4 hours. The network will be comprised of representatives from the substance abuse, mental health, domestic violence, education, special education, health, developmental services, and juvenile justice programs, along with foster parents, a child advocate, and a parent advocate. Both Care Managers and Resource Coordinators may request an emergency staffing prior to these weekly meeting to resolve an immediate need for access to a professional or service. The primary role of the Integrated Service Network will be to provide oversight of the care management service plans and to facilitate access to other community services located outside the HKI system (e.g., Medicaid Pre-paid Health Plan, special school services, and substance abuse treatment through TANF funds). This group must approve the need for residential treatment placements, and will follow these children as one step in a utilization-review process. This Network will also provide external quality assurance and oversight of the community-based system in addressing all safety needs or needs that are a barrier to safety. To accomplish this, the Network will facilitate the identification, appropriate intervention, and immediate access to the needed service or support.

5) Service Plan implementation will begin immediately, but will be formalized within the **first 60 days**.

6) Judicial reviews need to occur every **six months** to report on the progress of the family towards safe permanency, independent from the court oversight. Care Managers and Resource Coordinators will be required to complete monthly progress reports available to every stakeholder, including the parents, and to update service plans whenever any goals, interventions, or timelines are altered. Service Plans must be reviewed and updated, as needed, **every month** to ensure progress is
being made towards permanency, or that modifications are being made in a timely manner.

7) Decisions to close the case will be made by each individual child-and-family service-plan team and the Care Management Team, with the approval of the Integrated Service Network and Dependency Judge. Each discharge plan will include a detailed follow-up procedure delineating roles and responsibilities for each of the service plan members in providing support to the permanency placement. Adoptive parents may access follow-up services and supports immediately after the finalization of adoption, and at any point during the child’s first 18 years of life, by referring themselves to HKI Intake.

Service Array

The following array of HKI services and supports is not intended to be inclusive of all the options open to families, children, Resource Coordinators, and Care Managers. HKI will constantly add to its menu of services and supports, as stakeholders and consumers provide insight into the needs of the children and families served. This array of services is simply a guide to what should be included in the array of services and supports.

Prevention and Early Intervention

These are service and supports designed to aid low risk families. Target families include pre-incident groups experiencing high family stress, emotional and economic pressures.

- Family Group Decision Making
- Community outreach to promote early identification by community partners
- Concrete supports: furniture, clothing, car seats, assistance with housing, etc.
- In-home supports
  - Respite
  - Parent training
  - Family therapy
  - Conflict Resolution
• Behavior management
• Home management

• Community supports
  • Educational activities in the community
  • After-school, holiday, and summer programs
  • Tutoring programs
  • Special neighborhood activities
  • Outpatient mental health treatment
  • Outpatient substance abuse treatment
  • Outpatient sexual abuse treatment
  • Recreational programs
  • Vocational training and support
  • Parent support groups
• School supports
  • Classroom management
  • School advocates
  • Education to teachers/school personnel
  • Mediation between parents and school
  • Special academic evaluations
  • Behavior management

Family Preservation

These are the services and supports available to moderate-risk families. Usually these are families who have experienced instances of child maltreatment such as neglect, excessive/inappropriate discipline, inadequate medical care, and failure to provide adequate supervision. Primary concern is family intervention related to child safety.

• Safety plan and safety plan monitoring
• Family group decision making
• Service array determined by comprehensive assessment
• Judicial oversight
• Care manager development of a service plan with family and stakeholders
• In-home supports
• Respite
• Parent training
• Family therapy
• Individual therapy
• Behavior management
• Home management
• Referral and linkage to formal community services
  • Mental Health Services, including specialized services such as sexual abuse treatment, medical management, etc.
  • Health evaluations and services
  • Education and vocational support
  • Day Care/ out of school care
  • Housing
  • Non-traditional services, such as mentoring, Boys and Girls Clubs, Boy Scouts and Girl Scouts, faith-based organizations, etc.
• Concrete supports: furniture, clothing, car seats, assistance with housing, etc.

**Out-of-Home Care**

*These are services and supports to the highest-risk families. Child maltreatment has been established and is at the severity level that requires out-of-home placement to ensure the child’s safety. Children who have experienced serious injury, serious neglect, and sexual abuse are primary targets, along with those whose parents are actively involved in domestic violence, or who have substance-abuse problems.*

• Service array determined by comprehensive assessment
• Judicial oversight
• Placement
  • Temporary shelter
  • Relative placement
  • Foster placement
  • Group home placement
  • Residential placement
  • Foster/adoptive placement
  • Adoptive placement
• Care manager develops permanency plan with stakeholders
• Care manager responsible for plan implementation
• *Integrated Service Network* provides oversight and problem solving
  • *Mental Health Representative*
  • *Substance Abuse Representative*
  • *Domestic Violence Representative*
  • *Education and Special Education Representative*
  • *Health Representative*
  • *Developmental Service Representative*
  • *Juvenile Justice Representative*
  • *Foster Parent Representative*
  • *Child Advocate (Could be GAL)*
  • *Parent Advocate*
• Care manager reports to court on status towards permanency

**Permanency Placement Support**

After care services and supports to family, including continuing clinical services as needed, will include:
• Adoption support services
  • Phone link with other adoptive families
  • Adoptive parent child-and-family support groups
  • In-home supports
  • Linkage and advocacy with community services
  • Respite
• Independent Living supports
  • Vocational training
  • Transitional financial support
  • Linkage to formal and informal supports
• Supervision while child/youth is under court oversight
SYSTEMS OF CARE
COMMUNITY BASED CARE
IN SARASOTA COUNTY and
DISTRICT 15
COMMUNITY BASED CARE
IN SARASOTA COUNTY

COMMUNITY PARTNERSHIP FOR COMPREHENSIVE SERVICES

Continuum of Services

A full continuum of services will be offered by the community partnership of agencies. The following is an abbreviated outline of this continuum.

Parent Training and Support Groups, as needed, will be available to all families receiving services as well as foster families and shall include, but are not limited to: Active Parenting, Nurturing, Single Parents, Parents of Teens, Dads Only, Children's Foster Care, etc.

Outpatient Individual, Family, and Group Counseling will be available to all children and families receiving services, as well as foster families, and will include specialized treatment specific to the issues and needs presented by the children and families. These services will be provided by an assigned master’s level counselor who will share responsibilities for the case with the case manager.

Healthy Families Sarasota will be available to those children and families presenting a specific need or where this type of intervention is determined to be the most effective strategy, based upon a thorough assessment. These services are home-based for families with newborns and continue to work with these families until the age of 5. Developmental Day Treatment Services will be available to eligible children as it is determined, through their assessment process, that this type of intervention is an effective strategy towards resolving their identified issues. This will be a school or facility based intervention program that is Medicaid reimbursable.

Case Management will be available to all children and their families that are provided services. This is a direct support service that provided by a Bachelors level professional who shall assist the child
and family in a "hands-on" fashion to assure services are obtained, appointments are made and met, and necessary documentation is completed along the way. This service shall include all case management related activities including case plan development and management, coordination of all communication and staffings, court appearances, case record responsibility, and work directly with all parties to a case.

**Children's Psychiatric Services (Out-Patient)** will be available to all children and families determined to need such services.

**Family Preservation Services (In-Home Intervention)** will be available to all families with the goal of reunification or if the family remains intact during participation in the service to prevent removal of the child from the home.

**Comprehensive Assessment** will determine the type of placement as well as the specific home or facility that is a best match based on the child's immediate needs and long term plans. This assessment will be provided to each child and family eligible for services. This assessment will establish the individualized case plan that sets a course of action towards specific and identified goals for the family and child with estimated time lines. Concurrent planning, as appropriately determined will also begin at this point.

**Appropriate Out-of-Home Placement** will be available to all children needing such service. All placement facilities will be licensed appropriately, will be staffed by individuals properly trained and demonstrating competency in providing these services. These placement facilities will include but not be limited to: foster homes, therapeutic foster homes, group homes, residential treatment facilities, family/relative home, independent living, psychiatric care facilities, etc.

**Reunification/Postplacement Services** will be available to all children who are being reunited. These services include but are not limited to: In-Home Intensive Counseling Services, Out-Patient Counseling Services, Parent Education and Support Services, Recreational Services, etc.
Adoption Services will be provided to those children determined appropriate for adoption and legally freed for this placement. These services include but are not limited to: assessment of child’s needs, preparation of adoptive home, legal document preparation, and post adoptive services. Throughout the delivery of service the possibility of adoption will be concurrently planned thus avoiding "starting from scratch" if the reunification plans are not realized.
This Example of System of Care principles was provided by District 15

SYSTEM OF CARE
SERVICE/DELIVERY PRINCIPLES

1. Services will be provided with the safety and best interest of children as the first consideration.

2. Equitable services will be available to children and families in their residential county.

3. Services will be provided closest to the child and family’s natural setting, to include but not limited to, home, school, and other community-based settings. Provider settings will be utilized only by family choice or until natural setting provision of service is operationalized. Provider facilities will remain the location for service delivery if best practices require isolation from natural settings.

4. Services will be available in levels of intensity to accommodate a customized service plan.

5. Service plans will be considered dynamic documents, supporting changing child and family needs.

6. Time and location for service plan creation/amendment meetings will be flexible to allow family participation. All meetings involving plan creation/amendment will be held with family presence and active participation.

7. The family service plan will capitalize on the strengths of the child and family, while addressing their needs.

8. The comprehensive assessment tool utilized with children/families will address needs of the entire family. This tool will guide the creation of the family service plan, with appropriate providers at the table to pledge services and resources to support the plan at the time of its creation. Informal community supports will also be offered to the family by their representatives at the initial planning meeting. This collaboration of department, agency, and community providers to develop a child/family
service plan will coordinate planning, funding and delivery of services to meet needs without duplication.

9. Services will be provided in a manner that preserves the rights and dignity of all children and families.

10. Planning for families will be done on concurrent multiple tracks, as necessary to assure the child a sooth transition toward permanency regardless of final placement.
11. A comprehensive assessment will be done with the birth family and child immediately upon initial referral into shelter care. Children will leave shelter care with an individualized service plan addressing all needs identified at that time. The service plan will be amended whenever the child experiences a change in placement, with previous/future caregivers in attendance to share relevant information regarding the child. All individual plans of service form providers will be included in the family service plan. Proposed revision or discharge from provider services will require a meeting to amend the family service plan.

12. Service planning will be sensitive to cultural, ethnic and disability issues.

13. The lead agency will examine categorical funding streams/revenues of providers and departments to determine if they can be converted to flexible funding to support individualized services for children and families.

14. System effectiveness and performance will be evaluated formally through outcome measures. These measures will reflect federal, state, and local community expectations of the system to meet the needs of children and families. System success will also be determined by the use of family survey instruments and the creation of a volunteer Stakeholders Council, advising the lead agency of continuing deficits/challenges.

15. The Lead Agency will contract for effective/efficient services, and hold providers responsible for creating new capacity and new services as identified in family service plans to address unmet needs.

16. Interagency and community provider agreements to allow participation in funding/service commitments to the Wraparound process will be developed. These documents will be held at the Lead Agency so monitors can track the effectiveness of the Lead Agency and their providers in creating a community-based approach for children and families services.

18. All staff who coordinate or provide services to families will be both skilled and educated in their tasks, with training provided to maintain and improve staff capability. Training of foster/adoptive families will be provided side-by-side with professional staff at no cost to participants, when subject matter is beneficial to the child in care.

19. Families may change family service coordinators within the Lead Agency if the relationship becomes irreparably unsatisfactory.

20. The lead Agency will provide family service coordinator will coordinate the match of children with their alternative care providers, as necessary.

21. The Lead Agency will provide family service coordination as their only service to children and families to establish a family-centered, family choice principle of service delivery. Brokering services from a related, parent or subsidiary organization concerned with capacity utilization or profit is detrimental to family choice and perceived as a conflict of interest. Services will become more creative, innovative, flexible, and cost-efficient within a competitive environment.

22. Family service coordination will be accomplished within the family’s residential county.

23. Family service coordinators will become the child’s first and continuing source of advocacy and support. Coordinators will be responsible for collecting updated information from providers and participating in court hearings.

24. A specific family service coordinating team will follow the child/family from intake to discharge form services identified in the family plan.

25. Mental health services provided to the child/family will maintain continuity of therapeutic relationship across placements.

26. Families relocating within the four-county area will experience no disruption of services if the Lead Agency receives advance notice to convene a service plan amendment meeting.
27. Families experienced with the system of care will have the option to work as paid peer advocates/mentors on the family service planning team of families entering the system of care.

28. Housing supports to families in the system of care will be independent of other services (once this need is identified and provided through the service planning process.)
This Example of a System of Care was provided by District 15

SYSTEM OF CARE SERVICES
THAT WILL FOLLOW CHILDREN ACROSS PLACEMENT
AND WILL INCLUDE, BUT NOT BE LIMITED TO:

Wraparound Family Service Coordination for:
   1. Birth family
   2. Relative family
   3. Foster family
   4. Adoptive family

Out-of-home placement

Permanency Planning

Court Representation

Stratified Foster Care

Stratified Adoptive Placements

Scheduled Family Training to maintain provider status

Child and Adult Substance Abuse Services

Semi-Independent and Independent Living Supports

Transportation to services as needed

Therapeutic Respite-24/7 availability

Child Care-24/7

Day Treatment-needs based, not calendar based-12 months/year availability

Life Skills Training/Planning for Developmental Services Children’s Home Society

Behavioral Analyst/Behavioral Services
Domestic Violence Services
Supervised Visitation

Economic Services Supports for families/WAGES

Mental Health/Substance Abuse Crisis Services/Pharmacy-24/7-with linkage to Family Service Plan
Child/Adult Mental Health Evaluation

Child/Adult Outpatient-Individual/Family/Group Counseling

Attachment Disorder Services

Mentoring

Family Support Groups

Family Advocacy Groups

Family Self-Help Groups

Social/Recreational Opportunities

Parent University-volunteer parent training

Legal Services

Summer Camp Scholarships

Prevention/Early Intervention Services

Specific Home-Based Services/Interventions

Health Services

Medicaid Providers and Specialty Medicaid Providers

Transition Planning to Adult Services
Family/Child daily living skills training-age/functionally appropriate

Community Partner Supports

Family/Provider Communication Methodology

Crisis Hotline

Shelter

Runaway Services

Housing

Residential Crisis Stabilization

In-Home Crisis Stabilization

…and all other traditional or non-traditional services and supports that address specific needs in the family service plan.
SYSTEM OF CARE CAPABILITY WORKSHEET

This worksheet has been used successfully in several communities to track community-based systems of care.
**System of Care Capability and Project Management Tracking Work**

This worksheet is built on the work of Dr. Harry Shallcross, “System of Care Planning, Implementation and Management Work" seminal work of Dr. John Lyons on the *Child & Adolescent Needs and Strengths (CANS)* information integration tool that provide for child serving agency partners.

**March 2000**

### I. ADMINISTRATION, MANAGEMENT, AND ORGANIZATIONAL DEVELOPMENT

To provide organizational structure and operational capability to organize, coordinate, deliver, and monitor services of care sustainable in local market environments.

<table>
<thead>
<tr>
<th>Critical Issues</th>
<th>Critical Indicators</th>
<th>Q</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Representation from all child-serving agencies in planning, review, and decision-making.</td>
<td>• Functional processes are defined for business and clinical operations.</td>
<td>• Are the members of the interagency advisory council directly linked to decision-makers in their agencies?</td>
</tr>
<tr>
<td>• Core management and administrative functions are identified and described.</td>
<td>• Oversight structure represents interagency decision-makers, families, and community representatives.</td>
<td>• Does management staff have clear understandings of their roles and responsibilities?</td>
</tr>
<tr>
<td>• Organizational capability in all management functions.</td>
<td>• Organization chart represents roles, responsibilities, and lines of accountability.</td>
<td>• Are lines of accountability clear?</td>
</tr>
<tr>
<td>• Business planning processes are underway.</td>
<td>• Job descriptions that relate to functional responsibilities.</td>
<td>• Are families and communities represented in the oversight structure?</td>
</tr>
<tr>
<td></td>
<td>• Skills of management team match functional requirements.</td>
<td>• Are stakeholders familiar with and agree to use the <em>CANS</em> tool for referral to the System of Care and profiling of the target population?</td>
</tr>
</tbody>
</table>
### II. GOALS AND VISION

The System of Care (SOC) should have a clearly defined mission and vision, including concrete plans for organizing and implementing a community-based, family-focused system of care for children and adolescents with serious emotional and behavioral disturbances and their families. This mission and vision should be specifically tailored to meet the identified needs of target populations as defined by the Child & Adolescent Needs and Strengths (CANS) methodology, and the

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<td>• Common mission, values and vision among key stakeholders, including county human service systems, families, community residents, and project management.</td>
<td>• Mission statement, including objectives, values, and vision.</td>
<td>• How has planning process been conducted? Who participated and was collaboration among agencies, communities, and families facilitated?</td>
</tr>
<tr>
<td>• System of Care Principles are understood and fully supported by all stakeholders and service providers, including implications for service organization and delivery and the benefits of the CANS methodology.</td>
<td>• Strategic Plan, including business sustainability planning consistent with System of Care principles.</td>
<td>• What is the five-year vision for clinical care? Interagency collaboration?</td>
</tr>
<tr>
<td>• Organizational structure is in place for implementing and administering system of care.</td>
<td>• Organizational chart with clearly defined roles and responsibilities and lines of authority and accountability for: Management Staff Interagency representatives Advisory councils Contracted providers Family representative Community representatives</td>
<td>• Are visions among stakeholders consistent? If not, what are the major areas of difference?</td>
</tr>
<tr>
<td>• Strategies and critical tasks are identified for achieving implementation.</td>
<td>• Clearly delineated and documented target populations as defined by the CANS methodology</td>
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<tr>
<td>• System Reform is addressed in planning and organization.</td>
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</table>
### III. FAMILIES AND CHILDREN SERVED

Systems of Care exist to serve defined populations of children and families at risk. The needs and desired outcomes for populations are the foundation for all planning and represent core points of accountability for all service delivery. Populations of children and families must be clearly identified and described through the Child & Adolescent Needs and Strengths (CANS) methodology with concrete eligibility criteria and mechanisms for enrollment and assessment.

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<td>• Target population is defined through the CANS methodology.</td>
<td>• Clear guidelines for eligibility verification.</td>
<td>• What are the eligibility criteria and how will they be used?</td>
</tr>
<tr>
<td>• Target populations of children, families, and communities are clearly described, defined, and profiled for numbers, characteristics, needs, strengths, and desired outcomes.</td>
<td>• Profiles for target populations, including numbers, referral pathways, and historic outcomes and disposition, (historic costs and utilization patterns if possible)</td>
<td>• Does the target population as defined by the CANS methodology fit the perceived target population among collaborative agencies, communities, and core providers?</td>
</tr>
<tr>
<td>• Eligibility criteria and outreach/enrollment procedures are established.</td>
<td>• Families are actively involved in profiling and referral pathways.</td>
<td>• Do target population descriptions include issues central to child welfare, education, substance abuse, and juvenile justice?</td>
</tr>
<tr>
<td>• Referral sources and access routes are identified.</td>
<td>• Screening and referral pathways are identified and outlined for eligible and non-eligible children and families.</td>
<td>• How is the CANS methodology to determine profile of target population?</td>
</tr>
<tr>
<td>• Families are involved in outreach, referral, and enrollment.</td>
<td>• Use the CANS methodology to determine profile of target population</td>
<td>• How is the CANS methodology to determine profile of target population?</td>
</tr>
<tr>
<td>• Self-referral is available in partner communities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Screening and Referral pathways are developed for non-eligible children and families.</td>
<td></td>
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</tbody>
</table>
**IV. COMMUNITY OWNERSHIP/INVESTMENT**

To fully and directly involve community residents and indigenous community agencies and organizations as collaborative partners in the design and implementation of locally organized systems of care for specific neighborhoods, including all levels of planning, operations, and service delivery:

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<td>• Community stakeholders are identified and involved in planning and communication.</td>
<td>• Community leaders are represented in planning and oversight processes.</td>
<td>• Who are leaders and how have they been identified?</td>
</tr>
<tr>
<td>• Mechanisms exist for ongoing community input.</td>
<td>• Service maps are developed for community providers.</td>
<td>• How are collaborating agencies related to the leaders?</td>
</tr>
<tr>
<td>• Core services are available within neighborhood geographies.</td>
<td>• Cultural diversity is mapped for target communities.</td>
<td>• How is the community perspective brought into planning processes?</td>
</tr>
<tr>
<td>• Children placed outside the community have pathways back to community residence.</td>
<td>• Strategies for step down to community for out-of-community placements</td>
<td>• How are community perceptions of the System of Care identified and interpreted?</td>
</tr>
<tr>
<td>• Family organization represents targeted communities.</td>
<td>• Family organization meets regularly with community leaders.</td>
<td>• Are the collaborating agencies trained in the use of CANS for profiling the target population and referral pathway screen for children and families to the System of Care?</td>
</tr>
<tr>
<td>• Community is aware of program values and objectives.</td>
<td>• Communication plan for community is in place.</td>
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<tr>
<td>• Neighborhood resources are consistently included in system of care design and individual service plans.</td>
<td>• Community resources are mapped and available for plan of care design and coordination.</td>
<td></td>
</tr>
<tr>
<td>• Families represent target communities</td>
<td>• Using the CANS methodology, target populations are profiled by community, including cultural diversity</td>
<td></td>
</tr>
<tr>
<td>• Cultural diversity of communities is profiled and described.</td>
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|                  |                                                                                      |                                                                  |
| **Critical Issues** | **Critical Indicators**                                                                 | **Q**                                                                 |
| • Community stakeholders are identified and involved in planning and communication. | • Community leaders are represented in planning and oversight processes.              | • Who are leaders and how have they been identified?              |
| • Mechanisms exist for ongoing community input.                                 | • Service maps are developed for community providers.                                | • How are collaborating agencies related to the leaders?          |
| • Core services are available within neighborhood geographies.                  | • Cultural diversity is mapped for target communities.                               | • How is the community perspective brought into planning processes? |
| • Children placed outside the community have pathways back to community residence. | • Strategies for step down to community for out-of-community placements              | • How are community perceptions of the System of Care identified and interpreted? |
| • Family organization represents targeted communities.                         | • Family organization meets regularly with community leaders.                        | • Are the collaborating agencies trained in the use of CANS for profiling the target population and referral pathway screen for children and families to the System of Care? |
| • Community is aware of program values and objectives.                          | • Communication plan for community is in place.                                     |                                                                  |
| • Neighborhood resources are consistently included in system of care design and individual service plans. | • Community resources are mapped and available for plan of care design and coordination. |                                                                  |
| • Families represent target communities                                          | • Using the CANS methodology, target populations are profiled by community, including cultural diversity |                                                                  |
| • Cultural diversity of communities is profiled and described.                  |                                                                                      |                                                                  |

**STAGE 3 ~ ATTACHMENT D**
V. INTERAGENCY COLLABORATION

To promote and develop models and mechanisms for the effective integration of financing, policy, authority, servicing systems at the county level to support system of care objectives for target populations of children a the Child & Adolescent Needs and Strengths (CANS) methodology.

<table>
<thead>
<tr>
<th>Critical Issues</th>
<th>Critical Indicators</th>
<th>Q</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Core child-serving agencies (Mental Health, Child Welfare, Education, Substance Abuse, Juvenile Justice) are involved at all levels of planning and governance.</td>
<td>• Child-serving agencies are represented in oversight and planning.</td>
<td>How is the interagency perspective reflected in planning?</td>
</tr>
<tr>
<td>• Family and agency representatives collaborate with project management in planning and committee work.</td>
<td>• Communications plan that targets key staff and decision-makers in participating agencies.</td>
<td>How is communication managed with collaborating agencies?</td>
</tr>
<tr>
<td>• Cross agency funding is available for Individual Service Plans.</td>
<td>• Mechanisms are in place for integrating interagency revenue.</td>
<td>Is there a cross system planning process?</td>
</tr>
<tr>
<td>• Child-serving agencies are actively involved in program review and sustainability planning.</td>
<td>• Interagency agreements for referral and shared care management.</td>
<td>How is the project involved in the cross-system planning process?</td>
</tr>
<tr>
<td>• The System of Care fully participates in public sector managed care initiatives.</td>
<td>• The SOC is identified as a tool for system reform by participating agencies.</td>
<td></td>
</tr>
<tr>
<td>• The CANS methodology is in place for interagency pathway referrals.</td>
<td>• Strategies for participation and leadership with public managed care initiatives.</td>
<td></td>
</tr>
</tbody>
</table>
**VI. FAMILY INVOLVEMENT**

To fully and directly involve families representing target populations and communities as full partners in all levels of planning, administration, and delivery of service organization, management, and the Child & Adolescent Needs and Strengths (CANS) methodology.

<table>
<thead>
<tr>
<th>Critical Issues</th>
<th>Critical Indicators</th>
<th>Q</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Participating families are representative of target populations and communities.</td>
<td>• Policies and contracts reflect full family involvement.</td>
<td></td>
</tr>
<tr>
<td>• Families are directly involved at all levels of planning, administration, and service organization and delivery.</td>
<td>• Plan for family development with a separate budget under the direct control of the family member of the management team.</td>
<td></td>
</tr>
<tr>
<td>• Participating systems and community partnerships involve families collaboratively at all levels of planning and implementation.</td>
<td>• Families are directly represented at the planning, management, and oversight levels.</td>
<td></td>
</tr>
<tr>
<td>• Family advocates are trained in the use of the CANS methodology</td>
<td>• Training plan to support full family participation is designed.</td>
<td></td>
</tr>
<tr>
<td>• Families have authority and choice in design and implementation of individualized plans of care.</td>
<td>• Strategic plan for development of a family agency.</td>
<td></td>
</tr>
<tr>
<td>• Families have adequate resources and training to support effective participation in roles and responsibilities at all levels.</td>
<td>• Families are directly involved with training and orientation of management staff and providers.</td>
<td></td>
</tr>
<tr>
<td>• Professional staff and families collaborate in planning and management at organizational and individual plan levels.</td>
<td>• Barriers to family involvement are identified and addressed at all levels of administration, management, and operations</td>
<td></td>
</tr>
<tr>
<td>• Planning for development of a separate family organization.</td>
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</tr>
</tbody>
</table>

How are family members directly involved in:
- Planning
- Management
- Oversight
- ISP design and implementation

What is the vision for a family organization in 5 years?

Is that vision commonly held among project collaborators?

How are funds allocated for the family development budget, and how are they matched to the family development plan?

Are the families inclusive of kinship care families, i.e. grandparents raising their grandchildren?
VII. CULTURAL COMPETENCE/SENSITIVITY

To assure to design, development, and implementation of culturally sensitive and competent services and business processes in the context of the specific diversity represented by targeted populations and communities.

<table>
<thead>
<tr>
<th>Critical Issues</th>
<th>Critical Indicators</th>
<th>Q</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All components of project leadership understand the cultural diversity of</td>
<td>• Cultural diversity is mapped and profiled by target population and community.</td>
<td></td>
</tr>
<tr>
<td>target population and communities and implications for service financing,</td>
<td>• Plan for identifying and implementing culturally competent services is in place.</td>
<td></td>
</tr>
<tr>
<td>organization, management, and delivery.</td>
<td>• All polices, procedures, and business practices reflect commitment to cultural</td>
<td></td>
</tr>
<tr>
<td>• Commitment to cultural competence and sensitivity through all policies,</td>
<td>sensitivity and competence.</td>
<td></td>
</tr>
<tr>
<td>personnel practices, business strategies, and training/communication programs.</td>
<td>• Individual Service Plans (ISP’s) reflect use of appropriate, culturally diverse</td>
<td></td>
</tr>
<tr>
<td>• Nontraditional, cultural specific services are included in the service array</td>
<td>resources.</td>
<td></td>
</tr>
<tr>
<td>and are regularly used appropriately in ISP’s.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Project staff represent cultural diversity of target populations and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>communities at all levels of management, administration, and service delivery.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• What is the cultural diversity of target populations and how did you determine it?
• How has the cultural competence of providers and project management been assessed? What are the critical areas for improvement?
• What culture-specific services are available? How were they selected? How do they match the needs of the target population? What steps have been taken to train providers and care coordinators in appropriate utilization?
• What steps are taken to ensure that cultural competency/sensitivity training reflects the ethnic diversity of the target population’s neighborhood and/or community.
VIII. SERVICE ARRAY/STRENGTHS BASED RESOURCE DEVELOPMENT

To provide the full array of services and community resources needed, as documented by the Child & Adolescent Needs and Strengths (CANS) methodology, to support strength-based, child-centered, family-focused individual service plans for implemented in neighborhoods and communities and using a strengths based approach to resource development.

<table>
<thead>
<tr>
<th>Critical Issues</th>
<th>Critical Indicators</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Comprehensive array of services as indicated by population profile and System of Care values, including (minimally) diagnostic and evaluation services, outpatient mental health services, emergency services, intensive home-based service, intensive day treatment services, respite care, therapeutic foster care, and transition services to adult systems.</td>
<td>• Community-based service map.</td>
<td>• How are service providers identified and credentialed on core qualities and capabilities?</td>
</tr>
<tr>
<td>• Accessible, timely services by family-friendly standards, including self-referral.</td>
<td>• Provider participation standards that reflect family friendly practices and standards.</td>
<td>• How were the numbers and types of providers needed for target communities determined?</td>
</tr>
<tr>
<td>• Services responsive to Family involvement.</td>
<td>• Family-friendly standards for providers.</td>
<td>• How are providers evaluated for: Clinical effectiveness? Family friendliness? Cultural competence? Interagency Collaboration?</td>
</tr>
<tr>
<td>• Availability of community-based traditional and non-traditional services and resources.</td>
<td>• Services contracts reflect performance expectations and standards in critical areas.</td>
<td>• How are family members involved in provider selection and evaluation?</td>
</tr>
<tr>
<td>• Family focused orientation in service providers.</td>
<td>• Plans of Care use traditional and non-traditional services and resources.</td>
<td>• How are nontraditional providers recruited? Is a strengths based approach used for resource development?</td>
</tr>
<tr>
<td>• Cultural sensitivity and competence in service providers,</td>
<td>• Participating providers comply with family friendly standards.</td>
<td></td>
</tr>
<tr>
<td>• Choice of providers available to families.</td>
<td>• Range of cultural diversity is identified with specifications for cultural competence, including language, accessibility, and culturally based services.</td>
<td></td>
</tr>
<tr>
<td>• Referral pathways are mapped and CANS methodology is in place.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Providers are profiled and evaluated for clinical effectiveness, family friendliness, and cultural competence.</td>
<td></td>
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</tbody>
</table>

Attachment D
IX. PLAN OF CARE DESIGN AND CARE COORDINATION

To assure the design, implementation, and coordination of Individualized Service Plans (ISP’s) that consistently include:

- Full family participation
- Strength-based approaches to assessment and planning, using the Child & Adolescent needs and Strengths (CANS)
- Coordinated use of complimentary professional services and naturally therapeutic social relationships
- Optimal permanency of living arrangements, optimal strength-based participation in normal social development, or special clinical needs.

<table>
<thead>
<tr>
<th>Critical Issues</th>
<th>Critical Indicators</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Care coordination process is consistent with System of Care principles and guidelines.</td>
<td>Guidelines for individualized family focused ISP’s.</td>
<td></td>
</tr>
<tr>
<td>Individual Service Planning process is clearly defined.</td>
<td>Consistent format for ISP design and review required throughout the system.</td>
<td></td>
</tr>
<tr>
<td>All Individual Service Plans (ISP) are individualized and community based.</td>
<td>Monitoring mechanisms and review procedures for plans of care.</td>
<td></td>
</tr>
<tr>
<td>Child and family teams are organized to facilitate ISP design and implementation</td>
<td>Assurance of family involvement.</td>
<td></td>
</tr>
<tr>
<td>Families are involved with all aspects of ISP design and implementation.</td>
<td>ISP process is clearly defined and reviewed for:</td>
<td></td>
</tr>
<tr>
<td>Care Coordinators and providers are accountable to ISP objectives.</td>
<td>- Enrollment</td>
<td></td>
</tr>
<tr>
<td>ISP’s are grounded in comprehensive, strength-based assessments of children and families through the CANS methodology.</td>
<td>- Assessment-CANS methodology</td>
<td></td>
</tr>
<tr>
<td>ISP design, implementation, and monitoring are clearly documented.</td>
<td>- Child and Family Team organization</td>
<td></td>
</tr>
<tr>
<td>Service coordination and delivery are reviewed and documented.</td>
<td>- ISP design and Implementation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Service delivery and monitoring</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Transition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service delivery is accountable to ISP objectives.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ISP’s are documented consistent with guidelines and CANS methodology.</td>
<td></td>
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</tbody>
</table>

What are the core standards for ISP design, implementation, and coordination and how are these standards communicated and monitored?

Are families included in all ISP or Wraparound training?

Do family representatives participate in training families and workers in Wraparound?

How is consistency assured? How is deviation from standards addressed?

How is family participation in the ISP assured?

How is the ISP process documented and monitored? How is the CANS methodology used as a check for strengths?
**X. STAFF RESOURCES**

To assure the organization, recruitment, hiring, and development of critical staff at the administration, management and community levels that represent the values, skills, and talent needed to implement community-based, family focused locally organized systems of care.

<table>
<thead>
<tr>
<th>Critical Issues</th>
<th>Critical Indicators</th>
<th>Q</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organizational structures that support programmatic objectives and management functions.</td>
<td>• Functional requirements are defined for internal management and outsourced providers and service delivery.</td>
<td>Based on functional requirements, what are the strengths and gaps in the management staff?</td>
</tr>
<tr>
<td>• Training plan for addressing gaps in skills and knowledge.</td>
<td>• Training plan for internal and outsourced staff.</td>
<td>Based on performance expectations, what are the strengths and gaps of the provider network?</td>
</tr>
<tr>
<td>• Appropriate staffing ratios for all functions, consistent with CMHS standards.</td>
<td>• Job descriptions, including roles, responsibilities, and performance expectations.</td>
<td>How will gaps be addressed through training and staff development? What are the priorities?</td>
</tr>
<tr>
<td>• Properly defined staff positions, roles, and responsibilities that match functional requirements.</td>
<td>• Staffing ratios are defined for care coordinators and family support staff.</td>
<td>How will collaborative approaches to training and staff development that incorporate family, community and interagency perspectives be assured?</td>
</tr>
<tr>
<td>• Properly trained staff in System of Care values, principles, methodologies, and skills.</td>
<td>• Staff/family collaborative training and development plans.</td>
<td></td>
</tr>
<tr>
<td>• Direct family involvement with staff selection and training</td>
<td>• Supervision guidelines consistent with oversight of sic methodologies.</td>
<td></td>
</tr>
<tr>
<td>• Proper supervision of staff, including professional/family collaboration and integration</td>
<td>• Family involvement in all aspects of staff training.</td>
<td></td>
</tr>
<tr>
<td>• Contracts with providers and other outsourced functions that reflect core system of care values and practice standards.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
XI. **FUNDING, FINANCIAL MANAGEMENT, AND SUSTAINABILITY PLANNING**

To establish financial management structures, processes, and mechanisms that:

- Assure the optimal integration of available funding to support integrated Individual Service Plans (ISPs)
- Establish an administrative budget that allocates funds to effectively support programmatic objectives
- Model and monitor the costs and value of services delivered, including projections of costs and revenue necessary to support sustainability planning.

<table>
<thead>
<tr>
<th>Critical Issues</th>
<th>Critical Indicators</th>
<th>Q</th>
</tr>
</thead>
</table>
| - Flexible funding available from interagency sources for system of care development and ISP support.  
- Budget for operations, including itemized service and administrative costs.  
- Cost monitoring for ISP implementation.  
- Mechanisms for monitoring and projecting costs for case.  
- Comprehensive budget for projected revenues and anticipated operational and administrative expenses.  
- Financial modeling for care management based on population profiling and utilization projections.  
- Ongoing review of ISP costs individual and aggregate.  
- ISP authorization is linked to reimbursement mechanisms.  
- Sustainability planning for revenue resources consistent with System of Care principles and objectives.  
- Documented “value-added” of care management and System of Care to community and population-based outcomes objectives. | - Operations budget itemized for services and administrative costs  
- ISP design is coordinated with funding sources.  
- Cost and pricing methodologies exist for ISPs (Plans of care).  
- Cost per Case monitoring and reporting capability.  
- Utilization and cost projection capability for ISP’s. | - What is the project budget and how was it determined?  
- How will ISPs be financed and how will costs and revenue be monitored?  
- What cost management expectations are held by collaborating agencies?  
- How will financial information be organized and used for management? |
## XII. EVALUATION AND QUALITY MANAGEMENT

To design and manage functions needed to assure system of care outcomes research and continuous quality improvement of programmatic elements, including use of the Child & Adolescent Needs and Strengths (CANS) methodology for continuous review of the strengths incorporated in the Individual Service Plans (ISPs).

<table>
<thead>
<tr>
<th>Critical Issues</th>
<th>Critical Indicators</th>
<th>Q</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Quality Management Plan that reflects all stakeholder perspectives (agencies, families, communities, providers)</td>
<td>• Quality Management Plan for ISP review and System of Care performance, including critical indicators, monitoring and tracking mechanisms, and reporting.</td>
<td>How was the Quality Management Plan developed? How were all stakeholder perspectives, especially families, included?</td>
</tr>
<tr>
<td>• Quality management indicators reflect system of care principles and values and sustainability planning requirements and the strengths indicated through the CANS methodology.</td>
<td>• Documentation of service delivery and coordination, for individual Plans of Care, and aggregate system performance.</td>
<td>How were critical indicators determined for: Family involvement and development? Community investment and participation? System of care performance? ISP planning and implementation? Clinical effectiveness? Cultural Competence? Strengths based assessment (individual child and family objectives?</td>
</tr>
<tr>
<td>• Quality Management of individual ISP’s.</td>
<td>• Families are involved in QM/Evaluation planning and oversight functions.</td>
<td>How are operational problems identified on an ongoing basis? Corrective action planning designed and implemented?</td>
</tr>
<tr>
<td>• Quality Management of System of Care performance and outcomes.</td>
<td>• Mechanisms exist for ongoing problem identification and corrective action planning.</td>
<td>How are families involved in data analysis and turning data into useful information?</td>
</tr>
<tr>
<td>• Overall Quality Improvement resulting from evaluation and Quality Management</td>
<td>• Communication plan for dissemination of QM/Evaluation data to interested and affected stakeholders.</td>
<td>How is evaluation linked to sustainability planning?</td>
</tr>
<tr>
<td>• Family Involvement in all Quality Management design and oversight.</td>
<td>• CANS methodology is integral part of Quality Management Plan.</td>
<td></td>
</tr>
<tr>
<td>• Communication of Quality Management results to all stakeholders.</td>
<td>• Evaluation plan includes qualitative factors especially family view of process.</td>
<td></td>
</tr>
<tr>
<td>• Quality Management is integrated with Information Management.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Documented ongoing corrective action planning for all identified quality issues.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Quarterly and annual reports distributed to all stakeholders</td>
<td></td>
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</table>
## XIII. INFORMATION MANAGEMENT AND COMMUNICATION

To assure ongoing management of critical and appropriate information to all interested and affected stakeholders in the System of Care (SOC) process, to enable accurate and consistent dissemination of needed information.

<table>
<thead>
<tr>
<th>Critical Issues</th>
<th>Critical Indicators</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stakeholders are identified with information and communication needs.</td>
<td>• Information management plan is in place.</td>
<td>• Who are the key stakeholders and what are their information and communication needs? How did you determine this?</td>
</tr>
<tr>
<td>• Information is gathered and organized for internal management needs.</td>
<td>• Technical capability to obtain and organize databases for consumers, target population, providers, plans of care, evaluation and quality management, CANS methodology, costs, and communication.</td>
<td>• How do staff, families and stakeholders use information from the methodology?</td>
</tr>
<tr>
<td>• Information is gathered and organized for external reporting requirements.</td>
<td>• Families are involved with process and training is organized to facilitate this.</td>
<td>• How are the services/needs identified on the plans of care and communicated to the provider network and the community?</td>
</tr>
<tr>
<td>• Information is gathered and organized for internal and external communication needs, including education and public awareness and services enhancement.</td>
<td>• Communication plan is designed for identified stakeholders and specific information needs.</td>
<td>• How are staff responsible for information management system involved in overall system design and operations management? How are they made aware of the functions and systems they are supporting?</td>
</tr>
<tr>
<td>• Communication plan in place that includes all interested and affected stakeholders and general community.</td>
<td>• Range of information distribution pathways and methodologies are identified and used.</td>
<td>• Who is responsible for communication planning and implementation? What are the priorities for communication? How are families involved in the design of communication and information management?</td>
</tr>
<tr>
<td>• Families are involved in all communication design and review.</td>
<td>• Staff are assigned for communication plan design and implementation.</td>
<td></td>
</tr>
</tbody>
</table>
In this stage, the Community Alliance will develop their business relationships and shared accountability to work in collaborative partnerships

~ MAJOR FUNCTIONS OF A COMMUNITY ALLIANCE ~

- Provide for community education and advocacy on issues related to delivery of services (Stages 1-4 and ongoing)
- Needs assessment and establishment of priorities for service delivery (Stage 2)
- Determining community outcome goals (Stage 2)
- Promote prevention and early intervention services (Stage 3)
- Joint planning for resource utilization in the community (Stage 3)
- Serve as a catalyst for community resource development (Stage 4)

*Citation from Florida Statute 20.19 (6) describing duties of Community Alliances*

Shared accountability to its citizens is a positive result of collaborative and committed partnerships within the Alliance and the community.

Goals:
- To develop business relationships and shared accountability.
- To work in collaborative partnership with each other and other human service agencies in the community.

*These goals will be met when the Benchmarks & Achievements are completed.*
STAGE 4

~ BENCHMARKS and ACHIEVEMENTS ~

1. Business Relationship

- Evidence of shared principles and outcomes as demonstrated in working agreements, complimentary contracts/services and/or purchasing agreements between agencies that serve children and their families.

- Development of the role and function that each community agency establishes with the Community Alliance to their respective procurement and quality improvement processes.

- Each Community Alliance will develop their own community/agency relationships based on the individuality, diversity and uniqueness of the community.

- Each Community Alliances will develop strategies to improve outcomes for children and their families through collaboration.

- Possible business collaborations should include shared Quality Improvement (QI) strategies, contract monitoring, complimentary contracts, etc.

HELPFUL HINTS

- Each member of the Community Alliance assumes ownership of the “community outcomes” as well as each child-serving agency in the community.

- The outcomes will cross agency lines and therefore will mean true “community” ownership (shared accountability) for their success.
The business relationships of the Community Alliance with community agencies and providers of services to children and their families are an individual community preference and will evolve through their initial work with the Department of Children and Families and the Lead Agency during the development of the community based care initiatives.

The Alliance will set expectations for community agencies to review outcomes and eliminate service duplication. One effective way to do this is through recommending complementary contracts.

Shared/complimentary contracts:

- Are contracts that define points of integration between one contract and other contracts,

- Establish mutual expectations for service integration within the contract requirements therefore tying the provider to the same outcome expectation from each of the funding sources (cross-cutting agency outcomes), and

- Develop more informed purchasers of services and more informed providers of services.

Additional information about complimentary contracts is found in **Attachment A** at the end of this section. Florida’s Medicaid Pre-Paid Mental Health Plan contract is a good example of complimentary contract requirements. Wording from the Florida Medicaid Pre-Paid Mental Health Plan contract complimentary contract is found in **Attachment B** at the end of this section.
Shared Accountability

- Assessment of achievement of desired community outcomes
  - One of the most important activities of the Community Alliance is the reporting of the status of achievement of outcomes, sometimes referred to as a community report card.

- Customer satisfaction measurement process and analysis
  - A critical part of the community report card process is to establish a customer/stakeholder satisfaction measurement process.

- Shared accountability has been pilot tested by the Sarasota YMCA community Based Care Initiative by establishing a process for multi-funders to do an on site coordinated monitoring review of services all at the same time.

HELPFUL HINTS

- The community report card on community outcomes:
  - Must be short and concise,
  - Include customer/stakeholder quick and short surveys ~ similar to the customer satisfaction surveys found in motel/hotel chains around the country, one page or a postcard size,
  - Use the data you have ~ don’t collect data that is not needed, and
  - Is a major communication tool for the community.

- The community report card should be a joint process of the community Alliance, the Lead Agency and the network of community providers.

- There are several sources of “report cards” found on the Internet, however these seem to be very long and somewhat laborious.
- These Internet addresses are given as a point of reference for the reader to determine what information communities currently collect **NOT** as examples of good community report cards. The Internet addresses are:
  - The Nation’s Report Card ~
  - Jacksonville Quality of Life Project through JCCI ~
    [http://www.jcci.org/indic.html](http://www.jcci.org/indic.html)
  - Hillsborough Today ~
  - California Report Card ~

- Recommendations for quality improvements in the community-based System of Care
  - Feedback from the outcome measurement process will provide good information for quality improvement.
  - Customer/stakeholder satisfaction is a good source of feedback information, but only if it is used to improve services.

- Even though the Community Alliance is not set up to be a complaint resolution center, by the public nature of their work individual members and the body as a whole will receive complaints from the public.
  - The complaints may be about the work of the Alliance but will probably be related to the performance or nonperformance of one of the member agencies.
- It is important for the positive working relationships within the Alliance to determine from the beginning how complaints will be handled.

- It is suggested that the process be simple, direct (including referral of the complaint to the agency involved) and responsive to the public.

- This is an important part of the accountability to the public and trust earned from the public.
COMMUNITY ALLIANCES

A Community Alliance provides for community ownership and oversight; provides a focal point for setting community priorities; and is a catalyst for community resource and development.

Stage IV ~ To develop the business relationships and shared accountability, and to work in collaborative partnership with each other and other human service agencies in the community.

<table>
<thead>
<tr>
<th>ALLIANCE ACTIVITIES</th>
<th>ALLIANCE RESOURCE NEEDS</th>
<th>ALLIANCE BENCHMARKS &amp; ACHIEVEMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish the role of Alliance in procurement,</td>
<td>Examples of business relationships between community child serving agencies and/or providers</td>
<td>Recommendations for quality improvements in the SOC.</td>
</tr>
<tr>
<td>measuring performance and quality improvement through business relationships</td>
<td>Best practices of complimentary contracts or other collaborative processes.</td>
<td>Community Report Card to acknowledge milestones in desired outcome achievement.</td>
</tr>
<tr>
<td>Develop systematic efforts to focus on shared/complimentary contracts</td>
<td></td>
<td>Alliance produces document outlining shared principles or expectations from complimentary contracts or services.</td>
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</table>
THE STAGES IN DEVELOPING COMPLIMENTARY CONTRACTS

The following excerpt is taken from a national presentation by Celeste Putnam-Tanzy, Department of Children and Families, Tallahassee, Florida.
The following excerpt is taken from a national presentation by Celeste Putnam-Tanzy, Department of Children and Families, Tallahassee, Florida.

**What is Complementary Contracting?**
Complementary contracting is achieved when the points of integration between one contract and other contracts are defined and mutual expectations for service integration within contractual requirements are established.

**What is Service Integration?**
Integration is the weaving together of programs, procedures, priorities, resources, staff supervision, case plans, intake and referrals and other practices to create a system of care.

**The 4 stages of the Service Integration Process**

**Stage One** is really traditional service delivery. Services are provided by separate operating agencies that make policies and procedures in isolation of other agencies or providers. The funding is categorical and the planning and contracts are specific to the categorical funding. This results in fragmented services and different mandates and service philosophies among contract procedures.

**Stage Two** involves one individual or agency working with another agency to solve a problem or to coordinate care. This might include a substance abuse program working with the Family Safety operations program manager to help improve access to a particular program or a Family Safety worker coordinating care with a Targeted Case Manager. These are usually non-systemic activities, and although very useful, do not really modify the service system and are not reflected in contract requirements.

**Stage Three** involves new service development. This may involve the state government and counties coming together to jointly contract with a particular provider to provide a new or enhanced service. At this stage, agencies may begin to experiment with cross-agency placement of personnel such as in neighboring centers. The agencies also may do cross training such as the training of the child protection staff of the different provider referral processes and available services. The
providers begin to shift from an agency-centered orientation to a community-based or neighborhood focus.

**The Fourth Stage** of integration is when more formal contract changes are introduced. Providers begin to form provider networks. The importance of seeing children and families holistically is fully recognized. The expected operation of the system is defined with the required interaction of providers and provider networks clarified. Contracts reflect this defined interaction and often show mutual or supportive processes, performance measure and outcomes.

COMPLIMENTARY CONTRACTING – REQUIREMENTS OF THE MEDICAID PRE-PAID MENTAL HEALTH CONTRACT

Excerpts from State of Florida Medicaid Area Six Prepaid Mental Health Plan Request for Proposals

RFP-AHCA-0005
E. Coordination of Children’s Services – MANDATORY

1. General Principles

a. The delivery and coordination of children’s mental health services shall be provided for all children who are within a high-risk population and experiencing serious emotional disturbances. These children include those involved in the SED classes through the school system and those who exhibit the symptoms and behaviors of an emotional disturbance but are not receiving SED services through the school.

b. Services for all children shall be delivered within a strengths-based, culturally competent service design. The service design shall recognize and ensure the participation of family, significant others, informal support systems, school personnel, and any state entities or other service providers involved in the child’s life.

c. The contractor shall assure provision of medically necessary services to all children enrolled in the plan within seven calendar days of receipt of the request for services. A Log shall be maintained that records all calls or written requests received and the action taken related to each request. The date of the first service provided, along with the type of service and provider shall be part of the Log. The services shall be of sufficient intensity and continuity to provide a
realistic opportunity for progress. Services must be provided within the least restrictive and most normal environment that is clinically appropriate for the needs of the child and family.

d. For all children receiving services under the plan, the contractor shall work with the parents, guardians, or other responsible parties to monitor the results of services and determine whether progress is occurring. Active monitoring of the child’s status shall occur to detect potential risk situations and emerging needs or problems.

e. When the court mandates a parental mental health assessment, and the parent is a plan enrollee, the contractor must complete an assessment of the parent’s mental health status and the effects on the child. Time frames for completion of this service shall be determined by the mandates issued by the courts.

2. Department of Children and Families

a. Children’s mental health services should be developed and coordinated to augment any local system of care for high-risk populations served by the Department of Children and Families, Community Based Care providers, or by the Department of Juvenile Justice. (e.g. Medicaid eligible children in delinquency programs, shelters, and other in-reach initiatives in schools and housing projects).

a. The contractor must develop a service approach for children’s mental health services that is designed to support the state’s goals to achieve safety and permanency for children in the child
protection system. All children enrolled in the plan who are in the state’s care or custody and who have mental health needs shall have mental health services provided that are supportive of the department’s case plan for the child.

b. The contractor will be available to participate in the development of the department’s case plan for the child. Mental health treatment plans shall be consistent with the child and family’s permanency goals, promote safety and address enhanced functioning for the child and family (if family members are also enrollees). The contractor shall invite the child protection workers or the foster parents to participate in the treatment planning and service delivery process. If reunification is the goal, and with the department’s concurrence, the contractor must involve the parents in the treatment planning and implementation.

d. The contractor shall provide mental health-related court-ordered evaluation and expert witness testimony required for children who are Prepaid Mental Health Plan enrollees. The contractor must provide these services in a way that is responsive to the needs and requirements of the department and judicial system.

e. The contractor must be available, if requested, to participate in all department case review staff meetings, school staff meetings, or other related meetings which pertain to the anticipated needs of the child or the provision of services for which the plan is responsible.
3. Targeted Case Management

Children in the care or custody of the state who need targeted case management services, as defined in the contractor’s approved clinical protocols, shall receive case management from the contractor. These children will not be transferred to the new Medicaid Child Welfare Targeted Case Management program. The contractor must develop a cooperative agreement with the Department of Children and Families or their provider of Community Based Services, to address how to minimize duplication of case management services and to promote the establishment of one case manager for the child and family whenever possible.

4. Comprehensive Systems of Care

If the community in which the contractor will operate has an AHCA sanctioned grant or project for the development of a comprehensive system of care, the contractor, if invited, must actively participate with the community members in that project. In Tampa such a program currently exists. It is a federally funded Community Mental Health grant called Tampa Hillsborough Integrated Network for Kids (THINK), operated by the Hillsborough County Children’s Board. The contractor must be available to actively participate in that project and assist in helping to design and implement a comprehensive, integrated system of care.
5. Community Based Care Programs

If the community in which the contractor will operate has a Community Based Care Program contracted by the Department of Children and Families for the provision of children’s protective services, the contractor must determine how the prepaid mental health services will be rendered to recipients served by the Community Based Care Program. The contractor must develop, during the implementation phase of the contract, or upon notification that the department has contracted with a provider, a cooperative agreement between the contractor and the Community Based Care Program. Medicaid and the Department of Children and Families must approve the agreement. Medicaid Area Six has such a project currently under operation only in Manatee County and may have another such program in Hillsborough County by 2001. The contractor must be prepared to provide services in a collaborative manner in each county covered by the plan.

Performance Measures for this section will include:

- The number of court ordered evaluations completed within court mandated time frames for Prepaid Mental Health Plan enrolled recipients in the care or custody of the state.

- The extent to which mental health treatment plans are supportive of the department’s case plans for Prepaid Mental Health Plan children who are in the state child protection system.
STAGE 4 ~ ATTACHMENT B

- Stakeholder satisfaction survey results related to services provided. Surveys shall be distributed as designated in Section 2.28 in each county covered by the plan.

Additional outcomes related to children in the state’s child protection system can be negotiated as part of the response to this RFP.