Child and Family Services

An Office of the
Department of Health and Human Services

John E. Baldacci, Governor

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Office of Child and Family Services

2007/2008 Strategic Plan

Historical Version

Updated 2/2/09

Caring...Responsive…Well-Managed…We are DHHS

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HISTORICAL VERSION OF THE 2007/2008 OCFS STRATEGIC PLAN

This draft incorporates those elements of the 2007 OCFS Plan which were in process at the end of 2007, supplemented by additional work that the OCFS Leadership Team identified as important priorities for 2008. It also briefly notes the work completed on these strategies so far in 2008. The strategies are arranged under the four DHHS priorities; once the content is refined further, the entire plan will be formatted to be consistent with DHHS planning structure and terminology, arrayed in objectives (specific, measurable outcomes that can be achieved within a definable amount of time, defining the actual impact on the customer being served, rather than the level of effort expended), strategies (methods and programs to achieve objectives) and actions (detailed actions to implement strategies, including assignments and timeframes). The strategies below are not listed in priority order. The Plan includes any work that involves or affects in a significant way at least two of the three OCFS divisions. The work done here notes changes made for a "historical version" and we will move to develop a biennial Strategic Plan in 2009 for the FY'10-'11 Fiscal Year.

DHHS Priority A: DHHS supporting infrastructure is easily accessible, well integrated, and uses best practices.

Strategy 1.A.: Investigate ways to redesign contracting to make more efficient use of funds (Incorporates Strategies 6 and 13 in the 2007 Plan, revised to reflect 2007 accomplishments and 2008 work. Formerly strategy 2 – now 1.A.)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008
Investigate ways to redesign contracting to make more efficient use of funds.	A. Assure that needs assessments for OCFS treatment and support services are systematically and regularly done in order to identify and prioritize gaps in existing services that need to be filled. Build further on unmet needs data already collected (for example, annual surveys of unmet needs and parent satisfaction, such as the annual CBH Youth and Family Survey; needs identified in provider reports). Consider making greater use of focus groups with parents/ families/providers to discuss their needs and impressions of services that are effective. B. Review all current funding/expenditures related to treatment services for children and families. • What is each service cluster buying?	A. Jim and other Senior Managers conducted stakeholder needs assessment meetings at several locations throughout the state in 2008.	Associate Leads: Linda Brissette, Carolyn Drugge, Bill Fox, Christine Merchant, Doug Patrick, Joan Smyrski, and Patti Woolley

	• What do the services cost? • How are the services paid for? • What can be shared by service clusters? • What is duplicative? • What is the number of service units provided? C. Review all current funding/expenditures related to support services for children and families. • What is each service cluster buying? • What do the services cost? • How are the services paid for? • What can be shared by service clusters? • What is duplicative? • What is the number of service units provided?		
	D. Use the information from Activities A-C to restructure OCFS contracts.	D. Contract Provider Rider A including service requirements were revised.	
	E. Use the creation of contract monitoring staff in each district to reduce the number of people monitoring each agency, providing OCFS staff with a better overview of contract agencies' work and strengthening contractors' accountability for results.	E. Contract tracking sheets and plan for contract review to occur concurrently with Adult Services.	
	F. Investigate reducing the number of contracts that OCFS staff must monitor (for example, by making major contract providers responsible for developing and monitoring subcontracts with other providers, by doing regional contracts, by putting multiple related services offered by an agency under one contract, or by consolidating related	F. Contracts for CAN councils consolidated from 16 to 1, using the Children's Trust as agent...	

	contracts).		
	G. Investigate opportunities to lower administrative costs in contracts (for example, by lowering caps for administrative overhead and making them consistent across divisions, by identifying possible duplicate administrative costs where an agency has multiple OCFS contracts).	G. No outcomes	
	H. While doing the above work, coordinate and consult regularly with the DHHS Office of Integrated Services and Quality Improvement, the Office of Purchased Services, and APS Healthcare.	H. No outcomes	
	I. Issue RFP's for contracts on a regular cycle (every 3-4 years). Investigate ways to use the RFP's to encourage changes in practice through outcome-based contracting.	I. During FY '07/'08, Alternative Response Program, Family Reunification Program, Child Care 12-15 After School Program, and Wraparound ME RFP's were successfully completed/awarded.	
	J. Develop and implement a performance-based contracting process across all OCFS divisions.	J. 4-5 specific core performance measures included in Rider A of provider contract to be monitored quarterly.	
	K. Redo residential treatment provider contracts to reflect the residential treatment standards developed in 2007.	K. Delayed – will be done in 2009 (by	

	L. Look for opportunities to make contract language consistent across divisions.	July). L. E.g., done re: procedure for notifying OCFS when an agency/program closes.	

Strategy 1.B.: Develop a uniform process for monitoring quality and outcomes of contracted services (Was Strategy 5 in the 2007 Plan, revised to reflect 2007 accomplishments. Was formerly 1 and is now 1.B.)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008
Develop a uniform process for monitoring quality and outcomes of contracted services.	[Note: This work is related to Strategy 6] A. Develop a comprehensive strategy to provide fiscal and contractual oversight for all OCFS divisions, with active program review of all contracted agencies. B. Conduct regularly scheduled meetings of quality improvement staff from across the three divisions, to encourage coordination and learning from each other. C. Document current contract development and contract monitoring policies and processes in each of the divisions. Identify where policies and processes are similar and dissimilar (for example, the frequency with which contracts and contractor performance/effectiveness are reviewed, what elements are included in contractor reviews and how those are documented, how corrective plans are used with agencies that perform poorly in reviews, who is involved in reviewing contractor performance, how clear and measurable performance measures are developed and data on those is gathered and analyzed).	A. Not completed for contract oversight. Continue	Associate leads: Ann O'Brien, Theresa Dube, Joan Smyrski, Lindsey Tweed, and Patti Woolley Christine Merchant And Team Leaders

	D. Based on the analysis conducted in Activity C, identify areas where contracting and contract monitoring policies and processes can be made more consistent and systematic across divisions, focusing especially on situations where divisions contract for similar services. Work with quality improvement staff from all divisions to systematize and coordinate the identified policies and processes. E. As Activity D is completed, assure that staff training on how to implement those is also systematized across divisions. F. While doing the above work, coordinate and consult regularly with the DHHS Office of Integrated Services and Quality Improvement.		

Strategy 2 is now 1.A.

Strategy 3: Promote staff and contractor adherence to the OCFS vision/mission statements (Was Strategy 19 in the 2007 Plan, revised to reflect 2007 accomplishments)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008
Promote staff and contractor adherence to the OCFS vision/ mission statements	A. Devise strategies to keep the mission/vision statements before staff and contractors at all times (e.g., by including them on agendas).	This is being done in several ways: OCFS mission statement on agendas; referred to in communications with staff and providers; and serves as an overarching measure of employee	Lead: Jim Beougher Associate leads: Andy Cook, Dan Despard, and Patti Woolley

		performance during annual appraisals.	

Strategy 4: Continue to pursue co-location of OCFS staff (Was Strategy 20 in the 2007 Plan, revised to reflect 2007 accomplishments)

Strategy (What)	Activities (How)	Timeline/Outcome	Lead for 2007/2008
Pursue co-location of OCFS staff.	A. Explore co-location of staff in Penobscot County.	Not completed. Martha Kluzak is looking into filing space and PHN options to make room in this building.	Lead: Jim Beougher Associate leads: Elaine White

Strategy 5: Create a 2009 OCFS Strategic Plan (Was Strategy 21 in the 2007 Plan, revised to reflect 2007 accomplishments)

Strategy (What)	Activities (How)	Timeline/Outcome	Lead for 2007/2008
Engage in an annual strategic planning process which will focus on key organizational outcomes.	A. An OCFS Strategic Plan will be done annually. The planning process will include provider, consumer and family partnerships. B. Review progress on the Strategic Plan at least every six months..	Begin work on the 2009 Plan in 11/08	Lead: Jim Beougher

Strategy 6: Explore structural ways to further integrate OCFS work across its divisions (New strategy discussed at the March Management Team meeting; revised and broadened to reflect actual 2008 work) **We will remove this as completed and will keep a tracking document of examples of integration, which is also a weekly agenda item.**

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008

Explore structural ways to further integrate OCFS work across its divisions	A. Create a work group of employees from across OCFS to explore reorganization of OCFS staff (e.g., possible deployment of CBHS staff into the eight district offices; creation of staff to perform contract oversight and community collaboration across the divisions in the districts). The group should start by clarifying the vision for these organizational changes. Providers should also be involved at some point (e.g., to deal with issues like how they will report results of their work).	Work group created 5/08. Center for Applied Research facilitated a retreat for the group 6/08. Decided on fresh start 7/08.	Associate leads:

Strategy 7: Examine ways to systematically expand the role of parents and youth in OCFS work (New strategy discussed at the April Management Team meeting)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008
Examine ways to systematically expand the role of parents and youth in OCFS work	A. Create a work group to investigate ways to do this (for example, by having parent and/or youth partners in each district, participating in OCFS decision-making). The work group will include a diverse group of parents and youth with relevant skills and background. The group's work will include: --Considering possible roles that parents and youth can play (for example, helping other parents/youth to navigate "the system"; providing support/education to parents/youth; performing program oversight). --Discussions with OCFS initiatives that already involve parents and youth in various ways (for example, the Child Care Advocacy Council, the EBP workgroup, Wraparound Maine, Child Steps, THRIVE, the ECS Task Force) to determine what has worked. --Review of parent/youth involvement models used in other states.	Group of providers and initiatives formed, met twice by 7/08 to discuss standardizing training curricula. Reviewed models in other states. Will also talk with others (e.g., Head Start). A. Pursuant to revised uniform contract riders, CBHS requires that providers	Lead: Joan Smyrski Associate leads: Frances Ryan

	--Examination of programs that have experience in promoting customer involvement (for example, Head Start). --Examining possible ways to fund and sustain enhanced parent/youth involvement (for example, using a mix of funding sources or Medicaid) B. In addition, continue to seize particular opportunities to strengthen and expand parent and youth involvement as they arise (e.g., parent involvement in Thrive and the EBP Advisory Committee; CW Youth Advisory Committee; grants to NAMI, GEAR and MPF to enhance the voice and choice of families).	implement System of Care Principles, including Youth Guided and Family Driven care. Providers will be undergoing a standardized self assessment within the next year that will include measures on these Principles and will be working with CBHS staff to develop CQI plans to enhance adherence to the measures. B.	

Strategy 8: Proactively develop priorities for future reductions in the OCFS budget (New strategy discussed at the April Management Team meeting)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008

Proactively develop priorities for future reductions in the OCFS budget	A. Recognizing that future budget cuts will probably be needed, thoughtfully develop priorities for future cuts during regular Management Team meetings. Analyze current programs and needed program enhancements, and continuously identify further opportunities for creating efficiencies while enhancing OCFS' service to its customers. Plan for cuts that could be implemented starting in FY09 and extending over the next several years.	Discussions started with providers on possible cuts (e.g., CBH). Developed pro-posals to move cost centers from OMS to OCFS for all inpatient CBH hospital ser-vices and residential treatment.	Lead: Jim Beougher Associate leads: Management Team

Strategy 9: Promote more expert use of RFPs in OCFS work (New strategy discussed at the April Management Team meeting)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008
Promote more expert use of RFPs in OCFS work	A. Determine who on current OCFS staff is most expert in drafting RFPs and overseeing RFP processes. Assure that their expertise is used by other staff to minimize mistakes r that could result in things like appeals or delays.	We determined Chad Lewis as our expert resource. Three RFP's were successfully accomplished.	Lead: Dulcey Laberge Associate leads: Christine Merchant, Chad Lewis

DHHS Priority B: Staff and culture: Caring, responsive and well-managed staff work in an efficient and effective culture.

Strategy 10: Assess training needs and develop a training plan (Was Strategy 8 in the 2007 Plan, revised to reflect 2007 accomplishments)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008

Training will be aligned with organizational goals.	A. Building on work by Nancy DeSisto, review funding/ expenditures and training activities across all divisions • What is each service cluster buying? • What does it cost? • How is it paid for? • What can be shared? • What is duplicative? • What are the training gaps? B. OCFS Management Team will work with field representatives to identify expected core competencies and functions in the public and private workforce. C. Use above information in renegotiating the training portions of the Muskie contract. Consider reallocating funds to better address OCFS training needs. D. OCFS Management Team will prioritize training needs/ initiatives. Possible training issues include: more prevention/early intervention training, selective cross-training of staff across divisions, assuring that trainings address DHHS integration goals, training for OCFS staff and contractors on how to use Evidence-Based Practices, and in-service/refresher training.	This was done individual by service Divisions; however, we have an ongoing need for integration of this strategy.	Associate leads: Dan Despard, Joan Smyrski, Ann O'Brien, and Patti Woolley

DHHS Priority C: DHHS Service System is easily accessible, well integrated and uses best practices

Strategy 11: Create a single, integrated Children's Behavioral Health Service System that provides continuity of care (Was Strategy 1 in the 2007 Plan, revised to reflect 2007 accomplishments and 2008 work)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008

Continue work to create a single, integrated system of children's behavioral health services that provides continuity of care.	A. Continue work on identifying a screening tool that can be used voluntarily by a broad range of disciplines to determine if an asymptomatic child with MaineCare coverage might have a disorder or functional impairment meriting further investigation. B. Make consultation by mental health professionals more available to child care providers who serve children with problem behaviors, helping them to address the children's problems without expelling them from care. C. Implement the single system developed last year for review of placements in residential treatment. Assure that CW and CBH children who are in residential treatment really need to be there. D. As we expand the Trauma Informed System of Care and Wraparound Maine, continue to increase parent and youth involvement at all stages of program planning and operation (e.g., evaluation, program design, determining outcomes). (See Strategy 7)	Selected Pediatric Screening Checklist; need to implement This is complete and use of PSC began in October 2008 B. Identified re-sources to expand mental health training for providers. Training done by 3/08. System implemented. Ongoing	Lead: Andy Cook Associate leads: Dan Despard, Carolyn Drugge, Sheryl Peavey, Martha Proulx, Joan Smyrski, and Patti Woolley

Strategy 12: Continue to promote identification and use of Evidence-Based Practices in OCFS program work (Was Strategy 2 in the 2007 Plan, revised to reflect 2007 accomplishments and 2008 work) **Combined Strategy 19: Examine opportunities to fund EBP initiatives after current grants end** (Incorporates Strategy 9 from the 2007 Plan, revised to reflect 2007 accomplishments and 2008 work, and a new strategy discussed at the April Management Team meeting) This strategy should be combined or in proximity of Strategy #12. (Lindsey will work on this item, including the funding mechanisms piece. – historical piece for this one.)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008

Examine opportunities to sustain/expand current initiatives funded by time-limited grants.	A. The CBHS EBP Advisory Committee will continue to identify EBP's. --Complete work begun in 2007 on identifying EBP's for disruptive behavioral disorders. --Collaborate with MADSEC and DOE to begin identification of EBP's for autism spectrum disorders. B. Take steps to increase use of evidence-based practice by programs and clinicians when appropriate to the particular services provided and populations served. --Obtain funding for a study of the effectiveness of identified EBPs at three large clinics serving Child Welfare youth (KBH, CCC and CSI). As part of this work, provide training in implementing the identified EBP's for disruptive behavioral disorders. -- Begin trainings for clinicians in Trauma Focused CBT, an identified EBP that is the clinical part of the Trauma Informed System of Care. C. Examine and develop alternative sources of funding to further implement EBP initiatives (for example, Child Steps, THRIVE) in the future. This may include identifying appropriate rate structures to support best practices work.	Process is being piloted and initiated. Done 8/08 Begun 8/08 B.--Funding obtained from Casey Family Programs and the McArthur Foundation. --Trainings begun. Training begun. Also doing Child and Parent Psychotherapy C. Received grants for Child Steps, and for work with Juvenile Justice. Trauma Focused Cognitive Behavioral Therapy and Child Parent Psychotherapy learning collaboratives	Lead: Lindsey Tweed Associate leads: Andy Cook, Theresa Dube, Doug Patrick, Ann O'Brien, and Jay Yoe

	D. Explore funding strategies to expand Trauma Informed System of Care work to all districts.	have been established through THRIVE and clinicians are serving clients. D. Exploring Medicaid ad-ministrative cost reimburse-ment. Parent Partners are supported through state general fund dollars.	

Strategy 12A: Improve quality of services by better measuring the outcomes of OCFS work (Was part of Strategy 2 in the 2007 Plan, revised to reflect 2007 accomplishments and 2008 work)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008
Improve quality of services by better measuring the outcomes of OCFS work	A. Continue to work on establishing standardized outcome measures for individual children and their families using national assessment tools and benchmarks (e.g., CAFAS) whenever possible; develop information systems for reporting, analysis and communication of outcome results to ensure continuous performance and quality improvement. Work with the new managed care entity on outcome measures. --Select the instrument to be used for gathering outcome data. --Work with APS to begin collecting data using that instrument (i.e., determine data collection procedures, perform necessary modifications to APS software).	--Done --Data entry begun 12/08	Lead: Lindsey Tweed Associate leads: Andy Cook, Theresa Dube, Ann O'Brien, and Jay Yoe

Strategy 13: Reconsider the function of case management services and better integrate them across OCFS (Was Strategy 3 in the 2007 Plan, broadened and revised to reflect 2007 accomplishments)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008
Reconsider the function of case management services, and continue to integrate them across divisions in order to improve outcomes for families and children when they are served by more than one division.	A. Thoughtfully re-examine the rationale/philosophy that drives OCFS case management practice. Case management typically promotes continuity of care and brokering of services for clients, helping them to navigate "the system." Are there better ways to implement this service, making certain that clients do not become unnecessarily dependent on OCFS staff? How can we better incent continuity of care? Will better integration of services reduce need for case management as we know it? Can the family-case manager relationship be ongoing but sporadic, mobilized only when the family needs help? This discussion will be affected significantly by CMS' redefinition of case management. Ask OMS staff if they wish to participate in these discussions, since TCM is common throughout DHHS. Discussions might also involve DOE and DOC. B. Continue to implement the new single case manager model developed in 2007. Change in CMS' targeted case management regulations may affect this. All three divisions should operate from common principles (e.g., stress safety of the child, use strength-based methods, fully involve families in decisions); consider also defining common practice down to the domain level (the level below principles). Be more specific on common practices now that child welfare case managers will also be working, e.g., with mental health and disabilities issues. Implementation of the new case management model includes the following: • Adopt current healthcare industry practice to ensure the development and management of a sufficient targeted	Meetings began in Fall 08, as EC Division programs are moving from TCM Billing to Administrative Claiming. Several mtgs have been scheduled for EC Division and OMS for Winter 09 B. We have completed the implementation of a single case manager model that aligns common practice in CBHS and CW to meet the behavioral health needs of children in child welfare involved cases.	Lead: Patti Woolley Associate leads: Sharon Kelly, Virginia Marriner, Doug Patrick, and Joan Smyrski

	case management workforce with consistent minimum qualifications and core competencies aligned with the practice guidelines. • Continue to develop agreements among OCFS service clusters to enable efficient and effective transition among case management services, while eliminating any unnecessary duplication of case management with any one family. • Continue to work on resolving outstanding issues regarding confidentiality, in order to expedite referral and delivery of appropriate services and to ensure that the process of sharing client information guarantees consumer rights to choice and informed consent. • Review existing policies, rules, regulations, contracts and protocols that support unified practice guidelines. • Align performance and quality improvement (PQI) efforts for case management once the practice guidelines and standards are in place. Monitor implementation and outcomes of services provided to assure fidelity to the practice guidelines (e.g., by creating a unified process tool for assessing implementation of the guidelines). C. Explore other ways to legitimately use Medicaid funds to support case management.	Training was conducted jointly by CW and CBHS for CW supervisors and caseworkers in all of the districts statewide. Provider forums were completed in three sites across the state. CW Case Management policy has been changed to guide this process and a tracking mechanism has been developed that provides monthly reports.	

Strategy 14: Create a seamless service system to minimize disruptive transitions experienced by children (Was Strategy 4 in the 2007 Plan, revised to reflect 2007 accomplishments and 2008 work)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008
Minimize the number of disruptive transitions a child experiences, since the	A. Create a performance indicator that measures the number of unplanned, unexpected transitions children experience. Where possible, use existing data (e.g., CW data on the number of foster families children are placed with, CBHS	APS to have CBHS data on transitions by 8/08. Once	Lead: Dan Despard Associate leads: Andy Cook, Doug Patrick, and Patti

more of those transitions a child goes through, the more problems typically result. If transitions must occur, minimize the trauma/damage they cause.	data on transitions for residential clients, EC data on staff turnover, DOE data on children's moves among schools), augmented as possible by new data sources (e.g., expulsions from child care, Child Care Plus ME information on children having trouble in child care). Use data on transitions to identify children at risk of possible problems early, allowing intervention with greater chance of success.	available, will combine it with CW placement stability mea-sures. Talking with DOE and DOC re data. Thirteen clinicians have completed training on Early Childhood consultation. There have been no expulsions in centers being served. A Yale University study from 2005 indicated that 18% of pre-kindergarten teachers reported expelling children from Maine Two-Year Kindergarten and Head Start sites.	Woolley
	B. Continue/expand programmatic work to minimize disruptive transitions, including the new Intensive Temporary Residential Treatment team process (to avoid unnecessary residential placements), improved mental health consultation for child care providers (to minimize expulsions), and ways to more effectively use family team meetings to minimize such transitions. Focus particularly on children in care more than two years, since data shows disruptions tend to grow	B. Implemented the residential treatment team process 6/08. Funding identi-fied for mental health training for child care	

	after that.	providers. Initial Figures show @ 50% of children considered for residential treatment are receiving treatment in their community and avoiding the trauma of residential treatment	

Strategy 15: Promote successful transition from youth to adulthood (Was Strategy 10 in the 2007 Plan, revised to reflect 2007 accomplishments and 2008 work)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008
Strengthen and coordinate services that promote successful transition of foster children and youth with cognitive disabilities and serious emotional disturbances (SED) to adulthood.	A. Conduct a Lean process with stakeholders in January 2008 to discuss how to promote successful transitions. Submit recommendations to the Leadership Team for review and possible implementation	Done; follow-up continues, focusing on transition to adult mental health services. A. Lean Process workgroup met several times in 2008, and developed initial recommendations. At this time, DHHS is reviewing these recommendations	Lead: Dan Despard Associate leads: Doug Patrick and Lindsey Tweed

	B. Identify what youth need in order to make a successful transition to adulthood (e.g., permanency, connections with others, jobs, an education plan, safe housing, day-to-day external supervision, life skills, and a support network).	in light of the larger service context to determine transition strategies from the child system to the adult system. Dulcey Laberge and Sharon Kelly, OCFS, plan to continue to manage this effort in 2009 in partnership with Nancy Desisto, DHHS Commissioner's Office. B. Done Life domains were identified as part of the revised Youth Transition Tool. This work is also on-going through the Maine Youth Transition Collaborative. In 2008 an extensive stakeholder community planning group identified major life areas as part of on-going community collaboration work in York County. This work will continue and	

		expand in 2009, and learning from this project will be made available statewide. Also In 2009, community building will begin in Aroostook County around financial literacy in particular.	
	C. Assess whether current transitional living programs work (e.g., by reviewing discharge/outcome data from MACWIS for contracted providers)...	C. This was not completed, but could be done in 2009. The Youth Transition Program has a quality assurance worker assigned to review contracted agency performance; however, this did not happen extensively in 2008, given other priorities. There is a plan for QA agency reviews in 2009.	
	D. Review readiness assessments that can be used across programs (e.g., the seventeen year old assessment done several years ago with Muskie; the current strengths needs assessment).	D. Done A workgroup comprised of Child Welfare and Children's Behavioral Health Staff drafted a new Youth Transition Tool based on the	

		Strengths, Needs and Culture Discovery work of John Vandenburg, Wraparound Process. A focus group comprised on youth in care and youth formally in care provided valued feedback about the Draft Tool and their suggestions were incorporated. Beginning in 2009, this Draft Tool will be piloted with the youth from the focus group and other youth. It is anticipated that the Tool will be finalized and widely used by spring 2009.	
	E. Review protocols/policies relevant to transition with adult services, with an eye to linking more effectively with those agencies in addressing this problem.	E. It is anticipated that the draft of this new policy will be ready for comment by the spring of 2009. The Youth Transition Specialist began revising the existing Child Welfare policies into one Youth Transition Policy	

	F. Lindsey Tweed and Andy Cook will review the Independent Living survey developed for Child Welfare youth to see if it would also be useful for Children's Behavioral Health clients.	that better reflects new practice and legal expectations. F. Draft out for review This has been completed and is being piloted to determine feasibility and usefulness	F. Sharon Kelly and Dulcey Laberge

Strategy 16: Clarify the nature of OCFS prevention work (Was Strategy 11 in the 2007 Plan, revised to reflect 2007 accomplishments and work in 2008)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008
Clarify what OCFS' role in prevention work should be.	A. Identify and address disincentives to prevention in the existing service system (e.g., policies/procedures that cause unnecessary changes in caregivers, or how to deal with payment systems that require a diagnosis before service can be provided). This work will be supported by the Strengthening Families Initiative work. B. Build stronger communication and collaboration with the Office of Substance Abuse. Strengthen existing linkages at the top as possible (for example, through the Child Welfare and Substance Abuse Committee; perhaps EC and CBHS staff could join that group), and also focus on strengthening relationships at the working level (e.g., by linking with actors involved in developing the State Prevention Plan).	Have not made significant progress. B. Children's Behavioral Health staff are on the Steering Committee for the COSII – Co-occurring Integration Initiative. OSAA/COSII staff attended	<u>Lead</u>: Patti Woolley <u>Associate leads</u>: Carolyn Drugge, Virginia Marriner, Ann O'Brien, Sheryl Peavey, and Lindsey Tweed

		district meeting to train about co-occurring issues.	
	C. Explore ways to link more effectively with Maine CDC on prevention work (e.g., work with Valerie Ricker's group on abusive head trauma).	C. Summer 2008, OCFS and MCDC now serve as co-leads to a statewide workgroup on AHT. This has been completed and is being piloted to determine feasibility and usefulness	
	D. Implement recommendations from the Pediatric Symptom Checklist, which may indicate that a family is in need of further assessment.	D. The Pediatric System Checklist, a screening tool for behavioral health issues, is now in use by CW caseworkers for children who come to the attention of Child Welfare. Training in the use of the tool was incorporated in the training for the single case management process and was	

	E. Explore a common philosophical approach to prevention to be used throughout OCFS (e.g., Touchpoints?). Incorporate the System of Care values (family-driven, youth-guided, culturally and linguistically competent, and trauma-informed) into daily practice at the state and local levels. F. Seek more detailed information on the unified system serving children and families in Pittsburgh/Allegheny County.	completed statewide. Instructions for use have been incorporated in CW policy. E. Contract Riders have been updated to include system of care values. Discussions were had in management group meetings. Model Center for Social and Emotional Center for Early Grant application for State of ME submitted. Awaiting status. F. Explored; county government system not applicable in Maine.	

Strategy 17: Strengthen OCFS' work with communities (Was Strategy 12 in the 2007 Plan, revised to reflect 2007 accomplishments and work in 2008)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008
Strengthen OCFS' work with communities, particularly through continuation of the Future Search effort begun in 2006.	A. Constitute a small working group to re-energize/expand the community collaboratives' efforts. B. Identify the people now leading the community collaboratives' work across the state and convene them in November or December. Refresh their understanding of and commitment to the Future Search mission and core principles. Share updates on their activities. Discuss ways to facilitate communication among the collaboratives (e.g., better use of the website where information can be posted). Convene such meetings once or twice a year in future. C. Give community collaboratives readily available baseline information on challenges in their community, to educate them and help them identify problems to tackle. Also provide information on strategies/solutions that appear promising (e.g., encouraging business leaders to be mentors). Such information may be posted on the website D. Build mechanisms for providing feedback to communities on issues or questions that they surface in their work (e.g., submitting questions on the web site). E. Coordinate/integrate the work of Communities for Children with the work of the local collaborations.	Done Convened 11/4/08. Will continue to meet at least annually. C. Need to explore website hosting. New website is being created on the DHHS website. D. Annual reports were collected from Districts and shared with larger collaboratives. Wraparound Maine collaboratives are integrated with community collaboratives by contract. E. Began at 11/08 meeting	Lead: Sheryl Peavey Associate leads: Doug Patrick, Martha Proulx, Joan Smyrski, and Francis Sweeney

Strategy 18: Explore ways to effectively use ECS home visitors and CAN councils to assist the work now done by Alternative Response contractors (New strategy discussed at the March Management Team meeting)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008
Explore using ECS home visitors and CAN councils to assist the work now done by Alternative Response contractors	A. ECS home visiting staff are experienced in child development issues and how to engage families effectively, so they could supplement the work done by Alternative Response contactors if the families are eligible for service under the new home visiting standards of practice. Using home visitors could reduce hand-offs of clients and save money. CAN councils (which contain many home visiting providers) also have expertise useful to CW staff and Alternative Response contractors (e.g., knowledge of community resources). B. Determine how home visiting staff and CAN councils can best help families that might be referred to Alternative Response contractors. For example: --How might they provide additional primary prevention before families are sent to Alternative Response? --Is referral to Alternative Response always best? When might referral to home visitors be more useful? Who should make referrals (CAN councils, Intake, supervisors?) and how (e.g., while preserving confidentiality). C. Explore ways to promote more dialogue between CAN councils and the PA management team. D. Explore the potential for supplemental Child Welfare funds to be included in the FY'09 home visiting contracts	Discussions began Fall 08 and will continue through winter 09. Are hinging on internal dialogue and timing of TCM/Admin claiming changes. B. Winter 2009 C. Council Representation met with SMT in Oct 2008 D. The jointly developed	<u>Lead</u>: Sheryl Peavey <u>Associate leads</u>: TBD

	E. Implement the new mandated reporter training curriculum developed by Intake and the CAN councils.	mandated reporter training has been completed and is available on-line. Staff from CW Central Intake and the CAN Councils worked together and now jointly present the training to various providers, schools and other groups upon request. E. 9/08Posted online 12/08	

Strategy 19. now combined with Strategy 12.

DHHS Priority D: DHHS is a responsive, caring and well-managed organization that communicates effectively.

Strategy 20: Continue to develop/refine the OCFS communications plan (Was Strategy 14 in the 2007 Plan, revised to reflect 2007/2008 accomplishments)

Strategy (What)	Activities (How)	Timeline/Outcome	Leads for 2007/2008
Continue to develop an OCFS plan for internal and external communications.	A. Develop standardized communication expectations at all levels for internal communications. B. Leads from each service cluster will attend each other's	Being developed by plan Done - onngoing	Lead: Elaine White Associate leads: Dan Despard, Sharon Kelly, Sheryl

	management meetings at regular intervals to share relevant information. C. OCFS Management Team designees will provide information to the DHHS Director of Employee and Public Communications (John Martins) about each service cluster. D. For the near term, OCFS Management Team designees identify with John Martins and Lucky Hollander how decisions will be made about disseminating law, policy and budget information to external stakeholders and by whom. Special attention should go to providing briefing updates to legislators. E. Develop one to several over-arching messages for OCFS. F. Develop a process for regularly updating the email lists of internal and external stakeholders. Develop a plan for making the updated email lists readily available to OCFS staff (for example, by placing them on the OCFS web site or in folders on the State email system). G. Send out relevant monthly highlights to the updated list. H. Develop communications for each month where there is a relevant national theme (for example, Week of the Young Child, Autism Awareness Month, Child Abuse Month, Children's Mental Health Awareness Week). I. With approval from Jim Beougher and Nancy DeSisto, update OCFS website to reflect integration of Child Welfare, Children's Behavioral Health Services, Early Childhood Services, and Public Services Management. J. Before it is finalized, assure that the OCFS communications plan is coordinated with the communications plan for DHHS	 Ongoing Met with Lucky Hollander and gave input on HHS briefing. Done – on minutes Group will meet again to update lists, determine necessary action Ongoing Ongoing Will check with Mandy Elaine will check with Jim	Peavey, and Martha Proulx

	as a whole.		