Children's Services Work Group

Final Report To The

Joint Legislative Education Oversight Committee

Joint Legislative Corrections, Crime Control and Juvenile Justice Oversight Committee

Joint Legislative Health Care Oversight Committee

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

April 2006

April 13, 2006

Pursuant to Session Law 2005-276, Section 10.25, the Children's Services Work Group submits its Final Report to the Joint Legislative Education Oversight Committee; the Joint Legislative Corrections, Crime Control and Juvenile Justice Oversight Committee; the Joint Legislative Health Care Oversight Committee; the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services; and, upon commencement, the Coordination of Children's Services Study Commission.

Respectfully Submitted,

The Children's Services Work Group

Executive Summary

Session Law 2005-276 created the Children's Services Work Group and directed that the group address seven pre-determined legislative responsibility areas defined in the Comprehensive Treatment Services Program Section. Given the date of the signing of Session Law 2005-276 and the due date of the final report, the Work Group followed a very tight schedule to meet its mandate. The Work Group organized subcommittees, invited the participation of guests, and met 17 times between October 18, 2005, and March 14, 2006, to accomplish its assignment.

The Children's Services Work Group addressed each of the seven legislatively defined areas through a group effort that involved a detailed review of the existing services, supports and resources all the while keeping in mind the needs of children and their families. Collaboration, cooperation, shared information and combined resources were common themes throughout the Work Group meetings. The Work Group also reviewed initiatives from other states. The Work Group approached the task of developing recommendations with the goal of improving the lives of North Carolina's children and their families. These efforts resulted in 22 separate recommendations which are presented in detail in the body of this report and are summarized in the Executive Summary.

During the last five years, child-serving agencies in North Carolina have learned that they can accomplish more for children by working together. Legal mandates, policy requirements and funding solicitations now include collaboration as a requirement, and the response has been the creation of new collaborative groups which often address the needs of children and families based on the unique and specific perspective of the agency creating and housing the collaborative. Today, we have multiple groups, collaborations, or partnerships meeting and defining services, outcome measures and documentation tools to address the needs of children and families. A number of agencies are now working together to incorporate Family-Centered Practices and System of Care Principles. It is important that we build upon these successes. The work of the Children's Services Work Group should be used as a guide to next steps in accomplishing the vision of effective, respectful services and supports for youth and families.

Finally, the Work Group acknowledges the extensive involvement of the members, guests, and staff in developing the recommendations presented in this report. Without the concerted effort of all involved with the Work Group, this report could not have been accomplished.

Children's Services Work Group Summary of Recommendations

Legislated Responsibility Area 1

Identify common outcome measures for child-serving agencies that can be used for monitoring the safety, health, and well-being of North Carolina's children, youth, and families, including preventative measures.

Recommendation 1: Cross agency outcomes should include the following elements: a) the process is informed by research which is commonly and professionally accepted as credible; b) decisions about the resulting set of shared indicators and outcomes are vetted with focus groups and endorsed by stakeholders; c) ensure and link the shared indicators for school-aged children with those identified for children 0-5 in order to consistently connect the developmental trajectories for children across ages.

Legislated Responsibility Area 2

Identify strategies for funding flexibility between State and local agencies, including shared funding streams and the removal of financial and bureaucratic barriers.

Recommendation 1: Actively support and expand, from all North Carolina agencies, initiatives that promote shared and flexible funding. Determine how current examples of shared funding with state and local dollars that result in better outcomes can be replicated and/or expanded.

Recommendation 2: The named departments in the Comprehensive Treatment Services Program legislation should collaboratively assess the feasibility of implementing the strategies above in North Carolina.

Recommendation 3: Pilot promising new strategies for flexible and shared funding from all agencies and expand those proven to be successful.

Recommendation 4: Maintain a focus on the need for shared and flexible funding as state and local policies and procedures are developed.

Recommendation 5: Support all agencies funding of family participation on state and local planning entities to ensure their voice is included in all policy decisions.

Legislated Responsibility Area 3

Develop a common service terminology to be used across child-serving agencies that is appropriate and assists collaboration and coordination.

Recommendation 1: All child-serving agencies, when serving children/youth and families who require services and supports from multiple agencies, should adopt family-centered practices and implement the terminology associated with the terms "Child and Family Teams" and "Child and Family Plans."

Legislated Responsibility Area 4

Make recommendations regarding the creation of a shared database to track population and program outcomes information while protecting individual confidentiality.

Recommendation 1: Inventory current processes for using automation to share information.

Recommendation 2: Conduct an independent and thorough assessment and cost/benefit analysis with all key stakeholders to identify potential enhancement opportunities. Once the assessment is completed, secure funding from the General Assembly.

Recommendation 3: Obtain cost incurred by other states that have developed cross-system databases as a possible reference point for cost associated with developing a cross-system database.

Recommendation 4: Integrate tools and infrastructure to enable timely stakeholder access to needed information across agencies.

Recommendation 5: Identify a location that is secure and accessible to all the partner agencies where the shared database can "reside."

Recommendation 6: Distinguish between population and individual data and ensure that the system will restrict access and reports where necessary to protect confidentiality.

Recommendation 7: Utilize existing databases by standardizing and linking the existing systems while restricting access to search/query/generate reports while protecting individual confidentiality on population and outcome data.

Legislated Responsibility Area 5

Develop mechanisms that would allow agencies to share information about individual children receiving multiple services. Any recommendation must take into account confidentiality requirements, be voluntary on the part of the party receiving services, and be time-limited. The mechanisms may address intake, assessment, and release procedures.

Recommendation 1: Develop key components of a proposed Common Consent as a requirement among all participating parties. This will ensure a standardized, best-practice approach.

Recommendation 2: Attorneys at the School of Government should review the common consent form and/or request a formal Attorney General Opinion concerning the common consent forms being issued to allow counties to move forward without violating HIPAA, FERPA, 42CFR or any applicable state and federal law. Each agency should provide guidance and technical assistance to local stakeholders on the use of the common consent form.

Recommendation 3: Attorneys from each of the affected agencies should meet to agree upon a limited-use Common Consent form.

Recommendation 4: Attorneys should clarify the scope of HIPAA, FERPA, 42CFR and all applicable state and federal laws as it relates to the limited-use common consent form. Private sector accrediting bodies such as The Council on Accreditation would also need to be involved to ensure that HIPAA, FERPA, 42CFR and all applicable state and federal laws specific to non-profits are also included.

Recommendation 5: Statewide training should be conducted on the implications and scope of applicable confidentiality laws with particular emphasis on HIPAA, FERPA, 42CFR and all applicable state and federal laws.

Legislated Responsibility Area 6

Examine State and local training needs for implementing increased coordination and collaboration.

Recommendation 1: The General Assembly should encourage agencies to use appropriated funds for cross agency training, inviting representatives from family groups and other agencies. Training should include, but not be limited to, the following: Confidentiality Laws and Informed Consent, Building and Maintaining Child and Family Teams, Understanding Common Outcomes and Common Service Terminology.

Recommendation 2: Training should be developed in modules that can be repeated throughout the year and allow for the easy inclusion of emerging practices, new mandates or provision of services and automated efforts that enhance collaboration, coordination and sharing of information.

Recommendation 3: Involve elected officials and stakeholders in the development and support of cross agency training delivered in the local community.

Legislated Responsibility Area 7

Study other issues the Work Group determines would improve coordination and collaboration between child-serving agencies.

The Work Group did not identify additional areas to address, as permitted in Legislative Responsibility Number 7, to allow the Work Group to fully focus its efforts on the six pre-defined Legislative Responsibility areas.

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Attachments

Preface

The Children's Services Work Group was created by the General Assembly (Session Law 2005-267) to address gaps, barriers and needs related to improving and enhancing the services and supports available to children, youth and families in North Carolina.

This document has been prepared by the Children's Services Work Group in compliance with its legislative mandate to submit a Final Report by April 15, 2006. This report summarizes the legislation creating the Children's Services Work Group as well as the Work Group membership, methodology, accomplishments and recommendations.

Introduction

North Carolina's General Assembly, through passage of the Comprehensive Treatment Services Program (Session Law 2005-276), recognizes that "services to children, youth, and families are most effective when they are child- and family-centered, strengths-based, appropriate, and recognize and respect cultural differences." The legislation further states, "These practices can be successfully implemented only where there is significant and ongoing collaboration and coordination among multiple public agencies."

The goal of the Children's Services Work Group (Work Group) is to improve services for children, youth and families. With this in mind, the Work Group has adopted the following statement to guide its work:

> *North Carolina's human services agencies, which are charged with providing services and supports for children and their families, share responsibility and accountability to help families guide their children to succeed at home, in school, and in the community.*

In the Comprehensive Treatment Services Program Section of Session Law 2005-267, the Legislature assigned the Work Group the following seven tasks:

1. Identify common outcome measures for child-serving agencies that can be used for monitoring the safety, health, and well-being of North Carolina's children, youth, and families, including preventative measures.
2. Identify strategies for funding flexibility between State and local agencies, including shared funding streams and the removal of financial and bureaucratic barriers.
3. Develop a common service terminology to be used across child-serving agencies that is appropriate and assists collaboration and coordination.
4. Make recommendations regarding the creation of a shared database to track population and program outcomes information while protecting individual confidentiality.
5. Develop mechanisms that would allow agencies to share information about individual children receiving multiple services. Any recommendation must take into account confidentiality requirements, be voluntary on the part of the party receiving services, and be time-limited. The mechanisms may address intake, assessment, and release procedures.
6. Examine State and local training needs for implementing increased coordination and collaboration.
7. Study other issues the Work Group determines would improve coordination and collaboration between child-serving agencies.

The specific charges of the Children's Services Work Group (see Legislation Section beginning on page 6 of this report) are inherently interrelated. It should be recognized that not one of these issues can be effectively addressed without impacting others. The Work Group believes that

significant progress has been made toward comprehensively addressing the issues identified by the Legislature. More work needs to be done to achieve the level of integration necessary to achieve better results for children, youth, and families across North Carolina, but the Work Group believes that the work presented here is an important start.

During the last five years, child-serving agencies in North Carolina have learned that they can accomplish more for children by working together. Legal mandates, policy requirements and funding solicitations now include collaboration as a requirement and the response has been the creation of new collaborative groups which often address the needs of children and families based on the unique and specific perspective of the agency creating and housing the collaborative. Today, we have multiple groups, collaborations, or partnerships meeting and defining services, outcome measures and documentation tools to address the needs of children and families. It is important that we build upon these successes. This report should be used as a guide to next steps in accomplishing the vision of effective, respectful services and supports for youth and families.

The state has an interest in the delivery of evidence-based services to children and their families. Some services and supports, like those associated with education, are available to all children as a matter of right. Others, like health and mental health services, are available for those with needs that cannot be met privately. In some cases, the state provides services because the parents cannot or will not act in the best interests of their children. The goal of the Children's Services Work Group is to establish a comprehensive and integrated framework that more systematically supports the policies, programs and practices necessary to implement more effective services to achieve better outcomes.

One key framework that is suited for this endeavor is family-centered practice through a System of Care. System of Care is nationally recognized as the "best possible programmatic, fiscal, and organizational context for implementing and sustaining evidenced-based interventions" (CMHS, 2004). It is cited in the President's New Freedom Commission (2003), in Surgeon General Reports (Office of the Surgeon General 1999, 2000), the Child Welfare League of America, the Robert Wood Johnson Foundation and various other policy and research documents (Burns B, Hoagwood K. 2002) as the most effective comprehensive framework within which to plan and deliver services for children and their families. It is also widely advocated for implementation by family organizations, including the national Federation of Families for Children's Mental Health and North Carolina Families United; and, consistent with current policy of North Carolina's Department of Health and Human Services (specifically the Divisions of Mental Health, Developmental Disabilities, and Substance Abuse Services and Social Services) and the Department of Juvenile Justice and Delinquency Prevention.

Family-centered practice is a hallmark of System of Care, promoting essential partnerships between families, agencies, and providers. Family-centered professionals treat children and families the way they would like to be treated if they themselves were receiving services. Research tells us that unless and until families are fully engaged in treatment, positive outcomes are unlikely to occur or endure. Family-centered practice requires collaboration, accountability, cultural competence, and child and family "centeredness." Focus is on the individual's needs and is community based. The concept of family-centered and comprehensive care is the foundation

of all system efforts and best practice models for children and their families (President's New Freedom Commission, 2002).

The significant principles of Family-Centered Practice and the System of Care Model are outlined in the table below.

Family-Centered Practice	***System of Care Model***
• Everyone Desires Respect • Everyone Needs to be Heard • Everyone has Strengths • Judgments can Wait • Partners Share Power • Partnership is a Process	• Strengths Based • Family and Youth Involvement • Family-centered & Child Focused • Culturally Responsive • Evidence Based Practices • Outcomes Based Performance • Integrated Approach

When we do our work well – when we collaborate, support evidence-based practice and respect the desires and needs of families – we can accomplish stunning successes. As evidenced in the examples below, these successes are measured by improved outcomes: achieving permanency through the reunification of a family, adoption or a stable relative placement and by the rebuilding of community. These successes also frequently save the state money by reducing over utilization of restrictive services, "state" custody, or incarceration.

The following examples of successful collaboration were provided by the Dream a Better Dream collaborative (DABD). This collaborative of community stakeholders includes the Division of Mental Health, Developmental Disabilities and Substance Abuse Services Local Management Entities, the Department of Juvenile Justice and Delinquency Prevention Chief Court Counselors and their court counselors, local education agencies, the Departments of Social Services, private providers, families and youth. The focus of the collaborative is both prevention and intervention by stopping youth from entering Youth Development Centers or by reducing the numbers of youth placed in Youth Development Centers. This project covers thirty-one western North Carolina counties, eight judicial districts and six Division of Mental Health, Developmental Disabilities and Substance Abuse Services Local Management Entity catchment areas.

"YOUTH A" *was placed at a Youth Development Center in late 2004. Four months later the Chief Court Counselor referred her to Dream A Better Dream (DABD). Through a collaborative effort between DABD staff, the juvenile court counselor, the mental health case manager, Youth Development Center staff and the youth's family, she was released and placed in a residential facility close to her community.*

She successfully completed the first phase of treatment that included individual and group therapy, a residential placement and an education program. She then successfully returned to the family home, community and local education agency in late 2005. She is now on one of her school's athletic teams and is making A's and B's in her classes. She is expected to be successfully discharged from court supervision within two months and complete the final phase of treatment (outpatient) within nine months.

"YOUTH B" was being held in the local county detention center when he was referred to Dream a Better Dream by his court counselor in mid 2005. The young man displayed extreme runaway behaviors and was engaging in significant risk-taking behaviors. Thirteen missing person's reports had been filed prior to his involvement with Department of Juvenile Justice and Delinquency Prevention.

Through the collaborative efforts of Dream a Better Dream staff, the juvenile court counselor, and the mental health case manager, a residential placement was quickly found. The provider agreed not to discharge the client because of the predictable self-sabotaging behaviors as long as the court counselor, mental health case manager and family remained closely involved in the treatment. The youth did well initially but was then charged with larceny of a staff member's vehicle. After a stay in secure custody, he returned to that same residential facility and began to significantly improve his behaviors.

He was successfully returned to his family home in mid fall 2005. Dream a Better Dream funded 30 days of mental health community support that worked with the youth and his family during this transition. He was successfully discharged from mental health services in late fall 2005.

These examples demonstrate the importance of pooled resources, community-based services and a collaborative response to children and youth at high risk.

Before looking at the six tasks identified by the General Assembly, the Children's Services Work Group felt it was important to inventory the existing initiatives and programs where multiple agencies have begun to work together to better serve the children of North Carolina. By looking at accomplishments, the Work Group felt that they would be in a better position to build on existing successes, remove barriers to continued improvement, and identify new ways to better serve our children and their families.

The Work Group reviewed a number of collaborative initiatives working together to help families create better outcomes for their children including the Community Care of North Carolina Mental Health and Primary Care Integration Pilot, the School-Based Mental Health Initiative, the Therapeutic Courts Program, the Early Childhood Comprehensive System Initiative, Multiple Response System, the State Collaborative for Children and Families and the Durham System of Care. Examples of the successful collaborative efforts listed above, as well as other successful collaborations across North Carolina, are located in Attachment C of this report.

State and local agencies should be rewarded and supported when they work together successfully and demonstrate better results. Legislators and state and local agencies should expect and encourage more activities that promote collaboration and integration of services and resources across systems. Since agencies in some communities in North Carolina are sharing training resources, pooling funds, and finding new and creative ways to share resources, we must support all communities so that they may achieve similar results.

With resources, supports and staff being reduced while the challenging needs of children in North Carolina are growing, it is incumbent on all of us to continue these efforts. The Children's Services Work Group has examined how to build on past accomplishments in order to develop new ways to use information, share data and make better use of increasingly scarce dollars to better serve North Carolina's children and their families.

Legislation

The Children's Services Work Group (Work Group) was created within the Comprehensive Treatment Services Section (Section 10.25) of Session Law 2005-276. This legislation has been included as Attachment A of this report.

The legislation assigned pre-defined legislative responsibilities to the Children's Services Work Group. Those responsibilities are defined as follows:

1. Identify common outcome measures for child-serving agencies that can be used for monitoring the safety, health, and well-being of North Carolina's children, youth, and families, including preventative measures.
2. Identify strategies for funding flexibility between State and local agencies, including shared funding streams and the removal of financial and bureaucratic barriers.
3. Develop a common service terminology to be used across child-serving agencies that is appropriate and assists collaboration and coordination.
4. Make recommendations regarding the creation of a shared database to track population and program outcomes information while protecting individual confidentiality.
5. Develop mechanisms that would allow agencies to share information about individual children receiving multiple services. Any recommendation must take into account confidentiality requirements, be voluntary on the part of the party receiving services, and be time-limited. The mechanisms may address intake, assessment, and release procedures.
6. Examine State and local training needs for implementing increased coordination and collaboration.
7. Study other issues the Work Group determines would improve coordination and collaboration between child-serving agencies.

The legislation also defined the membership of the Children's Services Work Group. Designated authorities were identified to appoint the individual members of the Work Group. The list below summarizes the identified appointment authorities:

- Secretary of the Department of Health and Human Services
- Secretary of the Department of Juvenile Justice and Delinquency Prevention
- Chair of the State Board of Education
- Superintendent of Public Instruction
- Chief Justice of the North Carolina Supreme Court

Legislation also instructed the appointing authorities to make at least one appointment in the following categories:

- Representative from among the programs, divisions or departments under that administrator's control and that provide services to children and youth

- Parent of a child or youth who has or is at risk for behavioral, social, health, or safety problems or academic failure
- Member of a local collaborative body
- Private sector service provider

For budgetary and staffing purposes, the Children's Services Work Group was located in the Department of Administration. The Department of Administration assigned staffing responsibilities to the Youth Advocacy and Involvement Office.

A list of the Work Group members and staff has been included as Attachment B of this report.

In addition to the creation of the Children's Services Work Group, the legislation also required the creation of a Children's Services Study Commission. Among other assignments, this Commission was designated as the recipient of the Children's Services Work Group interim and final reports. As of the submission of this final report, appointments to the Coordination of Children's Services Study Commission have not been made. In the absence of the Commission, the Children's Services Work Group is instructed to submit its interim and final reports to the Joint Legislative Education Oversight Committee; the Joint Legislative Corrections, Crime Control and Juvenile Justice Oversight Committee; the Joint Legislative Health Care Oversight Committee; and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

The date for submitting the interim report was defined as December 15, 2005, with the final report being due on April 15, 2006. Legislation dissolves the Work Group upon the submission of its final report.

Children's Services Work Group Methodology

On September 1, 2005, the Department of Administration began corresponding with the appointing authorities for purposes of staff introduction and coordination of the initial Work Group meeting. The legislation required that the Work Group convene its first meeting within 30 days of the signing of Senate Bill 622. Although an initial meeting was scheduled within the defined time period, travel restrictions delayed the preliminary meeting until October 18, 2005. During the months of September 2005 and October 2005, staff from the Youth Advocacy and Involvement Office met with each of the appointing authorities for purposes of orientation and introduction. Following these meetings the appointing authorities began to designate their appointments to the Work Group.

The initial meeting of the Children's Services Work Group was held on Tuesday, October 18, 2005, and a second meeting followed on Tuesday, November 8, 2005. During these two meetings, general orientation for the membership regarding the seven legislatively defined responsibility areas was completed and decisions regarding meeting structure and organization of tasks and responsibilities were finalized. The Work Group decided that the meetings would be facilitated by the Youth Advocacy and Involvement Office staff and that Work Group decisions would be made through group consensus. It was also agreed that the staff would be responsible for taking minutes, coordinating meetings and providing distribution of information.

The pre-defined legislative responsibility areas were assigned to three subcommittees for purposes of facilitation and management of tasks. The Work Group members volunteered to serve on the subcommittees. The subcommittees were organized to allow each Work Group member to participate in multiple subcommittees at their discretion. This was accomplished by scheduling all subcommittee meetings non-concurrently on the same day. The subcommittees are listed below:

- **Subcommittee 1: Legislated Responsibilities Numbers 1 and 3** (defined below)
    1. Identify common outcome measures for child-serving agencies that can be used for monitoring the safety, health, and well-being of North Carolina's children, youth, and families, including preventative measures.
    3. Develop a common service terminology to be used across child-serving agencies that is appropriate and assists collaboration and coordination.
- **Subcommittee 2: Legislated Responsibilities Numbers 4 and 5** (defined below)
    4. Make recommendations regarding the creation of a shared database to track population and program outcomes information while protecting individual confidentiality.
    5. Develop mechanisms that would allow agencies to share information about individual children receiving multiple services. Any recommendation must take into account confidentiality requirements, be voluntary on the part of the party receiving services, and be time-limited. The mechanisms may address intake, assessment, and release procedures.

- **Subcommittee 3: Legislated Responsibility Number 2** (defined below)
    2. Identify strategies for funding flexibility between State and local agencies, including shared funding streams and the removal of financial and bureaucratic barriers.

Legislative Responsibility Number 6 (examining state and local training needs) was tabled until the completion of the initial subcommittee recommendations since it was agreed that these recommendations could affect decisions about training recommendations.

The Work Group did not identify additional areas to address, as permitted in Legislative Responsibility Number 7, to allow the Work Group to fully focus its efforts on the six pre-defined Legislative Responsibility areas.

Each member of the Work Group volunteered to participate in at least one subcommittee. A list of the subcommittee members is included as Attachment B of this report.

To acknowledge the importance of the pre-existing efforts that addressed the responsibility areas defined in the legislation, the Work Group agreed that, whenever practical, existing information would be used when creating recommendations. Additionally, the Work Group invited parents, community members and agency staff to participate in meetings as guests. The guests provided important feedback and information to the Work Group and played a vital role in the discussions leading to the development of the Work Group recommendations.

In the following months, the discussion, research and formulation of recommendations continued. The subcommittee and full committee meetings of the Children's Services Work Group were scheduled for, and held, as follows:

- **Tuesday, December 13, 2005 – Subcommittee Meeting Day**
    - Governor's Crime Commission Conference Room
        - Subcommittee 1: 9 a.m. to 11 a.m.
        - Subcommittee 2: 12:30 p.m. to 2:30 p.m.
        - Subcommittee 3: 3 p.m. to 5 p.m.

- **Tuesday, January 10, 2006 – Subcommittee Meeting Day**
    - Dorothea Dix Campus, Adams Building - Room 264
        - Subcommittee 1: 9 a.m. to 11 a.m.
        - Subcommittee 2: 12:30 p.m. to 2:30 p.m.
        - Subcommittee 3: 3 p.m. to 5 p.m.

- **Tuesday, January 31, 2006 – Full Work Group Meeting Day**
    - Dorothea Dix Campus, Adams Building - Room 264
    - 1 p.m. to 3:30 p.m.

- **Tuesday, February 14, 2006 – Subcommittee Meeting Day**
  - Dorothea Dix Campus, Adams Building - Room 264
    - Subcommittee 1: 9 a.m. to 11 a.m.
    - Subcommittee 2: 12:30 p.m. to 2:30 p.m.
    - Subcommittee 3: 3 p.m. to 5 p.m.

- **Tuesday, March 14, 2006 – Full Work Group Meeting Day**
  - Governor's Crime Commission Conference Room
  - 9 a.m. to 3:30 p.m.

In an effort to accomplish as much as possible, four sub-subcommittees were created by Subcommittee 1 and Subcommittee 2. The four sub-subcommittees met on the following dates:

- **Wednesday, January 3, 2006 – Common Consent Sub-Subcommittee Meeting Day**
  - Administrative Office of the Courts
  - 12:00 p.m. to 1:30 p.m.

- **Thursday, January 5, 2006 – Vision/Goals Sub-Subcommittee Meeting Day**
  - Albemarle Building, Department of Health and Human Services
  - 9:00 a.m. to 11:00 a.m.

- **Friday, January 20, 2006 – Common ID/MIS Link Sub-Subcommittee Meeting Day**
  - Albemarle Building, Department of Health and Human Services
  - 1:30 p.m. to 4:00 p.m.

- **Friday, January 27, 2006 – Outcomes Sub-Subcommittee Meeting Day**
  - Adams Building, Dorothea Dix Campus
  - 4:00 p.m. to 5:00 p.m.

The full membership was advised of the specific accomplishments of each subcommittee to ensure timely input of the full membership in all decisions. As stated previously, existing information was utilized to the fullest extent possible and the membership of the Work Group thanks the groups, collaborations and agencies that have shared their information and resources.

Issues and Recommendations

Between October 18, 2005, and March 14, 2006, the Children's Services Work Group, or its subcommittees, met a total of 17 times to address the legislatively assigned responsibility areas. The issues reviewed and recommendations for each of the six pre-defined legislatively assigned responsibility areas have been defined in the below sections.

Legislated Responsibility Area 1

Identify common outcome measures for child-serving agencies that can be used for monitoring the safety, health, and well-being of North Carolina's children, youth, and families, including preventative measures.

Introduction

For too many years, child-serving agencies have been driven by concerns about process (funding, eligibility criteria, error rates, etc.) and outputs (how many people were hired, dollars were spent, and children were served) instead of outcomes (whether the quality of life for our state's children and their families was improving). Furthermore, outcomes were measured from the perspective of each separate agency rather than a combined impact on all children and their families.

Today there is a growing national movement to change this emphasis to focus on child and family outcomes. It is also recognized that measuring outcomes that reflect changes in the quality of life for children and their families involves looking at outcomes that cross the organizationally defined boundaries that usually guide the ways agencies gather and use information. Just as the lives of any child and family are complex, likewise, agencies must take a more comprehensive view of each family in order to address those complex needs.

One strategy for increasing "significant and ongoing collaboration and coordination among multiple public agencies" is to establish common outcomes for those agencies. When agencies are held accountable for outcomes that they can only produce by working together, collaboration is no longer a choice; it is a necessity. The challenge is to identify the outcomes that measure meaningful improvements in the lives of children and their families, while increasing collaboration and coordination among the agencies charged to serve them.

The adoption of outcome measures that reflect changes in "life domains" such as health, finances, housing, safety, etc., is an important shift in the orientation towards a more comprehensive view. If child-serving agencies define success by whether or not children and their families experience improved circumstances in their everyday lives at home, in school, and in the community, the agencies will be motivated to better coordinate resources, decrease fragmentation, and become more responsive to the real needs of children and their families.

States and communities are increasingly aware that helping families help their children be successful at home, school, work and in the broader community requires that agencies work closely together to help improve the lives and functional outcomes of children and their families. At the federal and state levels, agencies are required to document how each is contributing to those common outcomes.

Examples

There are many reasons why we need to look across agencies to measure how the service system helps children and their families succeed.

> *Example 1:* Health and school success: While we usually hold schools accountable for academic success, absences caused by chronic diseases such as asthma and diabetes reduce academic achievement. Therefore, programs that lower the incidence of these conditions can contribute to improved attendance and academic success.
>
> *Example 2:* Mental health and crime reduction: Children who come into the juvenile justice system often have untreated mental health and substance abuse problems. Juvenile justice programs are often more successful when the children they serve have access to, and utilize, mental health and substance abuse treatment.

While schools can do much to improve academic success, and juvenile justice agencies can do much to reduce juvenile crime, neither of these two child outcomes can be produced by a single agency. Instead, these outcomes are jointly produced by a number of agencies working together with parents, private providers and community groups.

Increasingly, the Division of Social Services and county departments of social services are being held accountable to meeting the health, behavioral health, and educational needs of children they serve. Likewise, federal block grants for mental health and substance abuse track outcome measures such as involvement with the juvenile justice system, school attendance, and improved educational and social performance. To track these kinds of outcomes the state needs to go beyond information captured by single agencies.

Agencies should measure success not only in terms of whether the children they serve experience improvements while they are in the service systems, but also in terms of how well they are able to function at home, in school or at work and in their communities. A child may function well while in a juvenile justice institution or during mental health treatment. However, unless we measure success by how well the child does at home, in school and in the community after completion of treatment or incarceration, we will never know whether the treatment or incarceration was really effective.

North Carolina's child-serving agencies have moved toward greater accountability to actual results, with each of our agencies paying more attention to the impact of programs on the lives of our children. Just as North Carolina's ABC program in education predated the federal act, *No Child Left Behind*, the Department of Health and Human Services and the Department of Juvenile Justice and Delinquency Prevention have each put systems in place to improve the way

we measure the impact of services on the lives of our state's children and families. This is happening at both the state and the local levels.

At the local level, the Durham community (local Mental Health, Developmental Disabilities and Substance Abuse Services agency, local governments, public/private agencies, citizens and the local education agency) has established a set of common cross-system outcome measures through its implementation of a local System of Care for the following key child-serving agencies: social services, juvenile justice, local education agencies, health, mental health, developmental disabilities and substance abuse services. The purposes of the common cross-system outcomes are to:

1. Inform families about how their own children are progressing
2. Monitor the safety, health and well-being of children/families participating in the Durham System of Care
3. Clearly state that the Durham System of Care is outcomes-accountable, and makes decisions about service/system issues as informed by these outcomes
4. Track individual and program outcomes
5. Protect confidentiality through informed consent and password protected web access

Durham's System of Care was implemented initially for children who met the threshold for the Comprehensive Treatment Services Program and is now being systematically expanded to reach across the community to other children and families with less intensive needs and to adults with complex mental health and substance abuse treatment needs.

Other examples of how agencies are developing and using common outcome measures were reviewed by the Work Group. These examples include:

- The Shared Indicators for School Readiness project – Division of Public Health
- Exploring the Outcomes for Youth Aging Out of Foster Care – Division of Social Services
- Community Care of North Carolina Mental Health and Primary Care Implementation Pilot – Department of Health and Human Services
- System of Care Network Demonstration Sites – Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
- The Leading By Results Task Force – A joint project of the North Carolina Association of County Directors of Social Services, the North Carolina Association of County Boards of Social Services and the North Carolina Department of Health and Human Services.

Using the examples noted above, the Work Group explored preliminary common outcomes and indicators based on the principles that children should be safe and successful in the home, school and community.

Recommendations for Common Outcome Measures

Recommendation 1: Cross agency outcomes should include the following elements: a) the process is informed by research which is commonly and professionally accepted as credible; b) decisions about the resulting set of shared indicators and outcomes are vetted with focus groups and endorsed by stakeholders; c) ensure and link the shared indicators for school-aged children with those identified for children 0-5 in order to consistently connect the developmental trajectories for children across ages.

Legislated Responsibility Area 2

Identify strategies for funding flexibility between State and local agencies, including shared funding streams and the removal of financial and bureaucratic barriers.

Introduction

To "identify strategies for funding flexibility including shared funding streams and the removal of financial and bureaucratic barriers," we must examine why shared and flexible funding is difficult to achieve and what essential elements were in place in partnerships where this has been achieved.

Much of the funding dedicated to children's services is "categorical" or dedicated to a particular age, service type or group such as children placed out of home in a foster placement, children who are deaf or blind or children with serious emotional or behavioral needs. This kind of funding places limits on whom, how and why the money can or cannot be spent. It may require a family to use services they do not want or need, such as case management services to access a specific treatment or support. It may limit a child and their family to a particular service because they do not fall into eligibility categories or because the service or support requested is "outside the box" of traditional services.

Rigid funding restrictions can waste valuable resources by causing the overlapping of services, resulting in service duplication. These restrictions can also cause children to be placed in more restrictive, expensive out-of-home or out-of-community placements when the timely provision of non-traditional community supports would have stabilized the child and family. In fact, 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 and their families. Funding shapes available services. The delivery of more comprehensive, community-based services requires bringing funds together across programmatic lines, making them more flexible and more available to support individualized plans of care. For all of these reasons and many more, it is imperative that the federal, state and local agencies work to examine funding barriers and develop funding flexibility and shared funding.

Flexible funds or shared funds provide services or supports that cannot be accessed without cost and are typically not provided by entitlements, categorical funding streams, or through community agencies. They are necessary to ensure that the individual needs of children and their families are properly addressed. These funds are flexible in that they can be used to support a number of purposes, services, or supports.

The Work Group identified four common principles that should be part of any flexible or shared funding recommendation.

1. Self directed care is necessary for children and their families so that they may select the services and supports that are most appropriate for them
2. Immediate or timely access to appropriate and requested services

3. Flexibility in the use of funds at the state and local levels to ensure that the costs of necessary services and supports will be covered
4. Cost savings that are realized as a result of such coordinated and collaborative care must be reinvested in the system to allow further services and best practices to be accessed.

The Work Group also examined financial and bureaucratic barriers to shared or flexible funding. These barriers presented obstacles that restrict, or may restrict, the flexibility of funding that is needed to obtain better results. Most frequently this is due to narrowly defined guidelines for funding usage rather than a broader definition which would support an agency's ability to address the unique issues facing a child or family.

The Work Group identified the following five categories of existing and potential barriers to flexible or shared funding:

- Practice
- Legislative
- Funding
- Policy/Administrative
- Training

Certain practices by which state agencies, local agencies, and private providers operate and utilize resources can limit the flexibility of funds. Federal, state, and local legislation is often written such that it restricts the use of funds, thus creating barriers. Policies and administrative procedures often limit flexibility of funds because they are typically agency and/or population specific. Further, child-serving agency staff are not typically fully informed about funding streams within their own agency, much less those of other child-serving agencies. Finally, staff often do not view knowledge of funding as relevant to their daily work. Information about funding is generally not included in staff training.

It is necessary to note that these barriers are dynamic; that is, they can be changed. Once clearly identified, specific solutions can be posed to eliminate or minimize most financial and bureaucratic barriers.

Examples within North Carolina

Multi-Agency pooling of funding to address Flexible or Shared Funding: Guilford County offers an example of multi-agency pooling of funding to address flexible or shared funding.

Guilford County Family Involvement

In Guilford County, the local departments of Social Services and Public Health, Department of Juvenile Justice and Delinquency Prevention, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services local management agency, and the University of North Carolina at Greensboro each provide funding for the Guilford County Family Involvement Initiative. These funds are used for

advocacy and support and to offset costs for family participation in meetings and workshops, thereby empowering and engaging families.

County/State pooling of funding to address Flexible or Shared Funding: The Durham community mental health center and partnering agencies offers an example of county/state pooling of funding to address flexible or shared funding.

Durham County Finance Integration Protocol

The Finance Integration Protocol of Durham's Community Collaborative combines funds to develop new services and to provide immediate supports to children and families such as one-time expenses like a recreational membership to help provide after-school activities or car repair to help families get to important appointments and activities. All uses of shared and flexible funds are related directly to efforts to help children and their families access local services and supports and avoid unnecessary out of home placements. A non-profit vendor manages the flexible funds and checks are paid directly to the billing source or provider. The Finance Committee of the Community Collaborative closely monitors the use of flexible funds. Access to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services Comprehensive Treatment Services Program funds through non-unit cost reimbursement supports this community effort.

County pooling of funding to address Flexible or Shared Funding: Orange and Chatham counties offers an example of county pooling of funding to address flexible or shared funding.

Orange and Chatham Child Planning Conferences

In Orange and Chatham counties, the Chief District Court Judge worked with the Directors of the two county departments of Social Services to obtain two $10,000 grants (allocated to the district court in each county totaling $20,000) to fund a contracted facilitator to manage "child planning conferences" when either of the local department of social services files a petition for abuse, neglect and/or dependency.

Federal Demonstration Program Funding to address Flexible or Shared Funding: The North Carolina Division of Social Services offers an example of the use of federal demonstration program site funding to address flexible or shared funding.

Title IV-E Waiver Demonstration Site

North Carolina was one of only nine states named as a Title IV-E Waiver Demonstration Site by the U.S. Health and Human Services, Administration on Children and Families. The North Carolina Department of Health and Human Services, Division of Social Services waiver allows 38 counties to use restrictive federal funds flexibly to reduce the rate of child entry into foster care, reduce the length of stay in foster care, reduce the number of placements in foster care and reduce the rate of reentry into foster care.

Categorical Federal Funding to address Flexible or Shared Funding: The joint effort between the Department of Juvenile Justice and Delinquency Prevention and the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Managing Access for Juvenile Offender Resources and Services Program, offers an example of the use of categorical federal funding to address flexible or shared funding.

MAJORS Program
Managing Access for Juvenile Offender Resources and Services

The MAJORS Program is a federally-funded program that targets adjudicated juveniles with substance abuse treatment needs. Program implementation requires ongoing collaboration between the Department of Juvenile Justice and Delinquency Prevention and the Department of Health and Human Services. This effort provides a nationally recognized, innovative model of specialized substance abuse treatment, transition planning and care, and coordination of services for adjudicated juvenile offenders.

Examples outside of North Carolina

As part of Work Group's charge to identify strategies for flexible and shared funding, research was conducted to determine how other states are addressing this issue. Below are brief explanations of what some states are doing.

Legislative Mandate to address Flexible or Shared Funding: The State of Virginia offers an example of state implementation of shared or flexible funding as a response to a legislative mandate to pool funds and share accountability.

Virginia's Comprehensive Services Act for At-Risk Youth and Families

Under the Comprehensive Services Act, Virginia pooled state and federal funds from education, foster care, mental health, developmental disabilities, substance abuse, and juvenile justice. Each community received an annual allocation of these pooled funds to serve those children and youth entitled to services by state or federal law as well as all children and youth "at risk of out-of-home or out-of-community placement." To access funds, families and lead case workers are required to meet with an interagency team called a Family Assessment Planning Team to develop an Individual Family Services Plan. If the services needed are beyond what is available within the participating agencies and there are no other family or community resources available, the team may choose to purchase services with local Comprehensive Services Act funds. The legislation also mandated the collaborative planning and oversight of a Community Policy and Management Team.

Medicaid Waiver to address Flexible or Shared Funding: The State of New Mexico offers an example of state implementation of shared or flexible funding as a response to a Medicaid waiver program.

New Mexico's Medicaid Waiver

The State of New Mexico is an example of a state that has utilized a Medicaid waiver program authorized by the United States Department of Health and Human Services.

Such waivers allow states flexibility in operating Medicaid programs. Waivers may be used to: test policy innovations likely to further the objectives of the Medicaid program; implement managed care delivery systems, or otherwise limit an individual's choice of provider; or allow long-term care services to be delivered in community settings.

Private-Public Partnership to address Flexible or Shared Funding: The State of Indiana offers an example of state implementation of shared or flexible funding as a response to a private-public partnership.

Indiana's Dawn Project

The Dawn Project was created in 1997 to provide a coordinated services network in Marion County, Indiana, that was community based, and child- and family-centered, culturally competent, and financed through non-categorical, flexible funding streams. According to a report by the Research and Training Center for Children's Mental Health, the case cost rate that is created by these agencies is $4,254 per member per month, which is $1,763 less than standard treatment cost per child per month. The case-rate structure allows for flexible funding of services and supports for children and families. Through successful collaboration from all partners, flexible funding has been used to provide strengths-based services to more than 800 families.

Governmental Reorganization to address Flexible or Shared Funding: At least 16 states have implemented some level of governmental reorganization to achieve shared or flexible funding.

Children's Cabinets

According to the National Governors Association, at least 16 states currently have a Children's Cabinet. Though features may vary from state to state, the Cabinets typically involve senior state officials from a range of child and families serving agencies such as health, education, mental health, labor, juvenile justice, and child welfare. Despite its structure, a Children's Cabinet is a planning body that develops a comprehensive, multi-system collaborative plan to improve services and well-being for children and families. In several states, part of this comprehensive planning is the development of common outcome indicators for children and families and the tracking of these indicators.

Recommendations on the Identification of Flexible and Shared Funding and on the Removal of Financial and Bureaucratic Barriers

Recommendation 1: Actively support and expand, from all North Carolina agencies, initiatives that promote shared and flexible funding. Determine how current examples of shared funding with state and local dollars result in better outcomes can be replicated and/or expanded.

Recommendation 2: The named departments in the Comprehensive Treatment Services Program legislation should collaboratively assess the feasibility of implementing the strategies above in North Carolina.

Recommendation 3: Pilot promising new strategies for flexible and shared funding from all agencies and expand those proven to be successful.

Recommendation 4: Maintain a focus on the need for shared and flexible funding as state and local policies and procedures are developed.

Recommendation 5: Support all agencies funding of family participation on state and local planning entities to ensure their voice is included in all policy decisions.

Legislated Responsibility Area 3

Develop a common service terminology to be used across child-serving agencies that is appropriate and assists collaboration and coordination.

Introduction

All agencies should use common standardized terminology to successfully provide individualized appropriate services and supports to children and their families. This will not only help families move seamlessly through different child-serving systems, but will also assist agencies with communication and in developing common assessment tools, training curriculum, outcome measures, and shared indicators.

The Work Group found that agencies actively participating in the State Collaborative for Children and Families, the North Carolina Partnership for Children, the Community Care of North Carolina Mental Health and Primary Care Integration Pilot, and the Early Childhood Comprehensive Systems working group were more likely to create common service terminology or be working toward this goal.

In order to help families help their children succeed, those children with complex needs that cut across agency boundaries require a comprehensive approach to service/support planning and delivery. This is best achieved through a unified team, comprised of the child and their family, their natural support system (neighbors, etc.), and all service providers involved with that child and family.

Through this approach, each child-serving agency can more effectively and efficiently deliver services. However, the biggest "winner" in using this approach is the child and family, who: a) are more directly involved in the planning and service delivery process; b) avoid having to navigate the maze of agencies that provide these services; and c) receive more comprehensive services and supports without the duplication and frustration resulting from having a separate plan and process from each agency. Many child-serving agencies in North Carolina have adopted this collaborative approach, which is grounded in the system of care model and family-centered practice, including divisions within the Department of Health and Human Service, the Department of Juvenile Justice and Delinquency Prevention and the Juvenile Court System. These agencies use *Child and Family Teams*, as a best practice vehicle to ensure a more unified and comprehensive approach as described above.

Below is a common working definition of Child and Family Teams that is being used across these agencies.

*A **Child and Family Team** is a group of people that meets with a child and family to set goals and plan services. The Child and Family Team is built around the family to make sure that each family's strengths are promoted and their needs are met. Team members work together with the family to write a Child and Family Plan based on what the child/youth and family wants and needs. (Parent Handbook, 2006)*

Examples:

The collaborative effort between the Divisions within the Department of Health and Human Services along with families, providers and university partners to develop a cross agency blended curriculum on Child and Family Teams is a good example of an effort to develop common terminology. This curriculum will be used across agencies, with children and their families and providers to improve consistency and quality of Child and Family Team implementation and family-centered practices.

In Durham, a local Memorandum of Agreement establishes the use of common language across all child-serving agencies within the local System of Care. This common language is used throughout all training and practice tools, such as the Child and Family Team Handbook. Examples of common terminology now adopted by local child-serving agencies include: a) Child and Family Teams; b) Child and Family Plans (as the common vehicle to reflect each involved agency's role and responsibility within the overarching plan); c) One Family/One Team/One Plan; and d) Community Collaborative. Similar efforts are underway in other communities.

Families United, a statewide family support and advocacy organization works to provide information to families about processes, services, and common service terminology used by multiple providers is the *North Carolina System of Care Handbook for Children, Youth and Families*. This handbook, developed by North Carolina Families United, Inc. is being distributed by a variety of child-serving agencies across the state. The handbook can be reviewed at: http://www.ncfamiliesunited.org/.

Recommendations for the Development of Common Terminology

Recommendation 1: All child-serving agencies, when serving children/youth and families who require services and supports from multiple agencies, should adopt family-centered practices and implement the terminology associated with the terms "Child and Family Teams" and "Child and Family Plans."

Legislated Responsibility Area 4

Make recommendations regarding the creation of a shared database to track population and program outcomes information while protecting individual confidentiality.

Introduction

Data collected during an intake interview help providers and consumers determine what kind of care is needed. To access that care, the data must be entered into electronic data systems, called management information systems. The information may be placed in yet another database for eventual evaluation of the quality of care provided. Each time a consumer seeks help or requires help from a different provider, much of the same information must be collected. This situation is inefficient at best, but most importantly it is disrespectful and inconvenient for children and their families and may lead to the provision of the wrong services or no services at all.

Like the President's New Freedom Commission on Mental Health (2003), the Work Group envisions a time when:

> *"Access to information will foster continuous, caring relationships between consumers and providers by providing a medical history, allowing for self-management of care, and electronically linking multiple service systems."*
> http://www.mentalhealthcommission.gov/reports/reports.htm

The Children's Services Work Group clarified the benefits of sharing information across agencies and the necessary supporting infrastructure. This would provide:

- Consumers and families with a seamless and effective system of care based on family centered practices in the continuum of services, including the child to adult transition;
- A seamless integration of information, while maintaining information security, across the following agencies: Department of Health and Human Services, Department of Juvenile Justice and Delinquency Prevention, State Board of Education, Department of Public Instruction and the North Carolina Court System;
- Standardized service terminology across child-serving agencies, consumers, families, and other community partners that assists collaboration and coordination;
- Timely tracking of individual, population, and program service performance and consumer outcomes information across agencies and multiple providers; this may include, but is not limited to intake, assessment, and release procedures;
- Agency and individual confidentiality that is time limited;
- Timely and user friendly access to and assessment of specific state, regional, and local services and supports;
- Training, on-line technical assistance, and implementation needs;
- Enhanced coordination and collaboration.

Currently, information about individuals and their families is contained in multiple data systems. No one system contains all pertinent information, and we are unable to share common data across the systems. Without careful cultivation of common terminology, we will be unable to

measure outcomes across systems by "mining" data within individual systems. The President's New Freedom Report (2003) acknowledges, *"In a transformed mental health system, advanced communication and information technology will empower consumers and families and will be a tool for providers to deliver the best care."*

Collaboration within and across divisions and departments should be expected, but often the state or federal entity that urges better data sharing is the same agency that places barriers against it. Historically, agencies have developed databases as the result of particular data reporting requirements. Generally, these databases have been funded for specific purposes and with specific funding streams. This funding approach, over time, has led to the creation of "information silos" within government agencies as well as across government agencies. Undoing this past approach to data gathering and sharing is difficult but essential to creating an information-sharing culture within government.

The proliferation of databases has led both federal and state agencies to attempt to catalog and control database development. Federal guidelines provide state agencies with recommendations for data elements and data structures. Many state database systems have been developed with federal money.

To address this increasingly problematic issue, a designated "Single State Contact" was put in place to capture all database development within each state. While this requirement is no longer in place, the State Office of Technology Services still shares data collection guidelines and maintains some contact with all state Chief Information Officers. Data management continues to be challenging both because of government requirements about what and how information must be protected and because of the plethora of legacy systems and differing platforms in which data is stored. The promise of new technology, particularly web-based technology, will overcome many of the problems posed by "siloed" data and old information technology platforms.

To realize the vision of sharing information across agencies, much work must be completed. For instance, if all of the agencies could agree to use standardized language for intake, e.g. race, ethnicity, and other key information, standardized forms could be developed to track outcome data through several systems, while preserving individual client data within individual systems.

To better understand the scope of the differences in data points collected, the Work Group conducted a survey to obtain key data points being collected by each of the participating child-serving state agencies. The results of this survey are contained in Attachment D of this report.

The Department of Health and Human Services is in the early stages of developing a business plan to support the development of a Department-wide Information Technology Enterprise Architecture, yet it is already becoming clear that data sharing and database development are issues that will need to be addressed. Additionally, the Department of Health and Human Services is reviewing its Privacy Manual to determine whether modifications can be made to facilitate sharing of "de-identified" information in databases throughout the department.

Some work toward this goal has already been completed. The importance of a shared database to improve service delivery, while empowering consumers, providers, and the state with vital data

for decision-making has been recognized. Several communities and state agencies have already created a shared database in order to improve outcomes. Included below are several examples of promising technology.

Examples

Shared or integrated data systems are designed for different purposes. Some are created largely as a research tool or to provide a state or community with "aggregate" or "population-level" data. Even these "aggregate" systems pose particular challenges. Examples of this kind of data system include:

- **The North Carolina Department of Health and Human Services** operates a large cross-division Client Services Data Warehouse. This Department-wide data warehouse illustrates some of the complications with data collection, data sharing and the availability of aggregate data for analysis. Even within the Department there is restricted access to information in the database and it is the rare situation when individuals can access the full scope of information contained in the database.

- **The University of North Carolina - Charlotte Institute for Social Capital** has launched a project that fosters collaboration and data sharing among local agencies. The University serves as a "neutral" partner to collect and aggregate the data for evaluation and decision-making purposes. This is an example of "neutral" host agencies as data managers for the aggregation of data.

Some database systems are shared across divisions within the same agency or across the state as a secure location for individual consumer data that is needed by a variety of workers. This kind of system improves staff productivity, decreases user error and should therefore improve customer service.

- **The local Department of Social Services** allows caseworkers the Online Verification (OLV) system as a data resource to check eligibility verifications. This saves time for clients, giving them faster access to benefits while reducing errors, and providing better information for caseworkers. It also provides better protection for client privacy.

- **The Administrative Office of the Courts** is expanding a web-based database (J/WISE) to include all juvenile court delinquency and dependency data. The data are currently entered by court clerks and Family Court staff, but will soon include Guardian ad Litem child data and be available to Guardian ad Litem and Family Drug Treatment Court staff. There are plans to eventually link Department of Juvenile Justice and Delinquency Prevention's North Carolina Juvenile Online Network (NCJOIN) system with J/WISE.

- **The Community Care of North Carolina Mental Health and Primary Care Integration Pilot** is using a web-based case management system. The networks

and local Mental Health, Developmental Disabilities and Substance Abuse Services staff will be able to document and share information. To ensure that data collection is comparable across projects, common forms and tools have been developed including a telephone consultant form, behavioral health assessment form, case consultation request forms, and provider surveys.

Finally, there are shared database systems that may be used by consumers and staff for information, secure data storage and data extraction. These include databases designed to track services available. In the future, databases may include a rating system for those services provided for consumers by consumers.

- **The Durham System of Care**, facilitated by the local Division of Mental Health, Developmental Disabilities, and Substance Abuse agency, is finalizing a cross agency, web-based data-base that will track individual and program outcomes, protecting confidentiality through informed consent and password protected web access. A component of Durham's System of Care website is the "Network of Care." This feature provides an online resource center for the Durham community that includes: a fully searchable Community Service & Resource Directory; extensive on line library (available in English, Spanish, Chinese, Korean, Japanese and Russian); legislation tracking – up-to-date information about legislation and opportunities to directly communicate with lawmakers; and a "My Folder" feature where individuals and families can keep important information about their or their child's medical history, community support services, etc.

- **The Dream a Better Dream Project** is creating an online, fully searchable database of youth services in Western North Carolina. The database will be available to the public to help locate services for youth based upon several criteria including: age, gender, county, district, service, etc. The database will also include a glossary of mental health terms, contact information for Dream a Better Dream staff, and more.

Recommendations for the Creation of a Shared Database

Recommendation 1: Inventory current processes for using automation to share information.

Recommendation 2: Conduct an independent and thorough assessment and cost/benefit analysis with all key stakeholders to identify potential enhancement opportunities. Once the assessment is completed, secure funding from the General Assembly.

Recommendation 3: Obtain cost incurred by other states that have developed cross-system databases as a possible reference point for cost associated with developing a cross-system database.

Recommendation 4: Integrate tools and infrastructure to enable timely stakeholder access to needed information across agencies.

Recommendation 5: Identify a location that is secure and accessible to all the partner agencies where the shared database can "reside."

Recommendation 6: Distinguish between population and individual data and ensure that the system will restrict access and reports where necessary to protect confidentiality.

Recommendation 7: Utilize existing databases by standardizing and linking the existing systems while restricting access to search/query/generate reports while protecting individual confidentiality on population and outcome data.

Legislated Responsibility Area 5

Develop mechanisms that would allow agencies to share information about individual children receiving multiple services. Any recommendation must take into account confidentiality requirements, be voluntary on the part of the party receiving services, and be time-limited. The mechanisms may address intake, assessment, and release procedures.

Introduction

Children with complex behavioral, social, safety and academic needs, and their families, are likely to have many different agencies and service providers involved in their lives. Parents and children need a simple method to allow agencies to share appropriate information so that these services and supports can be better integrated.

Many mechanisms exist to permit appropriate sharing of information about an individual. These may include Child and Family Teams, shared database systems, and the use of "common consent to share information" forms. Child and Family Teams have been adopted by many child-serving agencies to develop comprehensive and coordinated Child and Family plans.

The sharing of information is a necessary step in the assessment of strengths and needs; in the development and provision of services and supports; and in the evaluation of the efficacy of the interventions. Use of a common consent can eliminate costly delays in the convening of Child and Family Teams and ensure timely communication between the families and multiple providers serving the family.

The Work Group acknowledged many challenges to implementing common consents across the state. A community's ability to utilize a Common Consent form will vary based on their progress toward implementing a System of Care/Child and Family Team approach to addressing the needs of children and their families.

Issues that complicate the development of a Common Consent form were discussed by the Work Group including challenges related to all state and federal laws, including HIPAA.

In 2001, the North Carolina Healthcare Information and Communications Alliance, Inc. organized a group, which prepared a report entitled, *"Analysis of the HIPAA Privacy Rule and Selected North Carolina Statutes."* (See Section B at http://www.nchica.org/HIPAAResources/Samples/Portal.asp for an 84-page crosswalk.) The report acknowledges its limitations in that it did not address state rules and regulations or case law. When the Family Educational Rights and Privacy Act (FERPA), Internal Revenue Services, Social Security Administration, and Substance Abuse and Mental Health laws among others are considered, decision making about how and what can be shared is a daunting and intimidating task. Fearful of violating state or federal law, state and local staff have chosen to err on the side of restriction and in many cases duplication.

Examples

Several communities in North Carolina including Orange County, the Chatham Child Well-Being Collaborative, and the Durham community are working to adopt the use of common consent forms to coordinate and convene an initial Child and Family Team meeting.

The Durham common consent form provides permission for the Child and Family Team to begin the strengths and needs planning process and for the collection of data. Each individual agency/provider maintains its own consent form which is then signed by the consumer upon initiation of services (if applicable). The Durham consent includes in its mission statement an option for participants to "opt out" of services/activities in which they do not wish to participate. The common consent ensures that the Parent, Legal Guardian, or Appropriate Consenter Defined by Law is fully informed about the purpose and impact of their consent, about their right to consent or refuse to consent without penalty, and the process by which they may revoke consent. The consent is also time limited.

Recommendations for Mechanism for Sharing Information

Recommendation 1: Develop key components of a proposed Common Consent as a requirement among all participating parties. This will ensure a standardized, best-practice approach.

Recommendation 2: Attorneys at the School of Government should review the common consent form. Consideration should be given to requesting a formal Attorney General Opinion concerning the common consent forms to support counties moving forward without violating HIPAA, FERPA, 42CFR or any applicable state and federal law. Each agency should provide guidance and technical assistance to local stakeholders on the use of the common consent form.

Recommendation 3: Attorneys from each of the affected agencies should meet to agree upon a limited-use Common Consent form.

Recommendation 4: Attorneys should clarify the scope of HIPAA, FERPA, 42CFR and all applicable state and federal laws as it relates to the limited-use common consent form. Private sector accrediting bodies such as The Council on Accreditation would also need to be involved to ensure that HIPAA, FERPA, 42CFR and all applicable state and federal laws specific to non-profits are also included.

Recommendation 5: Statewide training should be conducted on the implications and scope of applicable confidentiality laws with particular emphasis on HIPAA, FERPA, 42CFR and all applicable state and federal laws.

Legislated Responsibility Area 6

Examine State and local training needs for implementing increased coordination and collaboration.

Introduction

Throughout its proceedings, the Work Group agreed with supporting evidence that coordination and collaboration, when implemented correctly, increases positive outcomes for children and their families. Understanding the concepts of coordinating services and resources and collaboration, along with the tools to implement these practices, is paramount to the successful application of quality service coordination and collaboration.

The education, knowledge and skills of professionals have a major impact on the services children and their families receive from public agencies and private practitioners. In the past, most training occurred within individual agencies or through professional organizations. For example, law enforcement officers were usually trained by and with other law enforcement officers, social workers by other social workers, and legal professionals by other legal professionals. While this type of training remains a crucial component of licensure and professional development, as agencies adopt system of care, family-centered practice and other best practice models, there is an increasing need for cross agency training.

For purposes of this report, the Work Group defined cross agency training as training curriculums designed to simultaneously educate a cross section of providers, community supports and family members to achieve community-wide implementation of a practice or an intervention.

Cross agency training brings together individuals from various professions that each serve a particular consumer group or contribute to an identified need and can occur on a large scale, for example at a state or national conference, or on a smaller scale, when agencies within a county or a group of counties come together to share training resources.

Increasingly, North Carolina child-serving agencies, families and private providers have recognized the need to share training resources. Sometimes shared training opportunities are driven by the needs of serving specialized populations or particular initiatives, other times by local agencies deciding to combine their training resources. The end result has been an increased willingness of agencies to share training resources with professional and family partners. In addition to sharing resources, this has created new opportunities to build and enhance relationships between agencies, private providers, families and community partners. In other words, cross training assists with the promotion and development of more successful collaboration and coordination of services both within systems and outside systems.

Examples

North Carolina has a good foundation of cross agency training opportunities across the state as the brief examples below illustrate. An expanded summary of each cross agency training example is located in Attachment C of this report.

The Department of Health and Human Services, Division of Social Services and the North Carolina Association of County Directors of Social Services partnered to train more than 1,400 social workers in less than six months on the domestic violence policy designed for the Departments of Social Services. Community advocates are also invited to attend informational meetings regarding implementation of this policy statewide.

The State Collaborative for Children and Families training committee brings together trainers from multiple child-serving agencies. The result has been an increase in cross training.

North Carolina Therapeutic Courts are operated by a treatment court team of court staff and community providers/agencies. Training is provided to the full team using a cross training model.

Divisions within the Department of Health and Human Services, in partnership with the Department of Public Instruction, the Administrative Office of the Courts, Department of Juvenile Justice and Delinquency Prevention, private providers and Families are developing a Child and Family Team training curricula.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Office of Education Services with the Department of Health and Human Services, in partnership with the Division of Exceptional Children with the Department of Public Instruction and universities have developed training and multi-media materials to guide service transitions for children with special needs.

The Community Care of North Carolina (CCNC) Mental Health and Primary Care Integration Pilot is implementing coordinated consumer/patient education and transition planning; adoption of common measurements for program evaluation; and ongoing physician education, including case and pharmacology reviews between the Division of Mental Health, Developmental Disabilities and Substance Abuse Services local management entities and primary care providers. Lessons learned will guide the formation of Medicaid mental health policy and assist in forming targeted statewide training and technical assistance. The infrastructure and models developed and implemented by the pilots will be able to support replication and expansion efforts in other networks and communities.

Administrative Office of the Courts supports an annual conference that brings together court personnel and a host of organizations that provide services and advocate on behalf of children in an effort to improve successful collaboration and increase positive outcomes for children.

The Training Subcommittee of the North Carolina Court Improvement Project for Children and Families and the Administrative Office of the Courts sponsor three regional trainings using a cross training model to improve outcomes for older youth in the courts.

North Carolina Courts and their Partners provided a full-day program presented at three sites across the state using a cross training model to implement best practices in conjunction with the Adoption and Safe Families Act.

The Department of Crime Control and Public Safety, Governor's Crime Commission provides funding opportunities that support cross training. In recent years, funding from the Governor's Crime Commission has supported cross training at the national, state, and local level.

The Department of Public Instruction and the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services – Transition Services Initiative used and continued to call upon an interdepartmental team to assure that children receiving Community Based Services are experiencing smooth transitions for coordinated planning and approval of community support services/other new services allowed under the Medicaid state plan amendment. Joint activities have included regional trainings, community based forums and individual child and family team meetings. Partners include the Office of Education Services, the Department of Juvenile Justice and Delinquency Prevention, families, youth, providers, local education agencies and local mental health management entities.

Recommendation for Training to Enhance Coordination and Collaboration

Recommendation 1: The General Assembly should encourage agencies to use appropriated funds for cross agency training, inviting representatives from family groups and other agencies. Training should include, but not be limited to, the following: Confidentiality Laws and Informed Consent, Building and Maintaining Child and Family Teams, Understanding Common Outcomes and Common Service Terminology.

Recommendation 2: Training should be developed in modules that can be repeated throughout the year and allow for the easy inclusion of emerging practices, new mandates or provision of services and automated efforts that enhance collaboration, coordination and sharing of information.

Recommendation 3: Involve elected officials and stakeholders in the development and support of cross agency training delivered in the local community.

Conclusion

The Children's Services Work Group closes its official work with the submission of this final report. The Work Group appreciates the opportunity to participate in a forum that encourages the open involvement and input from agency staff, parents, private providers and community members. The process of meeting with a large, diverse group to focus on the needs of North Carolina's children, youth and families has been one that has brought new opportunities for collaboration and networking, resulting in a deeper understanding of the roles, responsibilities, resources and limitations of individual child-serving agencies. The involvement of parents as equal partners in the discussion and recommendations reinforced the importance of child and family centered services based on individual strengths and needs.

The fact-finding and decision-making process was filled with moments of enlightenment and commitment to inclusion and partnership among participants. The result was a true example of combined effort to find solutions in the midst of multiple challenges and restrictions.

The Work Group also acknowledges the agencies, collaborations, partnerships, networks, families, etc. for their willingness, hard work and diligence in response to the legislative charges; with a "special" thanks to the Youth Advocacy and Involvement Office, within the Department of Administration, for their excellent staff support to implement this legislative effort.

Attachment A

Comprehensive Treatment Services Program (Section 10.25)

COMPREHENSIVE TREATMENT SERVICES PROGRAM

SECTION 10.25.(a) The Department of Health and Human Services shall continue the Comprehensive Treatment Services Program for children at risk for institutionalization or other out-of-home placement. The Program shall be implemented by the Department in consultation with the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, and other affected State agencies. The purpose of the Program is to provide appropriate and medically necessary residential and nonresidential treatment alternatives for children at risk of institutionalization or other out-of-home placement. Program funds shall be targeted for non-Medicaid eligible children. Program funds may also be used to expand a system-of-care approach for services to children and their families statewide. The program shall include the following:

(1) Behavioral health screening for all children at risk of institutionalization or other out-of-home placement.

(2) Appropriate and medically necessary residential and nonresidential services for deaf children.

(3) Appropriate and medically necessary residential and nonresidential treatment services, including placements for sexually aggressive youth.

(4) Appropriate and medically necessary residential and nonresidential treatment services, including placements for youth needing substance abuse treatment services and children with serious emotional disturbances.

(5) Multidisciplinary case management services, as needed.

(6) A system of utilization review specific to the nature and design of the Program.

(7) Mechanisms to ensure that children are not placed in department of social services custody for the purpose of obtaining mental health residential treatment services.

(8) Mechanisms to maximize current State and local funds and to expand use of Medicaid funds to accomplish the intent of this Program.

(9) Other appropriate components to accomplish the Program's purpose.

(10) The Secretary of the Department of Health and Human Services may enter into contracts with residential service providers.

(11) A system of identifying and tracking children placed outside of the family unit in group homes, therapeutic foster care home settings, and other out-of-home placements.

SECTION 10.25.(b) In order to ensure that children at risk for institutionalization or other out-of-home placement are appropriately served by the mental health, developmental disabilities, and substance abuse services system, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall do the following with respect to services provided to these children:

(1) Provide only those treatment services that are medically necessary.
(2) Implement utilization review of services provided.
(3) Adopt the following guiding principles for the provision of services:
    a. Service delivery system must be outcome-oriented and evaluation-based.
    b. Services should be delivered as close as possible to the child's home.
    c. Services selected should be those that are most efficient in terms of cost and effectiveness.
    d. Services should not be provided solely for the convenience of the provider or the client.
    e. Families and consumers should be involved in decision making throughout treatment planning and delivery.
(4) Implement all of the following cost-reduction strategies:
    a. Preauthorization for all services except emergency services.
    b. Levels of care to assist in the development of treatment plans.
    c. Clinically appropriate services.

SECTION 10.25.(c) The Department shall collaborate with other affected State agencies such as the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, the Administrative Office of the Courts, and with local departments of social services, area mental health programs, and local education agencies to eliminate cost shifting and facilitate cost-sharing among these governmental agencies with respect to the treatment and placement services.

SECTION 10.25.(d) The Department shall not allocate funds appropriated for Program services until a Memorandum of Agreement has been executed between the Department of Health and Human Services, the Department of Public Instruction, and other affected State agencies. The Memorandum of Agreement shall address specifically the roles and responsibilities of the various departmental divisions and affected State agencies involved in the administration, financing, care, and placement of children at risk of institutionalization or other out-of-home placement. The Department shall not allocate funds appropriated in this act for the Program until the Memoranda of Agreement between local departments of social services, area mental health programs, local education agencies, and the Administrative Office of the Courts and the Department of Juvenile Justice and Delinquency Prevention, as appropriate, are executed to effectuate the purpose of the Program. The Memoranda of Agreement shall address issues pertinent to local implementation of the Program, including provision for the immediate availability of student records to a local school administrative unit receiving a child placed in a residential setting outside the child's home county.

SECTION 10.25.(e) Notwithstanding any other provision of law to the contrary, services under the Comprehensive Treatment Services Program are not an entitlement for non-Medicaid eligible children served by the Program.

SECTION 10.25.(f) Of the funds appropriated in this act for the Comprehensive Treatment Services Program, the Department of Health and Human Services shall establish a reserve of three percent (3%) to ensure availability of these funds to address specialized needs for children with unique or highly complex problems.

SECTION 10.25.(g) The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, and other affected agencies, shall report on the following Program information:

(1) The number and other demographic information of children served.

(2) The amount and source of funds expended to implement the Program.

(3) Information regarding the number of children screened, specific placement of children, including the placement of children in programs or facilities outside of the child's home county, and treatment needs of children served.

(4) The average length of stay in residential treatment, transition, and return to home.

(5) The number of children diverted from institutions or other out-of-home placements such as training schools and State psychiatric hospitals and a description of the services provided.

(6) Recommendations on other areas of the Program that need to be improved.

(7) Other information relevant to successful implementation of the Program.

SECTION 10.25.(h) It is the intent of the General Assembly to (i) improve the safety and well-being of North Carolina's children, youth, and families; (ii) support collaboration among State, regional, and local agencies that deliver services to children, youth, and families; (iii) make more effective use of existing federal, State, and local resources and programs for children, youth, and families; and (iv) streamline service delivery, fill service gaps, and eliminate duplication of services for children, youth, and families.

The Department of Health and Human Services, the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, the Administrative Office of the Courts, and other affected State agencies share responsibility and accountability to assure effective collaboration among State and local agencies to improve outcomes for children and their families leading to full participation in their communities and schools.

The General Assembly recognizes that services to children, youth, and families are most effective when they are child- and family-centered, strengths-based, community-based, use multidisciplinary approaches, use evidence-based practices when appropriate, and recognize and respect cultural differences. These practices can be successfully implemented only where there is significant and ongoing collaboration and coordination among multiple public agencies. The General Assembly also recognizes that

while agencies are making significant progress towards implementing these practices, there is also a need to focus State-level policy in order to provide support, remove barriers, and more fully implement these goals.

There is established a children's services work group. It shall be located in the Department of Administration for budgetary and staffing purposes only. The Secretary of the Department of Health and Human Services, the Secretary of the Department of Juvenile Justice and Delinquency Prevention, the Chair of the State Board of Education, the Superintendent of Public Instruction, and the Chief Justice of the North Carolina Supreme Court shall each designate at least one representative to serve on the work group from among the programs, divisions, or departments under that administrator's control that provide services to children and youth. Each administrator named in the preceding sentence shall also appoint to serve on the work group at least one parent of a child or youth who has or is at risk for behavioral, social, health, or safety problems or academic failure, at least one member of a local collaborative body, and at least one private sector service provider. The Chair of the State Board of Education and the Superintendent of Public Instruction may make joint appointments.

The work group shall meet at least monthly. The first meeting of the work group shall occur not less than 30 days after the effective date of this section. The Department of Health and Human Services, the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, and the Administrative Office of the Courts shall, in this order and on a rotating basis, host the monthly meetings of the work group. The Department of Administration shall provide staff and clerical support to the work group. The work group shall:

(1) Identify common outcome measures for child-serving agencies that can be used for monitoring the safety, health, and well-being of North Carolina's children, youth, and families, including preventative measures.

(2) Identify strategies for funding flexibility between State and local agencies, including shared funding streams and the removal of financial and bureaucratic barriers.

(3) Develop a common service terminology to be used across child-serving agencies that is appropriate and assists collaboration and coordination.

(4) Make recommendations regarding the creation of a shared database to track population and program outcomes information while protecting individual confidentiality.

(5) Develop mechanisms that would allow agencies to share information about individual children receiving multiple services. Any recommendations must take into account confidentiality requirements, be voluntary on the part of the party receiving services, and be time-limited. The mechanisms may address intake, assessment, and release procedures.

(6) Examine State and local training needs for implementing increased coordination and collaboration.

(7) Study other issues the work group determines would improve coordination and collaboration between child-serving agencies.

A majority of the work group shall constitute a quorum for the transaction of business.

Members of the work group shall receive per diem, subsistence, and travel allowances at the rate established in G.S. 138-5 or G.S. 138-6 as appropriate.

Upon the approval of the Secretary of the Department of Health and Human Services, the Secretary of the Department of Juvenile Justice and Delinquency Prevention, the Chair of the State Board of Education, the Superintendent of Public Instruction, and the Chief Justice of the North Carolina Supreme Court, the work group shall submit its findings and recommendations to the Coordination of Children's Services Study Commission created under Section 4 of this act. The work group shall submit an interim report no later than December 15, 2005, and a final report no later than April 15, 2006. The reports shall specify those recommendations that may be implemented without statutory changes and those that would require statutory authorization.

If the General Assembly has not adjourned by those dates, or if the membership of the Study Commission has not been appointed, the work group shall submit its reports to the Joint Legislative Education Oversight Committee, the Joint Legislative Corrections, Crime Control, and Juvenile Justice Oversight Committee, the Joint Legislative Health Care Oversight Committee, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

The work group shall expire upon the filing of the final report.

SECTION 10.25.(i) There is created the Coordination of Children's Services Study Commission ("Commission"). The Commission shall consist of 18 members appointed as follows:

(1) Nine members appointed by the Speaker of the House of Representatives as follows:

a. Five members of the House of Representatives, of whom at least one shall also serve on the House of Representatives Health and Human Services Appropriations Subcommittee, at least one shall also serve on the Joint Legislative Education Oversight Committee, at least one shall also serve on the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and at least one shall also serve on a House of Representatives Judiciary Committee; and

b. Four members of the public, including a district court judge, a member of a local collaborative body, a private sector service

provider, and a parent of a child who has or is at risk for behavioral, social, health, or safety problems or academic failure.

(2) Nine members appointed by the President Pro Tempore of the Senate as follows:

a. Five members of the Senate, of whom at least one shall also serve on the Senate Health and Human Services Appropriations Subcommittee, at least one shall also serve on the Joint Legislative Education Oversight Committee, at least one shall also serve on the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and at least one shall also serve on a Senate Judiciary Committee; and

b. Four members of the public, including a parent of a child who has or is at risk for behavioral, social, health, or safety problems or academic failure, a child who has or is at risk for behavioral, social, health, or safety problems or academic failure, a member of a local board of education, and a member of a board of county commissioners.

The Speaker of the House of Representatives shall appoint a cochair, and the President Pro Tempore of the Senate shall appoint a cochair for the Commission. The Commission may meet at any time upon the joint call of the cochairs. Vacancies on the Commission shall be filled by the same appointing authority as made the initial appointment.

SECTION 10.25.(j) The purpose of the Commission is to study and recommend changes to improve collaboration and coordination among agencies that provide services to children, youth, and families with multiple service needs. The Commission's recommendations shall include mechanisms for establishing clear State leadership, consistent policy direction, and increased accountability at the State and local levels. As part of its work, the Commission shall:

(1) Identify existing State, regional, and local collaborative bodies (including their charges, scopes of authority, and accountability requirements) that have been created by legislation, administrative rule, or agency policy and that are charged with serving, protecting, or improving the well-being of North Carolina's children, youth, and families. Once it has identified the collaborative bodies, the Commission shall consider how they could be consolidated, reorganized, or eliminated in order to improve their effectiveness and accountability, increase the likelihood that key players will actively participate, and reduce unnecessary duplication of effort. The Commission shall also consider the creation of a mechanism for coordination and communication among the State and local collaborative bodies, incentives for collaboration, clarification of roles

among agencies, and ways to monitor the extent to which groups are collaborating.

(2) Study the practices of agencies currently implementing a system of care platform of practices and make recommendations regarding whether to adopt those practices statewide and across child-serving agencies as the preferred mechanism for providing services to children, youth, and families. In examining this issue, the Commission shall identify those State and local agencies that are currently implementing practices that are consistent with a system of care, those states that have implemented a system of care as a statewide policy initiative, and the extent to which a system of care is cost-effective.

(3) The Commission shall also examine the following principles that are associated with a system of care and determine whether to recommend the adoption of a State policy that reflects these principles:

a. Services for children should promote success, safety, and permanence.

b. Services should be child- and family-centered, giving priority to keeping children with their families, in their home, school, and community.

c. Services should actively promote early identification and intervention.

d. Services should be designed to protect the rights of children.

e. Services shall be integrated and comprehensive, addressing the child's physical, educational, social, and emotional needs through a single child and family team.

f. Services shall be outcomes-accountable and tied to a unified child and family plan.

g. Agency resources and services shall be shared and coordinated.

h. Services shall be provided as close to home as appropriate in the least restrictive setting consistent with what is known to be effective.

i. Services shall be culturally competent.

j. Services shall address the unique strengths, needs, and potential of each child and family, and shall be sufficiently flexible to meet highly individualized child and family needs.

k. Management of the child-serving system is a responsibility shared among all public and private child-serving agencies that should be held collectively accountable for outcomes.

(4) In reviewing principles relating to a system of care, the Commission shall determine whether they articulate goals that are measurable and if not, determine whether they could be modified to reflect measurable goals.

(5) Receive and study the recommendations contained in the reports submitted by the work group created in Section 2 of this act and determine whether to recommend any of the statutory proposals.

(6) Study any other issues the Commission determines would improve coordination and collaboration among child-serving agencies.

SECTION 10.25.(k) Upon approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional and clerical staff to assist in the work of the Commission. Professional staff shall be those assigned to subject areas or agencies involving child-serving programs administered by the Department of Health and Human Services, the Department of Juvenile Justice and Delinquency Prevention, the Administrative Office of the Courts, and the Department of Public Instruction. Clerical staff shall be furnished to the Commission through the offices of the House of Representatives and Senate Supervisors of Clerks. The Commission may meet in the Legislative Building or the Legislative Office Building upon the approval of the Legislative Services Commission. The members of the Commission, while in the discharge of official duties, may exercise all the powers provided under the provisions of G.S. 120-19 through G.S. 120-19.4, including the power to request all officers, agents, agencies, and departments of the State to provide any information, data, or documents within their possession, ascertainable from their records, or otherwise available to them, and the power to subpoena witnesses. Members of the Commission shall receive per diem, subsistence, and travel allowances at the rate established in G.S. 120-3.1, 138-5, or 138-6 as appropriate.

SECTION 10.25.(m) The Department shall report on April 1, 2006, and April 1, 2007, on the implementation of subsections (a) through (g) of this section. The Coordination of Children's Services Study Commission, established under this section, shall report annually on April 1. The reports required under this subsection shall be made to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division.

Attachment B

Children's Services Work Group Members and Staff
Children's Services Work Group Subcommittee Lists

Children's Services Work Group Membership List

Name/Title	Department/Division/Agency/Office	Appointed By:	Appointed As:
Jackie Sheppard Assistant Secretary for Long Term Care and Family Services	Department of Health & Human Services/ Office of the Secretary	Secretary Hooker Odom Department of Health and Human Services	Department of Health and Human Services Representative
Flo Stein Chief of Community Policy	Department of Health & Human Services/ Division of Mental Health, Developmental Disabilities , and Substance Abuse Services	Secretary Hooker Odom Department of Health and Human Services	Department of Health and Human Services Representative
Cyndie Bennett Superintendent	Department of Health and Human Services/Office of Education Services	Secretary Hooker Odom Department of Health and Human Services	Department of Health and Human Services Representative
Carol Tant Head of Children and Youth Branch	Department of Health & Human Services/Division of Public Health	Secretary Hooker Odom Department of Health and Human Services	Department of Health and Human Services Representative
Pheon E. Beal Director	Department of Health & Human Services/Division of Social Services	Secretary Hooker Odom Department of Health and Human Services	Department of Health and Human Services Representative
Kevin Ryan Section Chief for Women's and Children's Health Section	Department of Health and Human Services/Division of Public Health	Secretary Hooker Odom Department of Health and Human Services	Department of Health and Human Services Representative
Vincent Newton Director of Community & Consumer Relations	Western Highlands Network – Local Management Entity	Secretary Hooker Odom Department of Health and Human Services	Local Collaborative Member Representative
Kathleen McGuire Program Manager	Area Services and Programs, Mount Airy	Secretary Hooker Odom Department of Health and Human Services	Private Sector Service Provider Representative
Elizabeth Vickrey Parent	Chatham County Together	Secretary Hooker Odom Department of Health and Human Services	Parent Representative
Michael Haley Grants Administrator	Department of Juvenile Justice and Delinquency Prevention/Office of Chief of Staff	Secretary Sweat Department of Juvenile Justice and Delinquency Prevention	Department of Juvenile Justice and Delinquency Prevention Representative

Children's Services Work Group Membership List

Name/Title	Department/Division/Agency/Office	Appointed By:	Appointed As:
Martin Pharr Clinical Services Administrator	Department of Juvenile Justice and Delinquency Prevention/Intervention and Prevention Division	Secretary Sweat Department of Juvenile Justice and Delinquency Prevention	Department of Juvenile Justice and Delinquency Prevention Representative
Dave Hardesty Vice President of Operations	Eckerd Youth Alternatives	Secretary Sweat Department of Juvenile Justice and Delinquency Prevention	Private Sector Service Provider Representative
Karen Monsanto Parent	Parent	Secretary Sweat Department of Juvenile Justice and Delinquency Prevention	Parent Representative
Martha Kaufman System of Care Development Specialist	The Durham Center	Secretary Sweat Department of Juvenile Justice and Delinquency Prevention	Local Collaborative Member Representative
Diann Irwin Section Chief	Department of Public Instruction/Exceptional Children Division	Superintendent Atkinson, Department of Public Instruction Howard N. Lee, Chairman State Board of Education	Department of Public Instruction Representative
Paul LeSieur Director	Department of Public Instruction/School of Business Services	Superintendent Atkinson, Department of Public Instruction Howard N. Lee, Chairman State Board of Education	Department of Public Instruction Representative
Kenneth Gattis Senior Research & Evaluation Coordinator	Department of Public Instruction	Superintendent Atkinson, Department of Public Instruction Howard N. Lee, Chairman State Board of Education	Department of Public Instruction Representative
Adele Spitz Roth Project Director	Duke University/Center for Child and Family Policy	Superintendent Atkinson, Department of Public Instruction Howard N. Lee, Chairman State Board of Education	Local Collaborative Member Representative

Children's Services Work Group Membership List

Name/Title	Department/Division/Agency/Office	Appointed By:	Appointed As:
Pat Solomon Parent Coordinator North Carolina Families United/Co-Chair State Collaborative for Children and Families/Exceptional Children's Advisory Center	North Carolina Families United State Collaborative Davidson, North Carolina	Superintendent Atkinson, Department of Public Instruction Howard N. Lee, Chairman State Board of Education	Parent Representative
Joel Rosch Senior Research Scholar/ Co-Chair State Collaborative for Children and Families	Duke University/Center for Child and Family Policy	Superintendent Atkinson, Department of Public Instruction Howard N. Lee, Chairman State Board of Education	Local Collaborative Member Representative
Lee Grohse Vice President of Programs	Triangle Family Services, Inc.	Superintendent Atkinson, Department of Public Instruction Howard N. Lee, Chairman State Board of Education	Private Sector Service Provider Representative
Jane Volland, Guardian ad Litem Administrator	Administrative Office of the Courts/Guardian ad Litem Program	Chief Justice Lake Administrative Office of the Courts	Administrative Office of the Courts Representative
Lana Dial Project Coordinator	Administrative Office of the Courts/Court Programs and Management Services	Chief Justice Lake Administrative Office of the Courts	Administrative Office of the Courts Representative
Kirstin Frescoln North Carolina Drug Treatment Court Manager	Administrative Office of the Courts/Court Management Services	Chief Justice Lake Administrative Office of the Courts	Administrative Office of the Courts Representative
Dana Hagele MD	MD, MPH NC Child Medical Evaluation Program	Chief Justice Lake Administrative Office of the Courts	Private Sector Service Provider Representative
David A. Horowitz MD, Pediatrician	Triangle Pediatric Center, PA	Chief Justice Lake Administrative Office of the Courts	Parent Representative
Toni Blackwell Parent	Parent	Chief Justice Lake Administrative Office of the Courts	Parent Representative

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Children's Services Work Group
Subcommittee List

Subcommittee 1: Legislated Responsibilities 1 and 3 (defined below)

- Joel Rosch, Chair
- Meeting Time: 9:00 a.m. – 11:00 a.m.
- Members: Jackie Sheppard, Martin Pharr, Jane Volland, Martha Kaufman, Pheon Beal, Kevin Ryan, Lana Dial, Diann Irwin, Pat Soloman, Lee Grohse, Adele Spitz Roth, Cyndie Bennett

1. Identify common outcome measures for child-serving agencies that can be used for monitoring the safety, health, and well-being of North Carolina's children, youth, and families, including preventative measures.
3. Develop a common service terminology to be used across child-serving agencies that is appropriate and assists collaboration and coordination.

Subcommittee 2: Legislated Responsibilities 4 and 5 (defined below)

- Kirstin Frescoln, Chair
- Meeting Time: 12:30 p.m. - 2:30 p.m.
- Members: Jackie Sheppard, Martin Pharr, Jane Volland, Dave Hardesty, Pheon Beal, Lana Dial, Toni Blackwell, Pat Soloman, Adele Spitz Roth

4. Make recommendations regarding the creation of a shared database to track population and program outcomes information while protecting individual confidentiality.
5. Develop mechanisms that would allow agencies to share information about individual children receiving multiple services. Any recommendation must take into account confidentiality requirements, be voluntary on the part of the party receiving services, and be time-limited. The mechanisms may address intake, assessment, and release procedures.

Subcommittee 3: Legislated Responsibility 2 (defined below)

- Michael Haley, Chair
- Meeting Time: 3:00 p.m. to 5:00 pm
- Members: Jackie Sheppard, Flo Stein, Martin Pharr, Jane Volland, Martha Kaufman, Pheon Beal, Kirstin Frescoln, Toni Blackwell, Pat Soloman

2. Identify strategies for funding flexibility between State and local agencies, including shared funding streams and the removal of financial and bureaucratic barriers.

Attachment C

Collaborative Efforts

and

Training Examples

Collaborative Efforts in North Carolina

Early Childhood Comprehensive System Initiative

The Early Childhood Comprehensive System Initiative, led by the Division of Public Health in the Department of Health and Human Services used a "Think Tank" process with representatives from government and non-government agencies and families to create a plan for a comprehensive, integrated early childhood system in North Carolina. The plan includes seven recommendations to strengthen the early childhood system in North Carolina in order to improve outcomes for young children and families. Each goal will be addressed during the three-year implementation phase of the grant program (September 2005 - August 2008).

Shared Indicators for School Readiness

North Carolina's Shared Indicators for School Readiness Project is a joint effort between the North Carolina Early Childhood Comprehensive System Grant in the Department of Health and Human Services coordinated through the Division of Public Health and North Carolina's Support Partnerships to Assure Ready Kids (SPARK). The SPARK project is coordinated through the North Carolina Partnerships for Children. Through a multi-agency and consumer consensus process, partners from the Department of Health and Human Services, parents, consumer groups, the Department of Public Instruction, the Administrative Office of the Courts, the Department of Juvenile Justice and Delinquency Prevention, the Office of Education Services and the university system have worked together to develop a set of shared indicators for school readiness.

Therapeutic Courts

North Carolina is a national leader in the development of drug courts and other treatment courts which require active participation by all child-serving agencies. In districts with therapeutic courts there is lower recidivism, better use of resources and improved coordination between and among agencies. North Carolina's treatment courts are recognized as national models for agency and funding integration and cooperation.

Community Care of North Carolina (CCNC)
Mental Health Integration Pilot

Several networks in the Community Care of North Carolina (CCNC) program began to see an increasing number of Medicaid enrollees at primary care provider practices with both behavioral and physical health care needs. As a result of efforts in the mental health reform and changes in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DDSAS) local management entities (LMEs) are piloting a collaborative approach to managing care for Medicaid enrollees who have both behavioral and physical health needs and serve them in the most appropriate setting. The mental health integration pilot is a state level collaboration between the Division of MH/DD/SAS, Medical Assistance and the Office of Research, Demonstrations and Rural Health Development (CCNC Program Office) and the North Carolina Foundation for Advanced Health Programs, Inc. The four community networks and LMEs involved in the pilot include: Access II Care of Western North Carolina and Western Highlands; Southern Piedmont Community Care Plan and Piedmont Behavioral Healthcare; Central Piedmont Access II and CenterPoint Human Services; and Partnership for Health Management and the Guilford Center.

Each network will work with both adult and pediatric populations using the Four Quadrant Clinical Integration Model as the foundation for communication, collaboration, assessment, referral and clinical management of care. Using CCNC's web-based case management system, the networks and LME staff will be able to document and share information. To ensure that data collection is comparable across projects, common forms and tools have been developed including a telephone consultation form, behavioral health assessment form, case consultation request form, and provider surveys.

All networks are implementing a universal screening tool and clinical pathway for depression. In addition to these standardized elements the pilots are also demonstrating improved outcomes through the following: incentives to primary care providers to complete behavioral risk screenings; co-location of behavioral specialists with physical health primary care providers for service provision; improve communications across providers to improve access to and care provided; development of screening tools that work well in primary care settings and apply evidenced based clinical behavioral health practices; consumer/patient education and coordinated transition planning; adoption of common measurements for program evaluation; and ongoing physician education, including case and pharmacology reviews between LMEs and Primary Care Providers.

The outcome and performance measures will be captured through the web-based case management system and through paid claims. In addition to tracking missed school or work days, no-show rates, medication adherence and patient reported functional status, information regarding the telephone consultations and screening tools will also be captured.

The lessons learned in the mental health integration pilots will be used to guide the formation of Medicaid mental health policy and assist in forming targeted statewide training and technical assistance. The infrastructure and models developed and implemented by the pilots will be able to support replication and expansion efforts in other networks and communities.

School-Based Health Programs

North Carolina has long been a leader in school-based health programs. The programs are recognized as national models and promote early screening and intervention which result in better outcomes for children's health and success in school. These programs have been developed over the past ten years through leadership from the Department of Health and Human Services coordinated through the Divisions of Public Health and Mental Health, Developmental Disabilities and Substance Abuse Services, and the Department of Public Instruction coordinated through the Healthy Schools Initiative. Such programs are supported by state policy and sustained by local collaboration. The local collaboration includes the participation of Mental Health, Developmental Disability and Substance Abuse providers as well as pediatricians and other medical professionals, staff from local education agencies, staff from the North Carolina's immunization programs, kindergarten health assessment and screening programs, and the school-based nurse program.

Multiple Response System

North Carolina's Multiple Response System is based on family-centered practice principles and system of care principles. The Multiple Response System is North Carolina's child welfare system reform effort that embraces the belief that the child, their family and their support systems are critical to the safety, permanency and well-being of families. The Multiple Response System has seven core strategies, one being Child and Family Teams. Child and Family Teams bring the entire family together with their supports, the Department of Social Services and other service providers at a time convenient for the family. Family input is welcomed and they participate in all areas of decision making. Child and Family Teams have prevented children from coming into foster care and help ensure that appropriate services are being provided in a timely manner. The Multiple Response System is now in all 100 county departments of social services. One social worker stated, "If you take away Child and Family Teams, it would be like going back to the Stone Ages."

School-Based Mental Health Initiative

The Department of Public Instruction coordinated through the Division of Exceptional Children and the Department of Health and Human Services coordinated through the Division of Mental Health, Developmental Disabilities and Substance Abuse Services have worked together through the school-based mental health committee of the State Collaborative for Children and Families to secure a $10,000 *Shared Agenda* seed grant. The *Shared Agenda* grant is a jointly funded federal special education and mental health collaborative initiative. This multi-agency group (which includes parents and private providers) is drafting a blueprint for school-based behavioral health services in response to the leveling-off of standardized testing scores and the growing concerns about escalating mental and behavioral health needs among North Carolina students.

Smart Start

Smart Start is North Carolina's nationally recognized and award-winning early childhood initiative designed to ensure that young children enter school healthy and ready to succeed. Smart Start is a public-private initiative that provides early education funding to all of the state's 100 counties. Smart Start funds are administered at the local level through local nonprofit organizations called Local Partnerships. The North Carolina Partnership for Children is the statewide nonprofit organization that provides oversight and technical assistance for local partnerships. Services at the local level range depending on local needs. Currently, eighty-two local partnerships are established throughout the state to administer funding and programs. Smart Start funds are used to improve the quality of child care, make child care more affordable and accessible, provide access to health services and offer family support. Smart Start has achieved tremendous results in these areas and continues to strive to reach all children in North Carolina.

State Collaborative for Children and Families

Since 2001, most of North Carolina's child-serving agencies have voluntarily come together with parents and private providers through the State Collaborative for Children and Families to increase interagency coordination. This can be evidenced through a number of accomplishments including the following:

- ✔ Cross agency training materials and guidelines for judges involved in juvenile and family courts.

- ✔ Through the Collaborative, the training and evaluation staffs of most child-serving agencies now meet regularly to coordinate projects and ongoing cross agency training.

- ✔ Working through the North Carolina Council of Community (Mental Health, Developmental Disabilities and Substance Abuse Services) Programs, the Courts, the Divisions of Social Services and Mental Health, Developmental Disabilities and Substance Abuse Services, the Mental Health Association, the National Alliance for the Mentally Ill Young Families Network, the North Carolina Families United and other organizations, there are now a variety of new multi-agency and cross agency training opportunities.

Through the State Collaborative, parent groups, private providers and other child-serving agencies, are encouraging and supporting local education agencies in their efforts to adopt the Positive Behavior Support (PBS) model. The Positive Behavioral Support is a systemic means of modeling, supporting and rewarding desirable behavior in youth within their school communities.

There is now a multi-agency communications protocol to help with the implementation of SB163. This bill requires that all agencies be notified when a child is moved from one county to another.

Regional coordinators from the child-serving agencies have met and some continue to meet. Although they often serve the same families and children in the same parts of the state, there had not been a mechanism for them to work collaboratively.

With the support of State Collaborative agency members, local communities have begun consolidating legislatively mandated local decision making entities such as the Local Community Collaborative, the Juvenile Crime Prevention Council and other community-based collaborative bodies. Often these groups have funding specific functions – all with a common focus of improving outcomes for children and families by improving the system of care that supports them.

The State Collaborative helped the Division of Mental Health, Developmental Disabilities and Substance Abuse Services ensure that other child-serving agency and parent input was included in the development of the Child Mental Health Plan (September 2003) and "best practice" guidelines that have become part of the State Mental Health Plan.

The State Collaborative has facilitated the improved understanding of roles, responsibilities, and funding resources and restrictions between and across agencies.

The State Collaborative has helped the courts, the Department of Health and Human Services, universities, parents' groups, the Departments of Public Instruction and the Department of Juvenile Justice and Delinquency Prevention secure a series of competitive federal grants requiring interagency collaboration.

A comprehensive list of all assessment tools used by child-serving public agencies is being created. In the past, there was no systematic way for agencies to know what kinds of information other agencies were gathering about the children they served.

The State Collaborative increases interagency cooperation by serving as the advisory group to initiatives in the Department of Public Instruction, the Division of Social Services, the Courts and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services making it more likely that these initiatives will achieve family-centered outcomes.

Division of Mental Health, Developmental Disability and Substance Abuse Services System of Care Initiatives

The Child Mental Health Plan, a part of the Blueprint for Change: State Mental Health Plan, was informed by the improved outcomes of children and their families who had a Child and Family Team, a person-centered plan and family support. Outcomes were measured for those involved in 22 counties who were implementing federal system of care grants secured by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. North Carolina has been a leader in the national evaluation and outcomes studies that have demonstrated improved outcomes resulting from a coordinated multi-agency System of Care which promotes family and youth leadership at all levels in the state and locally.

Durham System of Care

The Durham System of Care has received several local and state awards, and most recently a national award from the Council for Community Behavioral Healthcare for Excellence in Community Collaboration. Since its implementation in 2002, the local System of Care has achieved numerous outcomes, including a five-fold increase in the number of children and families accessing care, active participation of local government and community agencies in sharing resources to develop new community services, significant reductions in unnecessary out of home placements, significant reductions in county expenditures related to use of out of county placements, reinvestment of those savings to support and expand the System of Care for more children, families, and adults across the community, and an interactive System of Care website with local resource directories for Child and Family Teams. Key agency participants in these efforts include: Durham County Commissioners, Durham Public Schools, Departments of Public Health, Social Services, Cooperative Extension, Partnership for Children, The Durham Center (local Mental Health, Developmental Disabilities and Substance Abuse Services management entity), Juvenile Justice, Family Courts, Drug Treatment Courts, the Police Department, and numerous providers in the local Provider Community. New models of public/private best practices have been developed, such as Care Review and Rapid Response Homes. These models are now being replicated in several counties across North Carolina.

Mecklenburg System of Care

The local Mecklenburg County Mental Health, Developmental Disabilities and Substance Abuse Services provider and partner agencies secured a five year federal grant to develop a cross agency local infrastructure, working with families and youth, to support best practice elements using the System of Care framework. Expected outcomes include a more effective, efficient multi-agency system that assures person-centered planning through Child and Family Teams, and service delivery which builds on family strengths to help families help their children experience success in school, work and community.

Child Welfare System of Care Initiative

Mecklenburg, Alamance and Bladen Counties have secured a federal grant to create a joint Child Protective Services/Mental Health initiative that brings System of Care practices into the child protection system. Only eight states received this funding. Of the eight, North Carolina is recognized as having the highest level of cooperation between its private providers, local education agencies, non-profits, and social service and mental health systems.

Guardian ad Litem

The North Carolina Guardian ad Litem Program has received national recognition for the legal representation it provides to abused and neglected children in court proceedings. The program is a successful model of collaboration at various levels. First, it is the teamwork of a trained community volunteer and attorney that provides effective advocacy for the abused or neglected child. In fiscal year 2004-2005 the Guardian ad Litem attorney advocates and 4,033 volunteers represented 16,528 children in a record high of 37,322 court hearings. The annual cost per child for Guardian ad Litem representation last year was only $509, but this is because trained Guardian ad Litem volunteers provided the sate 744,336 hours of service, a value of over $13.3 million dollars. (Based upon the Independent Sector's 2004 calculation of volunteer value at $17.19 per hour).

In addition to representing the child in court proceedings, the Guardian ad Litem staff, volunteers, and attorneys participate in foster care review board meetings, mental health reviews, local child protection and fatality review, System of Care, and other community meetings related to child advocacy. The Guardian ad Litem program also recognizes that cross training among agencies is essential. The program offers trial and appellate training to the Guardian ad Litem program staff and volunteers, staff of the Department of Social Services and to parents' attorneys. As a specific example of collaboration, this year the Guardian ad Litem program received Governor's Crime Commission funding to focus on the needs of youth transitioning out of the foster care system, since growing numbers "age out" to homelessness with special medical or educational needs and without support systems. In partnership with Say So and the Departments of Social Services, the needs of youth are identified and youth are informed of their legal rights and learn from other youth how to better train the Guardian ad Litem volunteer and attorneys to advocate for more effectively for older youth in foster care.

Child and Family Support Team Initiative

The Governor's Child and Family Support Team Initiative was established by the North Carolina General Assembly in 2005. The purpose of the Initiative is to identify and coordinate appropriate community services and supports for children at risk of school failure or out-of-home placement in order to address the physical, social, legal, emotional, and developmental factors that affect academic performance.

The Department of Health and Human Services, the Department of Public Instruction, the State Board of Education, the Department of Juvenile Justice and Delinquency Prevention, the Administrative Office of the Courts, and other State agencies that provide services for children are charged to share responsibility and accountability to improve outcomes for these children and their families.

The Initiative is based on the following principles:

- The development of a strong infrastructure of interagency collaboration;
- One child, one team, one plan;
- Individualized strengths-based care;
- Accountability;
- Cultural competence;
- Children at risk of school failure or out-of-home placement may enter the system through any participating agency;
- Services shall be specified, delivered, and monitored through a unified Child and Family Plan that is outcome-oriented and evaluation-based;
- Services shall be the most efficient in terms of cost and effectiveness and shall be delivered in the most natural settings possible;
- Out-of-home placements for children shall be a last resort and shall include concrete plans to bring the children back to a stable, permanent home, their schools, and their community; and
- Families and consumers shall be involved in decision making throughout service planning, delivery, and monitoring.

The Child and Family Support Team Initiative will fund 100 school-based Child and Family Support Teams, each consisting of a school nurse and a school social worker, in 100 schools in 21 school districts across the state. The initiative will model family-centered interagency collaboration. It will:

- Increase capacity in the school setting to address the academic, health, mental health, social, and legal needs of children.
- Ensure that children receiving services are screened to identify needs and assessed periodically to determine progress and sustained improvement in educational, health, safety, behavioral, and social outcomes.
- Develop uniform screening mechanisms and a set of outcomes that are shared across affected agencies to measure children's progress in home, school, and community settings.
- Promote practices that are known to be effective based upon research or national best practice standards.
- Review services provided across affected State agencies to ensure that children's needs are met.
- Eliminate cost shifting and facilitate cost-sharing among governmental agencies with respect to service development, service delivery, and monitoring for participating children and their families.
- Require a local memorandum of agreement signed annually by the participating superintendent of the local LEA, directors of the county departments of social services and health, director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services local management entity, the chief district court judge, and the chief district court counselor.

Dream a Better Dream: A Thirty-One County Collaborative

Dream a Better Dream is a 31 county collaborative in Western North Carolina that identifies youth placed in youth development centers who are ready for discharge. It also works to prevent youth from being placed in youth development centers. The collaborative brings together many youth serving agencies and their resources. The agencies include mental health area authorities, juvenile justice, social services, local education agencies and private service providers. This project is the first to have six local mental health authorities' commitment to providing initial Division of Mental Health, Developmental Disabilities and Substance Abuse Services funding, in addition to grant funding from other sources, for the start up of a collaborative project. The projected outcomes of the project are to decrease in the current youth development center census numbers and to increase the prevention of youth placements in youth development centers. This will be accomplished by improving the development of services and the reduction of barriers to accessing and moving through a continuum of services. It seeks a reduction in detention bed use and reinvestment of cost savings in community-based services and supports for children and families.

The Domestic Violence and Child Welfare Initiative

The North Carolina Association of County Directors of Social Services leads the Domestic Violence and Child Welfare Initiative which assists county Departments of Social Services and their key community stakeholders in working towards enhanced capacity for and sustainability of effort to coordinate services, develop partnerships, and enhance collaborations to address domestic violence related to child maltreatment. This initiative is developed to complement and interface with existing initiatives such as Multiple Response Systems and Family-Centered Practice; System of Care and the North Carolina Collaborative for Children; and the development of Community Coordinated Response Teams in North Carolina.

North Carolina Training Examples

North Carolina has established a foundation for cross agency training, and a variety of mechanisms have been put in place to share training resources across the state. This is illustrated by the examples below:

Divisions within the Department of Health and Human Services, in partnership with the Department of Public Instruction, the Administrative Office of the Courts, Department of Juvenile Justice and Delinquency Prevention, private providers and families are developing a Child and Family Team training curricula on the seven core principles necessary to implement and coordinate Child and Family Teams. This blended child and family team training curricula can be implemented across agencies and taught through a family perspective by family co-trainers. The training was based on a review of evidenced-based practice and existing curricula.

The State Collaborative for Children and Families has a training committee that shares information on training initiatives and opportunities within the various child-serving agencies as well as develops new training opportunities that address the needs of children using a cross training approach. This committee is comprised of family members, representatives from educational institutions, local community providers and staff from multiple child-serving agencies. Currently, this committee is working to develop a web-based training resource to assist with the dissemination of training opportunities and initiatives across the state.

The State Collaborative is currently planning five regional meetings in the fall of 2006. These meetings will provide an opportunity for stakeholders to learn more about System of Care, cross agency Child and Family Teams, collaborative development and communications among local community collaboratives. The State Collaborative also hopes the meetings will provide opportunities for local collaboratives to utilize the State Collaborative as a resource for policy and agency specific questions or collaboration development questions.

The School Based Mental Health committee of the State Collaborative is planning cross-agency community training and planning initiative in targeted communities through additional Shared Agenda federal grant funding to improve coordination and delivery of behavioral health services to school age children.

The Department of Crime Control and Public Safety, Governor's Crime Commission provides funding opportunities that support cross agency training. In recent years, funding from the Governor's Crime Commission has supported cross training at the national, state, and local levels.

The Department of Health and Human Services, Division of Social Services has developed a Drug Endangered Children policy. This policy was developed for all 100 County Departments of Social Services to respond to the epidemic of methamphetamine use and manufacture. Cross training and community forums are being held throughout North Carolina to develop protocols for all agencies that are involved with responding to and providing services to children exposed to methamphetamines. The Division of Mental Health, Developmental Disabilities and

Substance Abuse Services provides staff and funding to support this policy through training and treatment in the local communities.

The North Carolina Association of County Directors of Social Services facilitates multiple training opportunities throughout the year and posts training opportunities provided by other agencies on their website.

Buncombe County Children's Collaborative has developed and facilitates a four-hour training on the various mandates and requirements of the child-serving agencies in Buncombe County. The training is offered at four different times over a two-week time period to allow providers and agencies staff members to choose a convenient time. The trainings were developed and facilitated by volunteer staff members from each agency. The agencies included the Local Division of Mental Health, Developmental Disabilities and Substance Abuse Services Management Entity, the Buncombe County Department of Social Services, the Guardian Ad Litem Program, the Department of Juvenile Justice and Delinquency Prevention court counselors and private providers. Over 250 individuals have attended the trainings. The plan is to offer the training each quarter so that new staff members can be trained in a relatively short period of time.

The above examples illustrated the growing support for shared training across agencies. As systems and practice change to meet the evolving needs of children and families, the importance of training grows. Most of the new evidence-based services for children and families, which appear to be improving child outcomes, require cross agency training and mentoring. Changes in funding streams, the allowable expenditures within funding allocations and new requirements in documentation and reporting are also driving the need for this kind of training. Meeting the evolving training needs of child-serving agencies in a manner that is cost effective and productive is a continuing priority for child-serving agencies, community partners and families.

The Department of Public Instruction and the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services – Transition Services Initiative used and continues to call upon an interdepartmental team to assure that children receiving Community Based Services are experiencing smooth transitions for coordinated planning and approval of community support services/other new services allowed under the Medicaid state plan amendment. Joint activities have included regional trainings, community based forums and individual child and family team meetings. To facilitate and support the communication and planning process, an interdepartmental DVD and workbook to guide Local Education Agencies, Local Management Entities and families were developed. Joint agency communications have been issued at the State and local levels. Partners include the Office of Education Services, the Department of Juvenile Justice and Delinquency Prevention, families, youth, providers, local education agencies and local mental health management entities.

Attachment D

Database Survey

Children's Services Work Group
Subcommittee 2 – Database and Shared Information
Common ID/MIS Sub-subcommittee—Administrative Office of the Court
North Carolina Service Delivery System Management Information System/Identification Matrix

Agency	What are the Management Information Systems housed at the agency? Please list one system per row.	What is the main ID generated/ used by the system?	Please check the identifying information that the system captures:	Quality Management/ Assurance: Is there a procedure for ensuring accuracy of data entry? (check all that apply)	Information Sharing: Does your agency share individual child data with other agencies?	Does the agency currently obtain individual child data from other agencies?	Is the data currently used for outcome measurement or program evaluation?
Administrative Office of the Court (AOC) **System 1:**	Name of System: *YTC MIS* Age of System: *1 year* Is the System fully implemented: ☐ Yes ☒ No. Describe: *Still putting reports and "bug" fixes in place*	Main ID: Please provide an example of the ID used in the MIS: *N/A*	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☐ Social Security # ☐ Language Pref. ☐ Please indicate total child age range captured by your database: *12 - 17*	☐ Pre-entry ☒ Post-entry ☐ Other: *Data entered is "checked" through the printing and review of bi-monthly court reports*	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: *All members of the YTC team may view some or all of the information in the MIS (dependent on security level).*	☐ No Information Obtained ☒ Yes, Information Obtained. Please describe type of information obtained: *DJJDP shares probation information, schools provide grades, attendance and behavior, treatment providers share treatment attendance, participation and drug screens.*	☐ No ☒ Yes. Please Describe: *We are currently engaged in a random assignment to YTC or juvenile probation and treatment as usual.*
Administrative Office of the Court (AOC) **System 2:**	Name of System: *JWISE* Age of System: Is the System fully implemented: ☐ Yes ☒ No. Describe: *Implemented in 53 counties*	Main ID: Case Number Please provide an example of the ID used in the MIS: 95JA000001	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☐ Social Security # ☐ Language Pref. ☒ Please indicate total child age range captured by your database: *0-18*	☐ Pre-entry ☒ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: *Among court personnel only*	☐ No Information Obtained ☒ Yes, Information Obtained. Please describe type of information obtained: *Petitions include information from DHHS*	☒ No ☐ Yes. Please Describe:

Children's Services Work Group
Subcommittee 2 – Database and Shared Information
Common ID/MIS Sub-subcommittee—Department of Juvenile Justice and Delinquency Prevention
North Carolina Service Delivery System Management Information System/Identification Matrix

Agency	What are the Management Information Systems housed at the agency? Please list one system per row.	What is the main ID generated/ used by the system?	Please check the identifying information that the system captures:	Quality Management/ Assurance: Is there a procedure for ensuring accuracy of data entry? (check all that apply)	Information Sharing: Does your agency share individual child data with other agencies?	Does the agency currently obtain individual child data from other agencies?	Is the data currently used for outcome measurement or program evaluation?
Department of Juvenile Justice and Delinquency Prevention **System 1:**	Name of System: *NC Juvenile Online Information Network (NC-JOIN)* Age of System: *3 years* Is the System fully implemented: ☐ Yes ☒ No. Describe: *Still need to implement YDC treatment planning and monitoring, aftercare, mental health diagnosis and treatment, and community program referral, participation, and outcomes in NC-JOIN.*	Main ID: *Unique sequentially generated numeric id* Please provide an example of the ID used in the MIS: *500068*	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☐ Language Pref. ☐ Please indicate total child age range captured by your database: *6-21* *Also have legal file number assigned by county clerks of court.*	☒ Pre-entry ☒ Post-entry ☒ Other: *Required fields; business rules, data quality checks, supervisor reviews of records*	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: *case specific data is made available to GCC and Sentencing Commission for purposes of producing mandated projections and reports, but not for individual case management*	☐ No Information Obtained ☒ Yes, Information Obtained. Please describe type of information obtained: *No electronic data is obtained, but case data provided by other agencies may be entered by DJJDP staff into NC-JOIN.*	☐ No ☒ Yes. Please Describe: *Data is being used for determining recidivism rates of juveniles served by DJJDP*

Children's Services Work Group
Subcommittee 2 – Database and Shared Information
Common ID/MIS Sub-subcommittee—Department of Juvenile Justice and Delinquency Prevention
North Carolina Service Delivery System Management Information System/Identification Matrix

Agency	What are the Management Information Systems housed at the agency? Please list one system per row.	What is the main ID generated/ used by the system?	Please check the identifying information that the system captures:	Quality Management/ Assurance: Is there a procedure for ensuring accuracy of data entry? (check all that apply)	Information Sharing: Does your agency share individual child data with other agencies?	Does the agency currently obtain individual child data from other agencies?	Is the data currently used for outcome measurement or program evaluation?
Department of Juvenile Justice and Delinquency Prevention **System 2:**	Name of System: *JCPC Client Tracking* Age of System: 5 *years* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: *Combination of juvenile name and date of birth* Please provide an example of the ID used in the MIS: *PRID02191990*	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☐ Address ☒ Social Security # ☐ Language Pref. ☐ Please indicate total child age range captured by your database: *6-18*	☒ Pre-entry ☒ Post-entry ☐ Other:	☒ No Information Shared ☐ Yes: Information shared. Please describe type of information shared:	☒ No Information Obtained ☐ Yes, Information Obtained. Please describe type of information obtained:	☐ No ☒ Yes. Please Describe: *Data is being used for determining Standard Program Evaluation Protocol rating of programs*

Children's Services Work Group
Subcommittee 2 – Database and Shared Information
Common ID/MIS Sub-subcommittee—Department of Public Instruction
North Carolina Service Delivery System Management Information System/Identification Matrix

Agency	What are the Management Information Systems housed at the agency? Please list one system per row.	What is the main ID generated/ used by the system?	Please check the identifying information that the system captures:	Quality Management/ Assurance: Is there a procedure for ensuring accuracy of data entry? (check all that apply)	Information Sharing: Does your agency share individual child data with other agencies?	Does the agency currently obtain individual child data from other agencies?	Is the data currently used for outcome measurement or program evaluation?
Department of Public Instruction **System 1:**	Name of System: *Comprehensive Exceptional Children Accountability System (CECAS)* Age of System: *1 year* Is the System fully implemented: ☒ Yes ☐ No. Describe: .	Main ID: Alphanumeric ID not related to student demographics. Please provide an example of the ID used in the MIS: Randomly generated letters and numbers, e.g., 5DP23N57XS	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☐ Address ☐ Social Security # ☐ Language Pref. ☒ Please indicate total child age range captured by your database: *0-22*	☒ Pre-entry ☒ Post-entry ☐ Other: *All*	☒ No Information Shared ☐ Yes: Information shared. Please describe type of information shared:	☐ No Information Obtained ☒ Yes, Information Obtained. Please describe type of information obtained: *DHHS Infant-Toddler Program transfers students to Special Ed. at age 3 with parent consent*	☐ No ☒ Yes. Please Describe: *Data used to look at service efficacy for students with disabilities.*
Department of Public Instruction **System 2:**	Name of System: *NC WISE* Age of System: *3 years* Is the System fully implemented: ☐ Yes ☒ No. Describe: *Only 1/3 of school systems using it.*	Main ID: System generates a unique number within school; when combined with 6 digit school ID becomes unique in the state. Please provide an example of the ID used in the MIS: 23456	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☒ Language Pref. ☒ Please indicate total child age range captured by your database:	☒ Pre-entry ☒ Post-entry ☐ Other: *System automatically checks for reasonable-ness of some data. Data also checked at DPI level post-entry.*	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared:	☒ No Information Obtained ☐ Yes, Information Obtained. Please describe type of information obtained:	☐ No ☒ Yes. Please Describe: *Data used for a variety of evaluations - dropouts, suspensions, graduation rates, etc.*

Children's Services Work Group
Subcommittee 2 – Database and Shared Information
Common ID/MIS Sub-subcommittee—Department of Public Instruction
North Carolina Service Delivery System Management Information System/Identification Matrix

Agency	What are the Management Information Systems housed at the agency? Please list one system per row.	What is the main ID generated/ used by the system?	Please check the identifying information that the system captures:	Quality Management/ Assurance: Is there a procedure for ensuring accuracy of data entry? (check all that apply)	Information Sharing: Does your agency share individual child data with other agencies?	Does the agency currently obtain individual child data from other agencies?	Is the data currently used for outcome measurement or program evaluation?
Department of Public Instruction **System 3:**	Name of System: *SIMS* Age of System: *20 + years* Is the System fully implemented: ☒ Yes ☐ No. Describe: *System phasing out as NC WISE phases in.*	Main ID: System generates a unique number within school; when combined with 6 digit school ID becomes unique in the state. Please provide an example of the ID used in the MIS: 62419 - Can be randomly generated or manually assigned.	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☐ Language Pref. ☒ Please indicate total child age range captured by your database: *Age 5 through graduation, completion, or dropout (16-21).*	☒ Pre-entry ☒ Post-entry ☐ Other: *System automatically checks for reasonableness of some data. Data also checked at DPI level post-entry.*	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: *Student information not routinely shared with other agencies, but aggregate and nonconfidential records are public information which may be requested by anyone.*	☒ No Information Obtained ☐ Yes, Information Obtained. Please describe type of information obtained:	☐ No ☒ Yes. Please Describe: *Data used for a variety of evaluations - dropouts, suspensions, graduation rates, etc.*
Department of Public Instruction **System 4:**	Name of System: *Accountablility Services* Age of System: *student level is 6 years old* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: LEA + School Code + Student ID Please provide an example of the ID used in the MIS: 2 schools within Wake County = 920306, 920310. Student ID is SIMS or NCWISE	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☐ Address ☐ Social Security # ☒ Language Pref. ☒ Please indicate total child age range captured by your database: *Age 8 through graduation, and dropouts*	☒ Pre-entry ☒ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: *Student information not routinely shared with other agencies, but aggregate records are reported as part of the state ABCs and federal NCLB.*	☒ No Information Obtained ☐ Yes, Information Obtained. Please describe type of information obtained:	☐ No ☒ Yes. Please Describe: *State ABCs, Federal NCLB*

Children's Services Work Group
Subcommittee 2 – Database and Shared Information
Common ID/MIS Sub-subcommittee—Department of Public Instruction
North Carolina Service Delivery System Management Information System/Identification Matrix

Agency	What are the Management Information Systems housed at the agency? Please list one system per row.	What is the main ID generated/ used by the system?	Please check the identifying information that the system captures:	Quality Management/ Assurance: Is there a procedure for ensuring accuracy of data entry? (check all that apply)	Information Sharing: Does your agency share individual child data with other agencies?	Does the agency currently obtain individual child data from other agencies?	Is the data currently used for outcome measurement or program evaluation?
Department of Public Instruction **System 5:**	Name of System: *Career Technical Education (CTE)* Age of System: *20 + years* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: SIMS or NCWISE number Please provide an example of the ID used in the MIS:	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☐ Language Pref. ☒ Please indicate total child age range captured by your database: *11-21*	☒ Pre-entry ☒ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: *Individual student information not routinely shared with other agencies, but aggregate and nonconfidential records are public information which may be requested by anyone.*	☒ No Information Obtained ☐ Yes, Information Obtained. Please describe type of information obtained:	☐ No ☒ Yes. Please Describe: *1) CTE course test scores for all enrollees broken out by demographics. 2) Outcomes regarding work & further education one year after graduation.*
Department of Public Instruction **System 6:**	Name of System: *Migrant System (MIS2000)* Age of System: *6 years* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: System generated Please provide an example of the ID used in the MIS: NC21-39588	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☒ Language Pref. ☒ Please indicate total child age range captured by your database: *Age 5 through graduation*	☒ Pre-entry ☒ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: *Student profile.*	☒ No Information Obtained ☐ Yes, Information Obtained. Please describe type of information obtained:	☐ No ☒ Yes. Please Describe: *Federal and state reporting.*

Children's Services Work Group
Subcommittee 2 – Database and Shared Information
Common ID/MIS Sub-subcommittee—Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS)
North Carolina Service Delivery System Management Information System/Identification Matrix

Agency	What are the Management Information Systems housed at the agency? Please list one system per row.	What is the main ID generated/ used by the system?	Please check the identifying information that the system captures:	Quality Management/ Assurance: Is there a procedure for ensuring accuracy of data entry? (check all that apply)	Information Sharing: Does your agency share individual child data with other agencies?	Does the agency currently obtain individual child data from other agencies?	Is the data currently used for outcome measurement or program evaluation?
Division of MH/DD/SAS **System 1:**	Name of System: **Integrated Payment Reporting System (IPRS)** Age of System: 2002 Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: Individual Claim Number# 999999999999999	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☒ Language Pref. ☐ Please indicate total child age range captured by your database: *All ages*	☒ Pre-entry ☒ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: **Division of Medical Assistance.**	☐ No Information Obtained ☒ Yes, Information Obtained. Please describe type of information obtained: **Division of Medical Assistance.**	☐ No ☒ Yes. Please Describe: *Program monitoring, evaluation, Federal reporting, etc.*
Division of MH/DD/SAS **System 2:**	Name of System: **North Carolina Treatment Outcomes and Program Performance System** Age of System: 2004 Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: 999999999	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☐ Social Security # ☒ Language Pref. ☐ Please indicate total child age range captured by your database: 5 and above.	☒ Pre-entry ☒ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. **Data is transmitted to the Client Data Warehouse.**	☐ No Information Obtained ☒ Yes, Information Obtained. **Data is transmitted to the Client Data Warehouse.**	☐ No ☒ Yes. Please Describe: *Program monitoring, evaluation, Federal reporting, etc.*

Children's Services Work Group
Subcommittee 2 – Database and Shared Information
Common ID/MIS Sub-subcommittee—Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS)
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Agency	What are the Management Information Systems housed at the agency? Please list one system per row.	What is the main ID generated/ used by the system?	Please check the identifying information that the system captures:	Quality Management/ Assurance: Is there a procedure for ensuring accuracy of data entry? (check all that apply)	Information Sharing: Does your agency share individual child data with other agencies?	Does the agency currently obtain individual child data from other agencies?	Is the data currently used for outcome measurement or program evaluation?
Division of MH/DD/SAS **System 3:**	Name of System: **Health Enterprise Accounts Receivable Tracking System (HEARTS)** Age of System: October 1999 Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: *9-99-99-99 System generated number*	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☒ Language Pref. ☐ Please indicate total child age range captured by your database: Adults	☒ Pre-entry ☒ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: **Division of Medical Assistance.**	☐ No Information Obtained ☒ Yes, Information Obtained. Please describe type of information obtained: **Division of Medical Assistance.**	☐ No ☒ Yes. Please Describe: *Program monitoring, evaluation, Federal reporting, etc.*
Division of MH/DD/SAS **System 4:**	Name of System: **Client Data Warehouse** Age of System: 1999 (7 years) Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: *System Generated*	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☒ Language Pref. ☐ Please indicate total child age range captured by your database: *All ages*	☒ Pre-entry ☒ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: **Division of Medical Assistance.**	☐ No Information Obtained ☒ Yes, Information Obtained. Please describe type of information obtained: **Division of Medical Assistance.**	☐ No ☒ Yes. Please Describe: *Program monitoring, evaluation, Federal reporting, etc.*

Children's Services Work Group
Subcommittee 2 – Database and Shared Information
Common ID/MIS Sub-subcommittee—Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS)
North Carolina Service Delivery System Management Information System/Identification Matrix

Agency	What are the Management Information Systems housed at the agency? Please list one system per row.	What is the main ID generated/ used by the system?	Please check the identifying information that the system captures:	Quality Management/ Assurance: Is there a procedure for ensuring accuracy of data entry? (check all that apply)	Information Sharing: Does your agency share individual child data with other agencies?	Does the agency currently obtain individual child data from other agencies?	Is the data currently used for outcome measurement or program evaluation?
Division of MH/DD/SAS **System 5:**	Name of System: **MMIS+** Age of System: 2002 Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: Individual Claim Number# 999999999999999	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☒ Language Pref. ☐ Please indicate total child age range captured by your database: *All ages*	☒ Pre-entry ☒ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: **Division of Medical Assistance.**	☐ No Information Obtained ☒ Yes, Information Obtained. Please describe type of information obtained: **Division of Medical Assistance.**	☐ No ☒ Yes. Please Describe: *Program monitoring, evaluation, Federal reporting, etc.*

Children's Services Work Group
Subcommittee 2 – Database and Shared Information
Common ID/MIS Sub-subcommittee—Division of Public Health
North Carolina Service Delivery System Management Information System/Identification Matrix

Agency	What are the Management Information Systems housed at the agency? Please list one system per row.	What is the main ID generated/ used by the system?	Please check the identifying information that the system captures:	Quality Management/ Assurance: Is there a procedure for ensuring accuracy of data entry? (check all that apply)	Information Sharing: Does your agency share individual child data with other agencies?	Does the agency currently obtain individual child data from other agencies?	Is the data currently used for outcome measurement or program evaluation?
Division of Public Health **System 1:**	Name of System: *NCIR* Age of System: *1 year* Is the System fully implemented: ☐ Yes ☒ No. Describe: *Roll out completed for Local Health Dept. Roll out to private providers is in progress.*	Main ID: *System generates a unique client ID* Please provide an example of the ID used in the MIS: *5920426*	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☒ Language Pref. ☒ Please indicate total child age range captured by your database: *Birth to Death*	☒ Pre-entry ☐ Post-entry ☐ Other: *The batch interface to pose significant risk to data quality.*	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: *The Local Health Dept. and providers can search and obtain child specific information. However, the search is restrictive and requires the provider to enter child's identifying information before providing access.*	☐ No Information Obtained ☒ Yes, Information Obtained. Please describe type of information obtained: *Will obtain information from Vital records.*	☐ No ☒ Yes. Please Describe: *The system has tools such as reminder/recall and assessment reports to provide feedback about Immunization rates in a LHD, provider or even at county level.*
Division of Public Health **System 2:**	Name of System: *WIC Automated Data System* Age of System: *27* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: local generated ID, but within the system the county and site number are added to ensure unique ID Please provide an example of the ID used in the MIS: 1234567	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☐ Social Security # ☐ Language Pref. ☐ Please indicate total child age range captured by your database: *Birth to Death*	☒ Pre-entry ☐ Post-entry ☐ Other:	☒ No Information Shared ☐ Yes: Information shared. Please describe type of information shared:	☒ No Information Obtained ☐ Yes, Information Obtained. Please describe type of information obtained:	☐ No ☐ Yes. Please Describe:

Children's Services Work Group
Subcommittee 2 – Database and Shared Information
Common ID/MIS Sub-subcommittee—Division of Social Services
North Carolina Service Delivery System Management Information System/Identification Matrix

Agency	What are the Management Information Systems housed at the agency? Please list one system per row.	What is the main ID generated/ used by the system?	Please check the identifying information that the system captures:	Quality Management/ Assurance: Is there a procedure for ensuring accuracy of data entry? (check all that apply)	Information Sharing: Does your agency share individual child data with other agencies?	Does the agency currently obtain individual child data from other agencies?	Is the data currently used for outcome measurement or program evaluation?
Division of Social Services **System 1:**	Name of System: *Eligibility Information System (EIS)* Age of System: *25+ years* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: EIS Case ID and EIS Individual ID Please provide an example of the ID used in the MIS: Case ID: 99999999 Indv. ID: 999999999A	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☒ Language Pref. ☐ Please indicate total child age range captured by your database: *All ages*	☒ Pre-entry ☒ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: *All data with DMA; limited information with other agencies, DPI & school systems*	☐ No Information Obtained ☒ Yes, Information Obtained. Please describe type of information obtained: *All data from DMA*	☐ No ☒ Yes. Please Describe: *Program monitoring, evaluation, Federal reporting, etc.*
Division of Social Services **System 2:**	Name of System: *Food Stamps Information System (FSIS)* Age of System: *26years* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: FSIS Case ID and Individual ID Please provide an example of the ID used in the MIS: Case ID: 99999999 Indv. ID: 999999999A	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☒ Language Pref. ☐ Please indicate total child age range captured by your database: *All ages*	☒ Pre-entry ☒ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: *Limited information with other agencies, DPI and school systems*	☒ No Information Obtained ☐ Yes, Information Obtained. Please describe type of information obtained:	☐ No ☒ Yes. Please Describe *Program monitoring, evaluation, Federal reporting, etc.*

Children's Services Work Group
Subcommittee 2 – Database and Shared Information
Common ID/MIS Sub-subcommittee—Division of Social Services
North Carolina Service Delivery System Management Information System/Identification Matrix

Agency	What are the Management Information Systems housed at the agency? Please list one system per row.	What is the main ID generated/ used by the system?	Please check the identifying information that the system captures:	Quality Management/ Assurance: Is there a procedure for ensuring accuracy of data entry? (check all that apply)	Information Sharing: Does your agency share individual child data with other agencies?	Does the agency currently obtain individual child data from other agencies?	Is the data currently used for outcome measurement or program evaluation?
Division of Social Services **System 3:**	Name of System: *Services Information System (SIS)* Age of System: *27 years (re-written 16 years ago)* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: SIS Client ID Please provide an example of the ID used in the MIS: 99999999999 or <>999999999A	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☒ Language Pref. ☐ Please indicate total child age range captured by your database: *All ages*	☒ Pre-entry ☐ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: *Limited identifiers, demographics with DCD; system shared with DAAS – could access individual child data*	☒ No Information Obtained ☐ Yes, Information Obtained. Please describe type of information obtained:	☐ No ☒ Yes. Please Describe: *Program monitoring, evaluation, Federal reporting, etc.*
Division of Social Services **System 4:**	Name of System: *Day Sheets (SYA)* Age of System: *26 years* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: SIS Client ID Please provide an example of the ID used in the MIS: 99999999999 or <>999999999A	☐ Name ☐ Date of Birth ☐ Race ☐ Gender ☐ Address ☐ Social Security # ☐ Language Pref. ☐ Please indicate total child age range captured by your database: *Single identifier is Client ID; can be linked to data in SIS*	☒ Pre-entry ☐ Post-entry ☐ Other:	☒ No Information Shared ☐ Yes: Information shared. Please describe type of information shared:	☒ No Information Obtained ☐ Yes, Information Obtained. Please describe type of information obtained:	☐ No ☒ Yes. Please Describe: *Program monitoring, evaluation, Federal reporting, etc.*

Children's Services Work Group
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Common ID/MIS Sub-subcommittee—Division of Social Services
North Carolina Service Delivery System Management Information System/Identification Matrix

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Division of Social Services **System 5:**	Name of System: TANF Data Collection System (*TDC)* Age of System: *9 years* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: EIS Case ID and EIS Individual ID Please provide an example of the ID used in the MIS: Case ID: 99999999 Indv. ID: 999999999A	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☒ Language Pref. ☐ Please indicate total child age range captured by your database: *All ages*	☒ Pre-entry ☒ Post-entry ☐ Other:	☒ No Information Shared ☐ Yes: Information shared. Please describe type of information shared:	☒ No Information Obtained ☐ Yes, Information Obtained. Please describe type of information obtained:	☐ No ☒ Yes. Please Describe: *Program monitoring, evaluation, Federal reporting, etc.*
Division of Social Services **System 6:**	Name of System: *Automated Collections and Tracking System (ACTS)* Age of System: *9years* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: ACTS Case ID and ACTS Participant ID Please provide an example of the ID used in the MIS: *Both are ten digit numbers, for example 0004136040*	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☒ Language Pref. ☐ Please indicate total child age range captured by your database: *all ages*	☒ Pre-entry ☒ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: *insurance information shared with NC DMA; participant and case information shared with the federal Office of Child Support Enforcement*	☐ No Information Obtained ☒ Yes, Information Obtained. Please describe type of information obtained: *Information obtained from DMA*	☐ No ☒ Yes. Please Describe: *Program monitoring, evaluation, Federal reporting, etc.*

Children's Services Work Group
Subcommittee 2 – Database and Shared Information
Common ID/MIS Sub-subcommittee—Division of Social Services
North Carolina Service Delivery System Management Information System/Identification Matrix

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Division of Social Services **System 7:**	Name of System: *Client Services Data Warehouse (CSDW)* Age of System: *6 years* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: Please provide an example of the ID used in the MIS: CSDW contains data from multiple systems; IDs are system-dependent, although some systems share common IDs	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☒ Address ☒ Social Security # ☒ Language Pref. ☐ Please indicate total child age range captured by your database: *All ages*	☒ Pre-entry ☒ Post-entry ☐ Other:	☐ No Information Shared ☒ Yes: Information shared. Please describe type of information shared: *Information may be shared between agencies upon approval of individual System Business Owner*	☐ No Information Obtained ☒ Yes, Information Obtained. Please describe type of information obtained: *Data included in CSDW from DCD, CSE, DAAS, DMH,DD&SAS, and DPH*	☐ No ☒ Yes. Please Describe: *Program monitoring, evaluation, Federal reporting, etc.*
Division of Social Services **System 8:**	Name of System: *Central Registry* Age of System: *15+ years* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: SIS ID Please provide an example of the ID used in the MIS: 99999999999 or <>999999999A	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☐ Address ☒ Social Security # ☐ Language Pref. ☐ Please indicate total child age range captured by your database: *0-17*	☐ Pre-entry ☐ Post-entry ☒ Other: *Data quality controls as determined by the county. Some counites may have supervisors sign off on all forms, others may not.*	☒ No Information Shared ☐ Yes: Information shared. Please describe type of information shared:	☒ No Information Obtained ☐ Yes, Information Obtained. Please describe type of information obtained:	☐ No ☒ Yes. Please Describe: *The data is used to measure the oucomes of a number of DSS's programs, as well as submitted to the Federal Government for our outcome-based Child and Family Services Reviews.*

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North Carolina Service Delivery System Management Information System/Identification Matrix

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Division of Social Services **System 9:**	Name of System: *Child Placement and Payment System* Age of System: *15+ years* Is the System fully implemented: ☒ Yes ☐ No. Describe:	Main ID: SIS ID Please provide an example of the ID used in the MIS: 99999999999 or <>999999999A	☒ Name ☒ Date of Birth ☒ Race ☒ Gender ☐ Address ☒ Social Security # ☐ Language Pref. ☐ Please indicate total child age range captured by your database: *0-20*	☐ Pre-entry ☐ Post-entry ☒ Other: *Data quality controls as determined by the county. Some counites may have supervisors sign off on all forms, others may not.*	☒ No Information Shared ☐ Yes: Information shared. Please describe type of information shared:	☒ No Information Obtained ☐ Yes, Information Obtained. Please describe type of information obtained:	☐ No ☒ Yes. Please Describe: *The data is used to measure the oucomes of a number of DSS's programs, as well as submitted to the Federal Government for our outcome-based Child and Family Services Reviews.*