

**ROGUE VALLEY WRAPAROUND COLLABORATIVE**  
**Proposal for Statewide Children’s Wraparound Initiative**

**I. Awareness of System of Care Values and the Wraparound Process**

**1. Demonstrate a working understanding of System of Care values and principles:**

The Rogue Valley Wraparound Collaborative (RVWC) process plans to provide individualized, comprehensive, community-based services and supports to foster children and adolescents with serious emotional and/or behavioral problems so they can be reunited and/or remain with their families and communities. By focusing on the individual strengths and needs of the children and families, RVWC will help families rediscover hope.

Integrating a System of Care will allow the RVWC to deliver a comprehensive spectrum of services to meet the multiple and always changing needs of children and their families. All treatment, support and care services will be provided in a context that meets a child’s psychosocial, developmental, educational, treatment and care needs. The treatment environment will be safe, nurturing, consistent, supervised and structured. Successful intervention with children will be in an atmosphere that encourages normal development, is the least restrictive necessary, fosters respect for others and is nonjudgmental. A child’s family will also be provided with continuing encouragement to engage as full partners in all aspects of their child’s treatment, treatment planning, and the decisions that are made. All treatment will be viewed as family-driven and youth-guided. Core values with all community collaborators have been determined to be:

- Services will be child and family driven, with the needs of the child and family guiding the types and mix of services provided.
- Services will be community-based, with services, management and decision-making responsibility resting at the community level.
- The System of Care will be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations we serve.

Guiding principles for the System of Care and community collaborators have been determined to be:

- a. Children with mental and behavioral disorders will have access to a comprehensive array of services that address the child’s physical, emotional, social and educational needs.
- b. Children with mental and behavioral disorders will receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
- c. Children with mental and behavioral disorders will receive services within the least restrictive, most normative environment that is clinically appropriate.
- d. The families, surrogate families and legal guardians of children will be full participants in all aspects of the planning and delivery of services.

- e. Children with mental and behavioral disorders will receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.
- f. Children with mental and behavioral disorders will be provided with Care Coordination or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.
- g. Early identification and intervention is critical for children with emotional problems in order to enhance the likelihood of positive outcomes.
- h. Children with mental and behavioral disorders will be ensured smooth transitions to the adult service system as they reach maturity.
- i. The rights of children will be protected, and effective advocacy efforts for children and youth will be promoted.
- j. Children with mental and behavioral disorders will receive services without regard to race, religions, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

Highlights of the RVWC System of Care will be:

- Sharing leadership
- Serving children referred from the state's child serving agencies
- Connecting all service delivery systems to create seamless service for youth
- Providing individualized, family-centered services
- Expanding the target population
- The development of strong interagency collaboration
- Working as part of a coordinated network of state and local services
- Locally-managed, community-based wraparound programs
- Turning shared values into outcomes
- Defragmenting children's lives
- Cultivation of sustainability

The Rogue Valley Wraparound Collaborative includes but is not limited to: Jefferson Behavioral Health, Options for Southern Oregon, Jackson County Mental Health, Jackson County Child Welfare, Jackson County Commission on Children and Families, Department of Human Services District 8, Community Works, CASA of Jackson County, Southern Oregon Child Study and Treatment Center, Oregon Family Support Network, Jackson County Community Justice, Southern Oregon Education Service District, Jackson County Foster Parent Association, OnTrack, Southern Oregon Adolescent Study and Treatment Center, Josephine County Commission on Children and Families, Josephine County Foster Parent Association, Josephine County Child Welfare, CASA of Josephine County, Josephine County Juvenile Justice, Choices Counseling Center, MidRogue Health Plan, Youth Advisory Council, children, parents, foster parents, family members, teachers, and other community stakeholders.

**2. Describe prior and current collaborative efforts by community partners to develop System of Care based on these values, principles, and planning processes. Describe lessons learned if applicable. Describe how current efforts will be coordinated with Statewide Children's Wraparound Initiative:**

Child serving professionals and family members from Jackson and Josephine Counties have been meeting regularly over the past year to discuss developing a System of Care for children with disruptive behavior disorders to address how to better meet the needs of this population beyond those that can be funded through Medicaid. This resulted in the development of the Rogue Valley Wraparound Collaborative (RVWC) in Southern Oregon to actively incorporate a System of Care for our community.

In addition to the System of Care planning process described above, a Jackson/Josephine County working group was convened in December of 2006 to examine mental health issues in schools. Members included mental health providers, an education representative, and parents of children receiving mental health services. The discussions and research led to development of a model for the provision of services in the schools.

A shared stakeholder understanding has already been established. RVWC has been taking concrete steps to translate the wraparound philosophy into solid policies, practices and achievements. Stakeholder values and beliefs have been aligning service planning and delivery strategies with System of Care principles that have been beneficial to children and their families.

RVWC believes that trust, commitment, and shared responsibility is critical to system functioning. Local collaborative structural changes to support the system implementation will include: 1) changes in the physical arrangement of services such as the co-location of cross-agency staff; 2) changes in the structures and budgetary authorities that facilitate interagency decision making regarding service eligibility and placements; and 3) creation of an infrastructure that facilitates transition across service environments such as home and school as well as transitions to varying levels of services.

From the collaborative efforts described above, lessons learned include the realization that there have been unintended consequences of the Children's Change Initiative:

- More silos have been created. We need bridges.
- The division between behavioral and psychiatric services has created some relationship problems between agencies. We need better understanding between the Child Welfare and Mental Health systems.
- Some needs are not funded through Medicaid.
- Information needs to be centralized.
- There is inconsistency in ongoing training and consultation.
- There is inconsistency in strengths-based training of facilitators.
- We need a single point of standardized accountability/criteria with demonstrated outcomes.
- The biggest service we offer is optimism.

Current efforts by the RVWC will be coordinated with the Statewide Children’s Wraparound Initiative by developing a healthy collaboration with the State and multiple agencies that will provide more administrative and fiscal flexibility surrounding children’s services. RVWC will work to strengthen our relationship with the State to better serve children and families.

RVWC will continue the process of developing collaboration and partnership with multiple State agencies in an effort to provide administrative and fiscal flexibility with regard to the traditionally categorical nature of children’s services. This collaboration includes creative ways to be more flexible in eligibility, program, and funding rules. RVWC will develop a successful model system of support to access state-level leaders and policy makers. RVWC desires to align State goals and practices with our own to foster local-level flexibility and develop a shared understanding of perspectives and needs with a mutual effort to problem solve.

JBH will be responsible for a shared decision making approach within the framework of State regulations and policies of the funding agencies. JBH will work with the Project Site Lead, who will provide technical assistance to JBH and the CMOs to implement the project.

## **II. Resource Plan**

### **1. Estimate the number of children to be served on an annual basis. Provide a draft financial plan that outlines both the monetary and in-kind resources available for a diversified array of services and supports.**

The RVWC will serve up to 100 unduplicated children and youth ages 0-18 who are in the custody of the Department of Human Services-Child Welfare and meet the Phase I criteria of the Statewide Children’s Wraparound Initiative, specifically children who have had “...four or more placements while in the custody of child welfare, with a total length of custody in excess of one year, OR those who have behavioral, emotional and/or mental health conditions that are severe enough to warrant direct entry into a specialized treatment service and support system that would otherwise not meet the Phase I criteria outlined above, and their families. This includes children currently in the custody of Child Welfare receiving Behavior Rehabilitation Services (BRS) and other children who currently receive services under the Intensive Community Based Treatment Services Oregon Administrative Rule.”

RVWC is developing fiscal strategies to support the wraparound effort to better meet the needs of children and youth participating in the wraparound effort. A strategic financial plan will establish infrastructure that supports our system design that will eventually support a blended funding pool (mental health, child welfare, juvenile justice, education). JBH, as the Administrative Service Organization (ASO), will operate financial management structures to track revenue and payment of mental health, behavioral health and substance abuse claims. The ASO will report encounters, process claims, track expenditures and prepare fiscal reports.

**Rogue Valley Wraparound Collaborative  
Children's Wraparound Initiative Phase I Budget**

**Revenue**

Wraparound Pilot Project	100 kids @ \$545/month	\$654,000
Admin	Infrastructure/Flex Funds	30,000
BRS		2,146,000
Jackson, Josephine (42 kids)	SOCSTC, Community Works, etc. (\$140/day x 42 kids x 365 days)	
Treatment Foster Care		121,872
DMAP/Skills Training	(4 kids x 2,539 x 12 months)	
Child Welfare	(4 kids x \$700/mo. X 12 months)	33,600
MH Revenue - BRS	(46 kids x \$525/mo x 12 months)	289,000
Child Welfare Foster Care	(54 kids x \$1,200/mo x 12 months)	777,600
System of Care		
Flexible Funding	In Kind	10,000
JBH Contribution		150,000
In kind from Community Partners	(Staffing/ Admin etc)	20,000
<b>Total Revenue</b>		<b>\$4,232,072</b>

**Expenses**

	<u>Cost for Care</u>	
Josephine County	1.0 FTE @ \$78,000 x 3 positions	\$234,000
Jackson County	1.0 FTE @ \$94,204 x 4 positions	376,816
Cost of Delivering BRS	(100 kids x \$525/mo x 12 months)	630,000
Foster Care		
Outpatient Costs	(43 kids x \$525/mo x 12 months)	270,900
PRTS (Residential)	(8 kids x \$10,646/mo x 12 months)	1,022,016
ITS (Day Treatment	(3 kids x \$3,456/mo x 12 months)	124,416
	(4 kids x \$323/mo x 5 days x 12 months)	
Crisis Respite		77,520
	(4 kids x \$180/mo x 2 days x 12 months)	
Family Support		17,280
Foster Care		1,449,124
In-Kind		30,000
<b>Total Expenditures</b>		<b>\$4,232,072</b>

**III. Project Planning at the Policy & Administrative Levels**

**1. How project will implement a governance structure utilizing the ASO model. Identify ASO heading up the project:**

Jefferson Behavioral Health (JBH) will serve as the Administrative Service Organization (ASO) for the RVWC project. It will remain the single oversight entity for the Care Management Organizations (CMOs). Its mission will be to build and sustain an effective System of Care in Southern Oregon within four distinct domains: resources, structure, process, and community. JBH currently manages the behavioral health benefits through contracts with the community mental health programs in Jackson and Josephine Counties, as well as the Intensive Treatment Service (ITS) and Behavioral Rehabilitation Service (BRS) contracts with providers statewide. It has established procedures for referral, review and authorization processes, utilization management, workforce development and quality oversight of intensive children’s services provided to children in the region with serious emotional and behavioral disorders and their families. These have promoted increasingly effective working relationships with community partners that will enhance the foundations for the RVWC System of Care project. JBH also has a

well established regional interdisciplinary advisory committee comprised of various community partners with over 51% family representation and hosts two county planning meetings between mental health and child welfare staff to address the problems emerging from current funding structures. JBH staff are well versed in the difficulties inherent in addressing the needs of the current target population, and the organization has the financial capacity to manage the project.

The RVWC will establish a specific local advisory group for Jefferson Behavioral Health, the ASO for this project. This will be comprised of representatives from the core project planning team and additional youth and family members recruited from the child-serving partner agencies and organizations, such as the Oregon Family Support Network (OFSN), the Foster Parent Association, and the Youth Advisory Council (YAC) for Options for Southern Oregon. A majority of members will be youth and family members. In Phase I, the advisory group will meet at least monthly to monitor implementation of the system of care and to recommend adjustments and revisions to operations, protocol and policies as necessary.

The project will also build upon an existing utilization review committee at JBH to establish the Rogue Valley Wraparound Utilization Review Committee (URC). The URC will include youth, young adults, and family members with experience in foster care, along with representatives from Child Welfare, Mental Health organizations, and other ASO advisory group members. The URC will provide oversight and guidance for the selection and management of resources for specific children and families served by the project.

JBH will establish policies and procedures for referral, access, screening and assessment; benefit design, service array and contracting; family and youth involvement; information technology; workforce development; quality assurance, quality improvement and utilization review; and evaluation.

## **2. Describe how the ASO will determine and monitor the cost of care per child:**

JBH currently monitors cost through an authorization process for services and through the help of PHtech. PHtech manages payments and develops reports that demonstrate costs per unique member. JBH also has monthly Utilization Reviews with Jackson and Josephine Counties. This process is one where the Care Coordinator, Child Welfare, and their service provider are all available to discuss the progress of the treatment and discuss any further treatment needs and plan for discharge. JBH also goes to the treatment sites to review charts.

Additionally, individual service packages are designed to achieve the most effective care for children/families in the least restrictive environment. JBH cannot guarantee providers specific numbers of children within any case rate package because services are designed to best serve the mental health needs of the children/adolescents and their families.

Service packages currently show the total rate in monthly increments. Authorizations may be made in one-month, two-month and three-month increments. The monthly rate is used to calculate the total available amount to cover the entire authorization or reauthorization.

In ICTS, where the monthly amount is a cap rather than a case rate, the total authorization is the cap and may be spent at any time during the authorized period. It is anticipated that a similar process will be used for this project.

**3. Describe how ASO will enter into MOU with system partners to include child welfare and mental health agencies and providers:**

The development of a Memorandum of Understanding across child-serving agency participants will expand the interagency collaboration carried out by RVWC. JBH (ASO) will provide written commitments/contracts signed by collaborating agencies that spell out standards for services, allocation of resources, procedures, forms and activities, or all of the above. JBH will connect all child-serving partners within the community, promote information dissemination, share decision making, establish collaborative partnerships, and effective care of children. JBH will ensure that providers embrace the concept of sharing decision making authority and responsibility for outcomes with families and youth. JBH will further contract with the CMOs, Jackson County Mental Health and Options for Southern Oregon, to operate a diversified array of services and supports through a provider network and/or a contracting and procurement process.

**4. Identify local funding sources. Clearly describe the investment of ASO, MHO, CMHP and Child Welfare resources that are directed to the project and the cohort of children identified in this project.**

RVWC will be providing an array of services to this project. In addition to the new care coordination, the partners will be providing foster care payments, a child welfare case worker, outpatient and inpatient mental health services, BRS, residential, day treatment and ICTS services such as crisis, respite, wraparound, and skills training as needed. Funding resources that will be directed to Phase I of the wraparound pilot project will include an investment from JBH in the amount of \$150,000. Jackson and Josephine Counties will be providing \$2,146,000 in revenue from BRS funding. Mental Health revenue for BRS will be \$289,000. Treatment Foster Care (DMAP/Skills Training) will be provided for 4 children for a total of \$121,872. Child Welfare contributions to the project will serve 4 children at \$33,600. Child Welfare Foster Care funding directed to this project will be for 54 children at \$777,600. Infrastructure Administration costs directed to this project are estimated to be \$30,000. The System of Care flexible funding amount is budgeted for \$10,000, and the in-kind contribution from community partners for staffing and administration is estimated to be \$20,000. The wraparound pilot project's target population is 100 children at \$545 per month for a total amount of \$654,000. The total budget for Phase I of the wraparound project is \$4,232,072.

**5. Describe coordination with and access to services that are the responsibility of the Fully Capitated Health Plans.**

Every child/youth in the pilot will have a Child and Family Team facilitated by someone trained in the Wraparound process. RVWC will create and implement a standardized execution and protocol for care coordination outcomes, training and consultation. RVWC will implement an expectation and acknowledgement of shared responsibility and accountability for the well-being

of children and youth by creating/providing a single platform and process for integrating support based on the individual needs of the child, youth and family with the family partners and Child Family Team as core elements.

The Primary Care Physician (PCP) for each child will be included in the Child and Family Team with the family's agreement. Optimally, the medical home of these children was preserved when they entered into the Child Welfare system so that the current PCP is one the child knows and who knows the child and his/her medical history. The Mental Health provider will seek to obtain medical records for each child in the program and will initial and participate in an on-going collaboration and consultation with the PCP.

JBH will notify the Exceptional Needs Care Coordinator (ENCC) of the Managed Care Organization in which each project child is a member to let them know that they are enrolled in the program and the name of the Care Coordinator for the family. The Care Coordinator will ensure that the Managed Care Organization (MCO) is aware of the service plan for the family through the ENCC and will work with the ENCC to address all medical needs and barriers to accessing services. The primary Managed Care Organizations serving Jackson and Josephine Counties will be represented on the ASO Advisory Group for the project.

**6. Describe how ASO will partner with, and identify family members and youth who have had personal experiences with serious emotional disorders.**

JBH, as the ASO, has successfully identified youth and family members for their Regional Advisory Committee. For the wraparound project, JBH will ensure that there are family and youth partners available who have their own experience(s) previously in living with serious emotional disorders. Youth and family members will be trained and available to serve on planning committees and advisory groups. The CMOs will have processes in place to partner with families and the Child and Family Team. JBH will identify and recruit youth and families to partner with them for this project through county committees, suggestions from the counties and other community partners, family advocates, advertisements, and through accessing recruitment suggestions from OFSN. Through OSN there is the potential of hiring, setting up interviews for family partners, and making sure they are trained to act as family/youth partners.

**7. Describe how the ASO will ensure that policies and procedures are culturally competent and that services are provided in a manner compatible with a family's cultural beliefs, practices, literacy skills, and language.**

Cultural and linguistic competence will be addressed in a variety of ways during both project planning and implementation. The RVWC project will use cultural and linguistic tools and process for organizational self-assessment, such as those developed by the National Center for Cultural Competence. Additionally, key organizational partners will continue to utilize bicultural and bilingual youth, family members, and staff members in developing the project. The project design will be informed by the Cultural Competency Plans, as included in the Addictions and Mental Health Biennial Implementation Plan updates adopted by each county. Other existing community strategies to address disproportionality in the target population will also be incorporated. Cultural competency will include race and ethnicity, along with other

cultural differences specific to the two counties, including those associated with socio-economic factors, such as poverty, and those related to the intersection of rural and urban differences including proximity to resources. Project implementation will also include ongoing training and consultation in cultural competency. Youth and family members from a variety of backgrounds and ethnicity will help drive the project design and implementation. RVWC will ensure that policies and procedures are more culturally competent, improve hiring practices, incorporate cultural competence in the certification training, including the provider network, and ensure that families play a central role at all levels.

**8. Describe how services will be identified in the Service Coordination Plan will be authorized and how much authority the Child & Family Team will have to authorize services.**

The purpose of the Service Coordination Plan is to serve children and their families in a coordinated, simplified, and cost effective manner. The Service Coordination Plan will describe the needs, long-range vision and short-term objectives for the child and family, and the services that will best fit their needs. The plan will reflect the family's prioritization of needs, goals and significant cultural considerations. It will also incorporate pertinent, identified strengths within its strategies; include clear assignments of team member responsibilities with time frames; and include measures or other means by which the child/family and Child Family Team will monitor accomplishments and progress. The plan will set objectives that can readily be accomplished and celebrated within a short timeframe. The intent of this approach is to encourage involvement, achievement and success by continually building on the strengths of the child and his/her family.

The primary venue for the service planning process will be the Child and Family Team meeting. Accountability for service planning should rest with a Care Coordinator. The care coordination role is to assure that planning, coordination, and implementation of the System of Care approach follows accepted procedures. Another key team member in both the service planning and provision will be the peer parent supporter, or "parent partner." The role of the parent partner is to ensure that there is an advocate for the family who can help them navigate the mental health care system. The service planning team will include the family, Care Coordinator, parent partner, therapist, and the relevant agency representatives. The child or youth also participates whenever possible.

The Child and Family Team will include, at a minimum, the child and his/her family/foster parents/guardians, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include teachers, extended family members, friends and other natural supports, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like Child Protective Services or the Division of Developmental Disabilities, etc. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, and by which individuals are needed to develop and coordinate an effective service plan. Team membership can therefore expand and contract as necessary to be successful on behalf of the child.

The Child and Family Team will have the authority to authorize services and supports identified in the Service Coordination Plan within the parameters set by Medicaid funding sources such as need for placement in least restrictive level of care, treatment services must meet criteria for medical necessity, etc. Should the Child and Family Team authorize or request services that do not meet these criteria, then the representatives from the JBH Utilization Review Committee for the project, including the family partner, will meet with the Child and Family Team to discuss possible alternate options.

**9. Describe how the ASO will evaluate project outcomes identified in the Statewide Children’s Wraparound Initiative.**

The goal for the RVWC project is “Children are at home, in school, and are out of trouble.” Standard assessment and outcome tools used by the project will be CASII/ECSII, BERS, CGAS and CANS. Educational outcomes will be monitored in relation to the Individual Education Plan for the child. Data will be collected from partner agencies involved with these children and reviewed during child and family team meetings. The primary tool used to track outcomes and monitor the success of the project will be the Statewide Children’s Wraparound Initiative (SCWI) Progress Review Report. Information for this report will be gathered by the Care Coordinator from the Child and Family Team and the partner agencies involved with the child.

To measure how children are successfully functioning in the home, school and community, data will be generated from a Child Behavior Checklist completed by the child’s family team members about behavior issues at intake and during the course of enrollment. Youth will also complete a self report. Effectiveness of services can also be examined by a) reporting improvements in a child’s functioning from intake to 12 months after initial enrollment; b) children achieving permanency, as measured by what percentage of children leaving the program are able to live at home in comparison to other settings, including foster care, group home care and residential care; c) school enrollment, and d) family satisfaction with services.

The collection, analysis and use of outcome data in the RVWC System of Care will be a tool used for decision making, guiding treatment and service planning, demonstrating cross-agency results, and suggesting areas for system improvement. Outcome data will be collected across agencies using measures that are relevant to the established and agreed upon vision and mission. Efforts to collect, distribute, and review outcome data will be necessary in order to use outcome information more effectively and to increase its impact on the system.

**10. Describe how the project will ensure that Medicaid regulations are adhered to.**

Current JBH contracts with the CMOs require adherence to Medicaid regulations. Internal quality assurance processes will include regular audits and clinical reviews, as well as audits by external agencies including JBH to provide monitoring, feedback and to set goals for correction or improvement. For this project, RVWC will review the particular treatment documents for each child every six months to make sure that JBH and the treatment providers are adhering to Medicaid regulations.

#### **IV. Project Management at the Service Level**

##### **1. Describe how the project will implement a governance structure that incorporates the functions of a CMO.**

As the ASO, JBH will contract with Jackson County Mental Health and Options for Southern Oregon (Options) to serve as the Care Management Organizations (CMOs) for the RVWC project. As the existing county mental health providers, each of these entities already holds the obligations and authorities commensurate with trained staff who provide care coordination for children receiving ITS and BRS services. Both agencies are familiar with the wraparound process and committed to family-driven and youth-guided care. The CMOs have extensive experience working with children in the Child Welfare and other child-serving systems and a history of collaboration on various grants. JBH currently has contract in place with both entities to provide Care Coordination functions for children eligible for Intensive Community-based Treatment and Supports services.

The CMOs will be responsible for ensuring that Strengths Needs assessments are completed, a Child and Family Team established and a service coordination plan developed. CMOs will ensure that all Care Coordinators work from wraparound principles in facilitating the Child and Family Team, and promote youth guided and family driven planning. CMOs will be accountable to JBH, as the ASO, for fulfilling these responsibilities and will be reviewed by JBH to determine whether they are meeting contacted expectations for the project.

JBH will ensure that the CMOs themselves have significant representation from family members, a commitment to culturally validated approaches, the capacity to meet funding, data and outcome requirements and processes that involve their community partners, including the Commissions on Children and Families, state partners for children and families, local Child Welfare agencies, mental health advisory committees, and others.

##### **2. Describe process for identifying children that will be served under the project, and screening tools used for access and intake.**

The children and adolescents (0-18) served by this program are under court order in the child welfare system and have a range of emotional and behavioral problems which have made long-term and permanent placements difficult to sustain. The process provides individualized, comprehensive, community-based services and support to these identified children so they can be reunited and/or remain with their families and communities.

For the purposes of access and intake to the project, referrals to the program will be screened for eligibility and then given an intake review. The review will determine eligibility for services, review the needs and strengths of a child and family accepted for services to form the basis of a service plan, and identify service gaps for the child and family in the immediate situation as well service gaps system-wide. Referral information will include history of the child's involvement in Child Welfare, mental health treatment history, a recent mental health assessment, and recent CASII, CANS and BERS. The primary criteria for eligibility are that the situation has a significant degree of complexity with the potential for multi-agency involvement, issues have not

been resolved by traditional programs, and that there is agreement from the family, foster family or guardian and child to participate. The access process will conclude with the referral summary and documentation of the findings of the eligibility review which will be completed on all referrals to establish whether the child meets the criteria. The assessment is a combined eligibility determination and comprehensive review of needs and strengths, and is not intended to be a clinical interview. The clinical information in the client's plan is obtained with the parents' permission from the clinicians who have worked with the child. The assessment interview is critical because the strengths and needs it identified will naturally drive the focus of the Child Family Team.

Following enrollment into the program the Care Coordinator assigned to the child and family by the CMO will meet with the family for an initial assessment which will include a comprehensive, strengths and need assessment. This will then naturally drive the focus of the Child and Family Team. The preferred practice for this assessment interview is that two people, the Care Coordinator and the Family Advocate, meet with the family. The comprehensive assessment will look at strengths, resources, needs, and concerns that lead to a Service Plan approved by the family. The Care Coordinator and Family Advocate will then work with the family to prioritize the life domain areas in which the child and family are experiencing the most needs. The Care Coordinator works with the child and family to form the Child Family Team. When the Child and Family Team convenes, strengths and needs will be addressed again and tasks will be assigned to help the family in meeting those needs. The service plan developed by the team will include behavior support plan as needed, an individualized crisis management plan and discharge criteria.

Care Coordinators will maintain a comprehensive record of all referrals. The six components will be: 1) a referral summary; 2) the eligibility review; 3) a comprehensive assessment; 4) service plan, including crisis/safety plan; 5) ongoing progress notes; and 6) discharge/disenrollment summary. Particular strategies will be adopted to ensure outreach to and facilitate access for those children disproportionately represented in the target population, such as Native American and Hispanic youth.

**3. Describe how the ASO will establish a Review Committee to approve participation in the project prior to entry into and transition from the project and adhere to federal and state confidentiality requirements.**

The project will build upon an existing utilization review committee at JBH to establish the Rogue Valley Wraparound Utilization Review Committee (URC). The URC will include youth, young adults, and family members with experience in foster care, along with representatives from Child Welfare, Mental Health organizations, and other ASO advisory group members. The URC will provide oversight and guidance for the selection and management of resources for specific children and families served by the project.

The URC will receive referrals for the project and will authorize enrollment into the program and assign a child to a CMO for implementation of a wraparound planning process. They will initiate the JBH data collection process by enrolling the child in the project. The child's guardian will provide written authorization for disclosure of information using state approved

forms for disclosure of necessary information to the members of the URC for purposes of admission, monitoring and transition out of the project.

The URC will review the progress of children in the project through six-month reviews and at transition out of the program. Discharge criteria and planning will be a part of the Child and Family Team process from the initial assessment. When the Child and Family Team decides that the child is ready to transition out of the project the UCR will be notified. The UCR will conduct a final review and evaluate the appropriateness of the transition plan.

**4. Describe how the CMO will implement a wraparound planning process that includes a strengths-based needs assessment, child and family team facilitation, and care coordination.**

Jackson County Mental Health and Options for Southern Oregon have been implementing key community and system supports in our wraparound planning process:

*Community partnerships:* Key stakeholder groups, including agencies, providers, youth, and representatives of youths and families have joined together in a collaborative effort to plan and implement wraparound.

*Collaborative action:* Stakeholders have been taking steps to translate the wraparound philosophy into concrete policies, practices and achievements.

*Fiscal policies:* The community will be developing fiscal strategies to support the wraparound effort to better meet the needs of children participating in the wraparound effort.

*Access to needed supports and services:* The community is developing mechanisms for ensuring access to the services and supports that wraparound teams need to fully implement the plans.

*Human Resource Development and Support:* The system will support wraparound staff and partner agency staff to work in a manner that allows full implementation of the wraparound model.

*Accountability:* RVWC will implement mechanisms to monitor wraparound fidelity, service quality, and outcomes, and oversee the quality and development of the overall wraparound effort.

The wraparound process itself will be strengths-based in that the team takes time to recognize and validate the skills, knowledge, insight, and strategies that each team member has used to meet the challenges they have encountered in life. The wraparound plan will be constructed in such a way that the strategies included in the plan capitalize on and enhance the strengths of the people who participate in carrying out the plan. This principle also implies that interactions between team members will demonstrate mutual respect and appreciation for the value each person brings to the team.

The commitment to a strengths orientation is particularly pronounced with regard to the child or youth and family. The RVWC wraparound process is intended to achieve outcomes not through

a focus on eliminating family members' deficits but rather through efforts to utilize and increase their assets. The RVWC process thus seeks to validate, build on, and expand family members' psychological assets such as positive self-regard, self-efficacy, hope, optimism, and clarity of values, purpose, and identity. Interpersonal assets include social competence and social connectedness, and their expertise, skill, and knowledge.

The CMOs will hold the critical function of care coordination. The CMOs, in concert with JBH as the ASO, will establish standardized expectations and protocols for care coordination, outcomes, training, and consultation. Each full-time Care Coordinator will be responsible for providing care coordination for at most fifteen families. The Care Coordinator will ensure that the strengths-needs assessment is completed and used to generate the services coordination plan. The Care Coordinator will act as an architect for the services plan under the direction of the family, will broker and advocate for services and coordinate and monitor the implementation of the plan. The Care Coordinator will be responsible for documentation and will ensure that all documentation is forwarded to JBH as the ASO. Care Coordinators will be trained in strengths-based practices and Child and Family Team facilitation from a wraparound perspective. The initial strengths-needs assessment will cover multiple life domains and will be regularly reviewed and updated by the Child and Family Team.

**5. Describe how the ASO/CMO will designate family members and youth to be primary decision makers and ensure that planning, development, and implementation of the local system of care is family-driven and youth guided. Include family member/youth participation on child and family teams and provision of peer support to families/youth participating on child and family teams.**

Youth and family involvement and shared decision-making will be an emphasis in the project because it is a crucial element to both the System of Care values and to fidelity in the wraparound process. Youth and family members will be supported in their involvement and decision-making at the policy and advisory level by resources and training available through Oregon Family Services Network (OFSN) and will be key contributors in designing the service arrays that most effectively and efficiently meet their needs.

The ASO and CMOs will ensure a family-driven and youth-guided System of Care through the recruitment, training, support and membership of families and Young Adults in Transition (YAT) on both policy and practice bodies of the system. Specifically, they will be valued team members in the Wraparound Initiative Case Flow Model in review of Entries determined to meet criteria for participation and Exits reviewed by the team of stakeholders upon clients' transition out of the program. The CMOs will include peer delivered services for both family members and YAT which will support child/youth and family teams to ensure the process remains family-driven or youth-driven, as appropriate. Peer Delivered Services (PDS) will support treatment plans and provide advocacy, system navigation, community-based support, or other needs driven by the family or youth. The inclusion of PDS will add a layer of accountability to the project, team and System of Care in the pursuit of better outcomes for families and youth.

The ASO, ASO Advisory committee, and CMOs will actively solicit feedback on the RVWC project from organized consumer and advocate organizations such as the Foster Parent

Association, OFSN, and the Youth Advisory Council, distinct participation of individuals on the Advisory Committee. Care coordination and case work will emphasize family-driven and youth-guided care. Finally, family-driven and youth-guided practices will be integrally incorporated into the Child and Family Team process for each youth.

Because the family and youth partner role on Child and Family Teams is extremely important to the outcomes of the process, this project will include a Family Navigator and/or Youth Navigator to provide training, support advocacy, systems navigation and ensure fidelity to the process. Additional provision of peer support will include support groups for parents and youth, Collaborative Problem Solving Book Clubs, and trainings for youth and families. OFSN will provide the training and ongoing support needed for these roles and other peer delivered services offered to the community. These trainings will include, but are not limited to: Family Navigator training; Youth Navigator training; core PDS training; facilitation of support groups and training; Collaborative Problem Solving facilitation training; youth M.O.V.E. video and training on YAT; and Advocacy 101.

The ASO/CMOs and Family Leaders (SOASTC Family Involvement Coordinator or Jackson County/OFSN Family Navigator and a Youth Peer support person) will work with the identified family (foster, adoptive, biological, etc) members and youth through the wraparound process. The Family Navigator and Family Involvement Coordinator will be among the first points of contact and will be a primary support for family involvement. The Family Involvement Coordinator and Family Navigator will find supports needed for individual cases. The ASO/CMO and Family Leaders will utilize resources available through SOASTC's Collaborative Problem Solving Book Clubs conducted by its Family Involvement Coordinator and OFSN's Peer Support, Family Navigator, youth and professionals such as policy makers, professionals in policy making, and families, and any other resource available (OrPTI, local support groups, NAMI, etc.) to support the family and youth.

Because family and youth involvement requires mutual respect and meaningful partnerships between families and professionals, families will be involved as key stakeholders, whether they are helping tailor their child's individualized plan of care or helping design, build, or maintain the System of Care. Families will be involved in policy development, care coordination, evaluation, strategic planning, service provision, social marketing, and individual and system advocacy. Engaging family members in the planning and provision of services emphasizes a respect for their capabilities and their role as part of the solution with the ultimate goal being permanency for children by reunification with their biological parents or other permanency options.

**6. Describe how the ASO/CMO will establish a provider network with access to care coordination and a full array of services and supports for the defined population of children in the community.**

JBH as the ASO already has an established provider network with access to care coordination and a full array of services and supports for the mental health treatment of the children in the target population. Local DHS Child Welfare agencies provide case management and residential services. This project would build on this already established array to appoint specialized Care

Coordinators for the children enrolled in the project and fund additional services and supports that cannot be funded through Medicaid, such as crisis respite that does not meet criteria for acute care payment under Medicaid, family partners, peer services, concrete family needs, etc.

JBH will partner to provide PDS to the counties. OFSN is a family organization that specializes in a full array of PDS and works closely with Jackson County Mental Health where they are contracted to provide a Family Navigator and a Promotora. These two positions focus on System Navigation, prevention, education, outreach, support, resources, referral, and advocacy. The partnership between OFSN and the CMOs will create endless opportunities for families and youth to inform, partner and lead the agencies that are receiving services.

**7. Identify the service array funded by DHS/CAF, DHS/AMH and DHS/DMAP that is available in the community, as well as services provided to the Phase 1 cohort by other system partners. Describe efforts being made to expand the diversity of the service array. Describe what evidence-based practices will be available through the project and how fidelity to the models will be achieved.**

RVWC children and their families currently have access to the mental health service providers previously listed in this proposal. All State grant required services will be available in the service array and other services, or service enhancements, will be added over the life of the program. Partners in RVWC the wraparound process are not limited to the agencies and/or their services listed in this proposal. The existing RVWC Child and Family Team process has elements of wraparound and RVWC's comprehensive services currently available to the Child and Family Team include, but are not limited to:

- Strengths based case management
- Psychiatric assessment and oversight
- Medication management
- Outpatient psychotherapy
- Psychiatric residential treatment
- ICPS services
- School-based mental health services
- Intensive Community Care (a brand of foster care)
- Outpatient therapy
- Supervised visitation
- Special treatment services for sexually abused children
- Skills training – outpatient and in-home
- Family respite
- A & D services
- Family support groups
- Collaborative Problem Solving Book Club
- BRS residential and treatment foster care
- Parent skills training
- TI-CBT (all therapists trained at Family Friends)
- Wraparound services

Evidence-based practices used at Jackson County Mental Health include Parent Child Interaction Therapy, Collaborative Problem Solving, Cognitive Behavioral Therapy for depression, anxiety and trauma, and Motivational Interviewing. Evidence-based practices used at Options for Southern Oregon are Functional Family Therapy, Dialectic Behavior Therapy, Positive Behavioral Supports, Parent Child Interaction Therapy, and elements of evidence-based processes for Collaborative Problem Solving and Cognitive Behavioral Therapy. Partner agencies also provide an array of evidence-based practices in Jackson and Josephine Counties. SOCSTC and Family Friends use Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, Collaborative Problem Solving, Solution-Focused Brief Therapy, Strengthening Families Program, Second Step Violence Prevention, Positive Behavioral Supports, Nonviolent Crisis Prevention, Dialectic Behavior Therapy, and Eye Movement Desensitization and Responses. SOASTC currently practices evidence-based programs including Collaborative Problem Solving and Motivational Interviewing. OnTrack provides evidence-based programs that include the HOME, DAD, and TEEN programs, as well as Cognitive Behavioral Therapy 5 & 7 and Adolescent Community Reinforcement Approach. Another partner, Choices Counseling Center, uses early intervention techniques, Matrix model family education models, Family Systems approaches, Motivational Interviewing, as well as using a sound developmental model.

Fidelity to the models will be achieved through ongoing staff consultation and training, peer review, clinical supervision and external clinical review of documentation. Jackson County and SOASTC have ongoing consultation with Edward Keating, MSW, for the Collaborative Problem Solving program, with an ongoing fidelity review with Dr. Ablon. Jackson County has a consultation contract with Dr. Cheryl McNeil, one of the national developers of PCIT, to monitor fidelity to national PCIT standards. SOCSTC and Family Friends consult with Gabe Gomez on its CPS program. RVWC plans to contract wraparound training and hopes to move to high fidelity training with other people in the State to meet fidelity requirements.

DHS contract to provide services to children and families and help parents access drug and alcohol, mental health, parenting, domestic violence, etc. programs. Caseworkers provide case management and assess children's safety, either in the home or out of the home, by making face-to-face contact at least every 30 days. DHS also licenses foster homes for children who cannot safely live with their parents, and pays for services such as IFS, Parenting, and Foster Care. DHS does emphasize placement with relatives when at all possible. DHS also provides training in the community regarding mandatory reporting and child abuse laws.

**8. Describe the plan to develop crisis/emergency services related to placement, treatment and service provision of a therapeutic nature that will be used for children served under this project. Describe the plan to develop mechanisms for rapid access to placement services if needed.**

- **Crisis Management Plan:** Every child will have a crisis management plan developed by the Child and Family Team. This plan will be established as soon as possible following admission into the program. The Child and Family Team will identify several possible crisis scenarios and make a plan for how they would handle each. The family or youth will be asked to identify what they see as the most likely situation that might jeopardize placement or their child or themselves at risk. Youth will be asked to identify safe people

or places that they would be willing to talk to or go to if they felt that they were unsafe or about to leave a placement. The plan will include at least three people who can act as crisis support to the family or youth as needed and at least two alternate temporary crisis placement options for the child/youth.

- **Available Crisis Respite Placements:** Crisis respite resources of various kinds will be available to children/youth served in this project. They will have access based on availability to a crisis respite bed at the SOASTC secure residential treatment facility. Designated crisis respite beds will be available at foster care homes in both counties. Individual crisis respite options for particular children and youth will also be identified. For example, a previous foster family to whom the child feels connected may be willing to act as a crisis respite resource. There will also be limited Family Respite and Support Services available for planned respite through a service operated by SOASTC.
- **Access to Crisis Support.** The foster family, and the youth if over 14, will have a designated emergency contact to call at any time who will assist with crisis intervention and placement if needed. They will also be able to call the on-call staff of the 24/7 crisis response team at each county CMHP. Each county's crisis response staff will be aware of the children enrolled in the project and have access to emergency crisis management plans and identified strategies and supports. They will assist the family or youth in ensuring the immediate safety of the child or youth. They will have the ability to make placements in the various crisis respite placements as needed. Should acute psychiatric care be required to measure the safety of the child or youth the county crisis worker will access acute in-patient services as they do currently for any child in crisis needing such services. Other crisis supports will be available in the form of additional staff to support the foster family in monitoring safety, mediation to resolve conflicts between family and child/youth. The emergency contact, together with the county crisis worker, will be responsible for developing a plan to ensure the child or youth's safety until the care coordinator, family and Child and Family Team can work together to put added supports in place to resolve the crisis.
- **Crisis Follow-up:** Following a crisis episode the care coordinator will be in touch with the family as soon as possible. The care coordinator will meet with the family the next day to develop an immediate plan to ensure the safety of the child or youth and determine what supports would be needed to keep the child or youth safely in the current placement. Needs for enhanced treatment services will be identified and the care coordinator will ensure that these are put into place. Psychiatric consultation will be available on the next business day as needed. The Child and Family Team will be convened to review the crisis episode, discuss what strategies might have been used to avert the crisis episode and update the crisis management plan for the future.

**9. Describe how culturally competent services will be provided in a manner compatible with a family's cultural beliefs, practices, literacy skills, and language.**

RVWC will adopt the recommended statement for state and local agencies to describe culturally appropriate services and supports in a System of Care context:

“Individuals are treated respectfully, compassionately and effectively in a manner that recognizes, affirms and values the worth of children, individuals, families and communities, protecting and preserving the dignity of each. This includes culture, language, national origin, class, race, age, ethnic background, disability, stage of development, religion, gender, sexual orientation and other differences/diversity factors.”

RVWC will ensure that policies and procedures are more culturally competent, improve hiring practices to include a diverse staff and leadership that is representative of our demographic area and population, work to actively attract qualified bilingual/bicultural staff, incorporate cultural competence in certification training, and ensure that families play a central role in all this. All cultural data will be provided to the State administrator for state level evaluation and assessment.

RWVC will continue its commitment to the ongoing pursuit of knowledge, understanding, acceptance, and skills in working across cultures, identify individual cultural and spiritual beliefs and values and incorporate these into treatment, receive regular external training and consultation and know what is current in terms of best and evidence-based practice models. As a collaborative network of equal opportunity employers, we endeavor to recruit and hire culturally diverse staff representative of the community and the population we serve, partner with community resources to help generate objective support and services responsive to enhance cultural responsiveness.

## **V. Project Oversight at the Policy, Administrative & Service Levels**

### **1. Describe how the project will implement a governance structure that includes the functions of an ASO Advisory Group.**

The governance structure for RVWC includes JBH as the ASO. JBH is an intergovernmental entity of member counties under a Board of Directors consisting of all county commissioners from the JBH region. The Board has approved JBH to act as the ASO for this project. RVWC will initially serve children and youth in Jackson and Josephine Counties for Phase I. Based upon this experience, the collaborative plans to explore expanding the project to include Coos, Curry, and Klamath Counties to align with the entire JBH service region for subsequent phases. The Phase I partners of the RVWC have an established history of collaborating on projects that involve multiple systems and organizations. This has included the development of a regional proposal for a federal System of Care project that would have served a similar target population to the Children’s Wraparound Initiative, and a Child Welfare Improvement Project in Josephine County supported by the national Center for Healthcare Strategies. (The federal proposal was not submitted because the region decided to partner in an application submitted by the State of Oregon instead.)

JBH currently has several advisory groups, including a children’s system advisory group, with over 50% family membership. For this project JBH will establish an RVWC advisory group dedicated to this project. This will be comprised of representatives from the core project planning team and additional youth and family members recruited from the child-serving partner

agencies and organizations. A majority of members will be youth and family members. In Phase I, the advisory group will meet at least monthly to monitor implementation of the System of Care and to recommend adjustments and revisions to operations, protocol and policies as necessary.

JBH currently has contracts in place with Jackson County Mental Health and Options for Southern Oregon who will serve as CMOs for the project. These contracts include service provision for all services needed through this project and include mechanisms for oversight, review and collaborative planning. The CMOs will be responsible for providing Care Coordination, establishing Child and Family Teams and accessing the services and supports identified in the service coordination plan.

As part of the governance structure for the project JBH will also establish the Rogue Valley Wraparound Utilization Review Committee (URC) that will include youth, young adults, and family members with experience in foster care, along with representatives from Child Welfare, Mental Health organizations, and other ASO advisory group members. The URC will provide oversight and guidance for admission to the program, periodic reviews and oversight of transition from the program. It will also make recommendations to JBH regarding the selection and management of resources for specific children and families served by the project.

**2. Describe how the ASO will establish membership in the advisory group to include 51% family members and youth/young adults, and with attention to appropriate cultural/ethnic diversity representative of the community.**

The current JBH Regional Advisory group has established a 51% family representation by ensuring that family/youth members have the majority of votes compared with non-family/youth members. Cultural diversity in the wraparound advisory group will include populations of ethnic backgrounds representative of our cultural and ethnic statistics. Self-identified Hispanic and Native American populations will be represented on the advisory committee. Child Welfare or mental health staff from these communities will also serve on the advisory group, as well as other cultural diverse populations in our community.

The Surgeon General Executive Summary report U.S. Department of Health and Human Services Center for Mental Health (DHHS, 2003) concludes that race and culture have been identified as barriers to health care. Barriers include lack of or limited health insurance, lack of financial resources to cover services, lack of a primary health care provider, cultural and spiritual differences, language barriers and issues of discrimination.

The U.S. Census Bureau Quickfacts (2008) shows that Jackson and Josephine Counties are fairly homogenous geographic areas. Ethnic population statistics for Hispanic, Asian, African American, and American Indian populations are less than the State average. The socioeconomic culture for the population served in the RVWC region show high rates of poverty.

The 2008 OHCS Poverty Report shows Jackson and Josephine County poverty statistics. Jackson County was reported to be high at 13.1%, while Josephine County was among the highest rates found among Oregon counties (17.9%). Single mothers were especially hard hit. The report

further states that in Josephine County, 57% of families with children under age 18 are headed by a single woman who had income less than the poverty level and that the leading cause of the increasing poverty was likely the high unemployment rate. Jackson County's poverty among single mothers was reported to be 31% in 2007. OHCS also reported in 2008 that "an increasing number of families, while not officially below the poverty level, struggled to make ends meet. One indicator is the growth in the number of students receiving free or reduced-price lunches."

Socioeconomic disparities result in lower mean household income and levels of education may hinder the opportunities to obtain services and remain in care. RVWC recognizes that socioeconomic issues have a major effect on how we experience, understand, express and address mental health. Sensitivity to the cultural, ethnic, linguistic and social diversity of our area will provide better outcomes for the children and families we serve. Engaging the family and gaining the trust of parents is critical in treating children and youth from cultural backgrounds. RVWC plans to create a culturally friendly environment by providing multi-lingual services, literature and other tools to better serve a diverse population.

JBH actively serves a population of 59,748 individuals throughout its service region. 12% are identified as Hispanic, 1% as Asian, 1% African American, 74% Caucasian, and 12% are identified as Other. Options for Southern Oregon currently has 1,145 active clients identified as 3% Hispanic, 55% Caucasian, and 42% Other. The numbers served in the African American and Asian populations are minimal, but 42% of the clients are identified as Other. Jackson County Mental Health has identified 1,527 clients actively enrolled in its programs where 6% self-identified as Hispanic and 2% self-identified as Native American. RVWC partners have experienced that the "Other" populations are often individuals who do not wish to be identified by race and that some multi-racial individuals fall into this category.

Cultural differences can affect how people perceive mental health care. RVWC acknowledges that it is vital for mental health providers to have an understanding of a person's culture and culturally sensitive programs. RVWC sees the following as steps to decrease ethnocentric behaviors and to become educated about others as a catalyst to cultural knowledge and health care reform:

**For practitioners:**

- Awareness and acceptance of cultural differences in our community
- Awareness of our own culture and its biases
- An understanding of the dynamics of working across cultures
- Acquisition of cultural knowledge
- Acquisition/adaptation of skills to fit cultural context of client

**For providers:**

- Valuing and adapting to diversity
- On-going organization self-assessment
- Understanding and managing the dynamics of cultural difference
- Training/experience of culture knowledge
- Service adaptations to better serve culturally diverse clients and their families.

**3. Describe how the ASO will ensure that advisory group membership will be representative of community stakeholders with the authority to endorse and promote the project and development of the local system of care.**

The RVWC advisory group for JBH will be comprised of representatives from the core project planning team and additional youth and family members recruited from the child-serving partner agencies and organizations. A majority of members will be youth and family members. Efforts will be made to ensure sustained and ongoing participation by all stakeholders in the local System of Care including all those parties currently forming the collaborative and listed in section I.1 of this proposal.