Washington County Mental Health
Statewide Children's Wraparound Initiative
Response to Site Readiness Criteria

February 25, 2010

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

Since the 2004 implementation of the Children's System Change Initiative (CSCI), Washington County Mental Health (WCMH) has incorporated the Child and Adolescent Service System Principles (CASSP) into all levels of our children's mental health system, from prevention to intensive services. Our Mission Statement, adopted in 2003 during the planning stages of the CSCI, states:

Washington County, in collaboration with our System of Care Partners, will insure the provision of mental health services to children with severe emotional disorders which are child-centered, family-focused, community-based, culturally competent, multi-systemic, comprehensive, well coordinated, and are provided in the least restrictive setting possible. The Child and Adolescent Service System Principles (CASSP) will guide the planning, management and delivery of mental health services to children in need in Washington County.

As a values-driven organization, WCMH has used the CASSP to guide decision-making and service delivery design from the administrative macro level to the individual youth and family service planning level. We include CASSP in:

- All subcontracted provider contracts
- All Requests for Proposals
- All Memo of Understanding documents for youth-serving collaborations
- All program promotional materials
- Youth and Family Policies and Procedures
- Staff training and orientation

We strive as an organization to ensure that these core principles guide how we implement all of our contractual obligations with the State of Oregon as a Mental Health Organization and a Community Mental Health Program.

Washington County Services are Child-Centered:

No service types within our children's mental health system prescribe a specific amount or type of service. Instead, the type, frequency, duration and location of services are individualized to a particular client and family's needs. A streamlined process for authorizing services with non-contracted providers is in place in order to meet individualized treatment needs that cannot be met within our contracted provider network.

Washington County Services are Family-focused:

It is our primary value to ensure that our youth and families have voice, access and ownership of their plans, and we bring a holistic approach that looks beyond the mental health treatment needs to the well being of the entire family system.

J is a 17 year old with a history of trauma, depression and social anxiety, who was interested in increasing her social activities and making friends. During the course of a child and family team meeting J was encouraged to speak about what she wanted for herself. This discussion led to J using her connection at her local church to become a dance teacher to younger kids while she also pursued some more advanced dance classes. This led to a sustained involvement with her church in a variety of activities, which has become a primary support for J and her family.

In addition to the development of the plan, Child and Family teams are empowered with payment authorization for services identified in the plan.

WCMH strives to include families and advocates at all levels of the service system. We have a Family Advisory Committee, which is a subcommittee of our Children's Intensive Services Advisory Council. This group meets every other month and has been instrumental in developing additional support services for families. In addition they have had input in various policy decisions around funding and eligibility criteria. We have family members and advocates on both our Quality Improvement Committee and our Behavioral Health Council. We are also in the process of recruiting family partners, which will be described in more detail later in this proposal.

Washington County Services are Community-based and provided in the least restrictive/least intrusive settings:

Our commitment to providing services in the least restrictive setting has resulted in a significant increase in utilization of community based services, along with a corresponding decrease in facility based care. This is achieved through significant collaboration and integration of services with other agencies and systems, and increase in our investment in community-based services, as well as the development of natural supports for families.

T is a 14 year old boy with a history of trauma and unstable living situations who was living in of our Intensive Community Care homes and attending day treatment. As the home struggled with some of their own issues and T's mental health symptoms increased, there was discussion of whether PRTS would be the appropriate intervention. T's child and family team met, and T's mother was not in support of residential treatment. The team developed an alternative plan that consisted of T living with mom, attending day treatment, and a home-based stabilization provider coming every morning to assist T in getting up and ready, and every evening for several hours to assist T and mom with the evening routine and bedtime transitions. In addition, this team decided to meet biweekly

to check on how things were going, and more frequently if needed. They are also exploring natural supports that might eventually replace the treatment interventions in the home. While this intervention is much more costly than residential treatment, it was family driven and allows T to remain in a less restrictive setting.

Washington County Services are Multi-System:

By including our youth service partners from the beginning in the planning for the CSCI, we insured their buy-in and continued involvement and commitment in making our system of care operational. For this reason, our Child and Family team members consistently include representatives from Child Welfare, Juvenile Justice, Education and other partners.

A is in a treatment foster care home outside of our county, in a somewhat small rural community. Her team consists of her care coordinator, child welfare case worker, foster family, school principal, special education director for her school district, home based clinician, home based skills trainer, psychiatrist, sibling's foster family and a respite provider. Her foster care agency also brought in consultants from the Developmental Disabilities system to assist with a safety plan and comprehensive behavior plan, though this youth does not qualify for the DD system. Her school staff has collaborated with her treatment team to ensure her treatment plan is consistent across settings. Her foster parent advocated for a change in psychiatrists and care was shifted to a private practitioner who could better meet the client's needs.

In 2005, in conjunction with the implementation of the CSCI, WCMH collaborated with our system partners and other stakeholders to apply for a federal System of Care grant. While we were not successful in this application, this process was invaluable in solidifying our collective commitment to work together to enhance our local system of care. One outcome of this work is a protocol between child welfare and WCMH for referrals of voluntary cases to Child Welfare. This ensures that families do not have to make multiple phone calls or re-tell their story. It is due to the trust between our agencies that child welfare will accept these referrals from our office and offer voluntary services.

Washington County Services are Culturally Competent:

With Latino youth and families being our largest minority population, we ensure that Spanish-speaking clinicians are available at all of our outpatient provider agencies, and in both of our home-based stabilization programs. We also have bilingual skills trainers in several of our programs. Whenever possible we strive to offer families a primary clinician that is bi-cultural as well as bilingual. In addition to serving the Latino population, WCMH also contracts with Asian Health and Services and OHSU Intercultural Psychiatric Program to serve clients of Asian, Eastern European and some African cultures in a culturally competent manner. All of our contracted provider agencies have access to interpreter services and are able to be reimbursed for that cost on a fee-for-service basis. WCMH is currently exploring further workforce development in this area, which will be covered in more detail later in this proposal.

Washington County Services integrate the Principles of Wraparound:

In the development of our Intensive Service Array (ISA) program WCMH took care to provide training to our ISA Care Coordination Team and our partners, stakeholders and contracted providers in the Wraparound model. We are fortunate to have several Care Coordinators who have a combined 21 years of experience in fidelity Wraparound and have contributed to the integration of the Wraparound principles within our program. The continued support and consultation from Pat Miles during the first several years of the ISA was also instrumental in helping us education and orient our provider system to the Wraparound approach on a case by case basis.

Additionally, with ongoing training in the community provided by Wraparound Oregon and by David Barkan, our Care Coordinators have increased their ability to shift between the roles of team facilitator and authorizer of treatment services in a way that is effective and understood by the entire team. We believe this to be critical piece of our program's success, which is also attributed to the experience and skill of our Care Coordinators.

II. Resource Plan

Please see the attached Pilot Resources document that has the detail of contributions by various agencies. The total amount requested from the state pilot funds in this proposal is $422,400.00 for year one. As stated in our letter of interest, WCMH intends to serve 60 pilot youth in year one, and expand capacity gradually over time. That said, we are also willing to adjust our timeline for expansion if requested.

III. Project Planning at the Policy and Administrative Levels

1. Governance Structure

WCMH will serve as the Administrative Services Organization (ASO), using our existing administrative structure. This allows us to capitalize on our expertise within the domains of quality assurance and improvement, program coordination and development, procurement and contract development, data collection, financial management and oversight of care management functions. WCMH is a division located within the Health and Human Services Department of Washington County, with the Department Director reporting directly to the County Administrator, who reports to the elected Board of County Commissioners.

In addition, WCMH takes direction from our Behavioral Health Council (BHC), which includes representation from provider agencies, consumers, family members, law enforcement and advocates. This council is responsible for system oversight, setting priorities, system planning, and advocacy. There is a direct link between the BHC and the Washington County Commission on Children and Families, and the Children's Intensive Services Advisory Council is a subcommittee of the BHC. This ensures coordination between oversight bodies for both prevention and intervention services in Washington County.

2. Cost per child

WCMH currently employs Care Coordinators for the Intensive Service Array, and these positions would be the same classification as the Care Coordinators hired for the pilot. As these are salaried positions at Washington County, the cost of care coordination is predictable and fixed, other than annual salary and cost of living adjustments. The cost of care coordination per client per month is $616 on average, with $71 of that amount to be contributed in kind by WCMH.

In regard to the cost of services, this will be highly variable and individualized. Our average monthly cost of mental health treatment services (exclusive of care coordination) per child in the Intensive Service Array is $2746. This does not include Behavioral Rehabilitation Services (BRS) services but does include any mental health treatment services provided to youth in BRS placements. Additionally, whenever services to OHP covered youth that have been identified in the service coordination plan are not Medicaid covered services, WCMH will utilize general fund dollars to ensure that the service plan can be implemented.

It is the policy and practice of the WCMH Intensive Service Array to empower the child and family team to select and authorize treatment services. We believe that the child and family team make the most appropriate decisions about service type, frequency, location and duration, and should be empowered to make these decisions in the meeting with the Care Coordinator present, which we see as the most efficient practice. This removes any extra burden of having to wait for an authorization. WCMH does not have spending limits for individual clients, but rather empowers the child and family team to participate in the utilization review for their services to the extent possible, utilizing our policies on Utilization Management to guide the process. Thus, the services offered to an individual child will vary significantly.

WCMH contracts with a third party administrator to process our claims and provide routine financial reports. This allows us to track cost of services for individual clients as well as by program, time period, service type, etc. We intend to utilize this capacity to track the cost of care per client, in combination with information received from child welfare about the cost of any BRS or other services provided from their agency.

3. Memoranda of Understanding

WCMH currently has Memoranda of Understanding (MOU) developed with Child Welfare, Juvenile Justice, Oregon Youth Authority (OYA), and four of our seven local school districts. Historically this has been a collaborative and non-contentious process in our system. If we have the opportunity to become a demonstration site, these existing MOU would be updated, and we would pursue development of additional MOU with other partners as needed. Our primary initial focus would be to revise our MOU with Child Welfare and to develop an MOU with one or more of our local Fully Capitated Health Plans (FCHP).

Please find attached our current MOU with Child Welfare as an example.

4. Local Funding Sources

With WCMH acting as the ASO, both Oregon Health Plan funds from the MHO and General Funds from the CMHP are being contributed with in-kind resources. The MHO will be contributing two half-time Family Partners, as well as a full time Bachelor's level Team Support Specialist. Both the MHO and CMHP are contributing a percentage of the Program Coordinator FTE for program development and oversight, as well as a portion of the Program Supervisor FTE for supervision of additional staff. (Detail provided in section II.)

As stated above under #2, 100% of covered OHP services will be available to youth in the pilot cohort, as well as general fund dollars as needed for non-Medicaid covered services.

WCMH and our local Child Welfare have collaboratively developed a Treatment Foster Care Program with LifeWorks NW that will be an in-kind contribution from both agencies toward serving this cohort of youth. There are currently four shared beds that will be allocated to the pilot as needed. We also have collaboratively developed and funded a Family Finding pilot project that will have a primary focus on the pilot cohort of youth. This program is based on Kevin Campbell's Reconnecting Youth with Families and strives to build family connections for youth in the foster care system. This is funded through OHP, Commission on Children and Families, a United Way grant and in-kind resources from Child Welfare.

Child Welfare will contribute a portion of time from both Hillsboro and Beaverton Program Managers, and will allocate a portion of identified case workers' FTE toward additional case collaboration with the WCMH Care Coordinators for clients in the pilot. They have also agreed to contribute in-kind staff resources to manage emergency placement needs for pilot youth in collaboration with the identified Care Coordinator.

In addition Child Welfare is willing to contribute office space at each branch to support co-location for other team members as needed.

5. Coordination with Fully Capitated Health Plans

Currently we have the benefit of a strong relationship with Tuality Health Alliance, one of our four FCHPs. A representative of Tuality participates in our Coordinating Committee for the Intensive Service Array and has facilitated improved coordination between their Exceptional Needs Care Coordinators and our staff. This has been tremendously helpful for clients with medical issues such as eating disorders and diabetes, as well as those with substance abuse problems. Through coordination with the medical plans in our community, and through proactive communication with their Exceptional Needs Care Coordinators, we have successfully supported a client with brittle diabetes and co-morbid mental illness in her home and community. We endeavor to increase our coordination of care with all of our FCHPs, and have begun those conversations. As a concurrent step in this process, we have started discussions with both Behavioral Rehabilitation Services programs (BRS) in our region and Psychiatric Residential Treatment Services (PRTS) providers about developing some dual-diagnosis

treatment options for a small cohort of clients. System-wide this is recognized as a pressing issue for further development.

6. Family Member and Youth Involvement

WCMH is fortunate to have relationships with two family support organizations and to offer an array of services and supports to youth and families in the mental health system. Oregon Family Support Network (OFSN) provided a "Parents and Policy Partners" training in early 2009, which inspired the involvement of several new family members on our Advisory Council. During the same time period, WCMH worked with our local chapter of National Alliance for Mentally Ill (NAMI) to develop a monthly family support event for family members currently or previously in the ISA. For the past year we have offered a monthly dinner with activities for youth and a roundtable discussion on a variety of topics for the family members and caregivers. The momentum from these activities has resulted in a new peer mentor program at NAMI for family members of youth with mental illness, as well as the development of a youth leadership group.

In addition, WCMH is currently developing a Family Partner Program that will be in place this spring, with two half-time Family Partners who will work directly with families involved in intensive mental health services. Both OFSN and NAMI have committed to be involved in the training, support and integration of the Family Partners. Through this program WCMH will be able to continue to identify family members who might be interested in advocacy and mentor opportunities and provide appropriate training and support.

The next phase of program development in this arena will be a similar training from OFSN for youth as policy partners. This will be provided to youth in the leadership group as well as interested youth with current or past involvement in the mental health system. The goal over the next year is to recruit several youth interested in participating in policy development and program planning, and support them in participating on the advisory council.

7. Cultural Competence

With a significant minority population in Washington County and 18% of the population speaking a language other than English at home, WCMH places a high value and priority and culturally and linguistically competent service delivery. To that end we have invested recently in a comprehensive evaluation of the cultural competence of our contracted provider system by Pacific University's School of Professional Psychology. This evaluation was inclusive of provider agencies, family members, advocates, community members and our internal policies and procedures. This led to the creation of the Washington County Cultural Competence Committee which has recommended a position to function as the county coordinator for implementation of some of the recommendations made in the Pacific University evaluation. Responsibilities of this position will include:

- Coordination of training of all the contracted mental health providers on the overall concept of cultural competence as it applies to any minority culture or group.

- Coordination of training on effective and respectful provision of clinical services through the use of an interpreter.
- Identification of system wide and agency-specific barriers to treatment access for minority populations as well as methods to remove barriers (e.g., recommendations about integrating or locating services within naturally occurring minority communities, hands-on problem solving for effective communication with non-English speaking consumers from first point of contact, etc.).
- Recommendations for system-wide standards for language proficiency of bilingual clinicians and cultural competence of clinicians.
- Consultation to contracted providers on agency cultural competence plans.
- Outreach and education for leaders of various cultural groups.

This is currently in the selection process and we intend to fund this position for at least two years.

As the ASO, WCMH would utilize our existing contracts, policies and procedures in place to ensure culturally and linguistically competent service delivery. Specific information is included under section IV of this proposal.

8. Authorization for Services

As stated above, WCMH firmly believes in the child and family team's ability to make the best decisions about the services from which they will benefit. We have aligned our utilization management policies and procedures with this belief and allow the Care Coordinators to authorize services directly in the child and family team meetings. There are times when decisions need to be made imminently and authorizations for emergency services are done outside of the team, however the ongoing utilization review of those services is then inclusive of the team. Additionally, the Care Coordinator is able to help the team when they struggle with the notion of medical necessity and develop a plan that is least restrictive yet still meets the child and family's needs.

9. Project Outcomes

WCMH is in full support of the key indicators for success identified by DHS for the Wraparound Initiative. We have a system in place for consistently completing the BERS and ISA Progress Reviews that we will adjust to include the Progress Review Report for the Wraparound Initiative. Several of the key indicators highlighted for focus will be addressed within these two measures; however WCMH will take additional steps to capture a breadth of data.

In terms of the first key indicator of the number of children receiving mental health assessments and ongoing behavioral health services, we have a written agreement in place with Child Welfare that outlines our commitments in this arena. WCMH has three contracted children's outpatient mental health providers that dedicate specific days each month to be on site at the Child Welfare branch offices to complete mental health assessments. This data is tracked by each branch and then cross checked with our encounter data from our third party administrator. This continues to improve, and clients are referred for ongoing treatment as indicated.

Our quarterly internal chart audit will include random samples of pilot youth (representative of 10-15%). Audits will evaluate not only Medicaid compliance but also quality of clinical care and whether the individualized needs identified in the service plans are being met satisfactorily.

WCMH will include our new Cultural Competence Coordinator to determine the most appropriate means to evaluate whether children and families are truly receiving culturally and linguistically competent services. This will also be an ongoing dialogue in partnership with AMH and Child Welfare.

Our local child welfare district has a mechanism currently in place to track re-abuse rates, which is also a key indicator for our local Casey Project – Safely Reducing the Number of Kids in Foster Care. WCMH will coordinate with child welfare to track this outcome specifically for the pilot cohort.

10. Adherence to Medicaid Regulations
It is under our current functions of Community Mental Health Program and Mental Health Organization that WCMH will ensure that Medicaid regulations are adhered to through a variety of oversight processes and which requires us to recertify our contracted providers on a regular basis. In addition to the certification site reviews, we conduct bi-annual chart audits of each contracted service provider, as well as quarterly internal chart audits. This allows us to review not only provider compliance with regulations, but also quality of clinical care. These audits are followed up with specific feedback to providers and technical assistance as indicated, and may result in formal corrective action up to and including contract termination, when deemed appropriate.

IV. Project Management at the Service Level

1. Governance Structure
As stated earlier, WCMH intends to act as the ASO, building on our existing infrastructure as the CMHP and Mental Health Organization. WCMH also intends to act as the Care Management Organization (CMO). The CMO will incorporate the existing ISA program located within the Mental Health Department, with support and oversight through the ASO structure. (Please refer to the diagram submitted with our letter of interest.) The CMO will include the Program Supervisor, Care Coordinators, Family Partners, and Team Support Specialist.

Roles of the CMO include facilitation of child and family teams, data collection and outcome monitoring, utilization management, coordination and supervision of visitation, coordination of intakes, etc.

2. Screening Process and Eligibility for Pilot
WCMH and Washington County Child Welfare realize that during this initial phase of the pilot, there will be many more youth who meet the basic criteria than we are able to serve. Our primary value in screening youth for the initial cohort is to ensure we provide

the services first to those who are most in need. To that end, we have established some additional criteria to guide in our decision making that will not be used to exclude any youth, but rather to prioritize the youth that are identified. As our capacity increases, we will be able to continually expand our criteria to include more youth, though we will always strive to serve those most in need first.

One of our primary criteria will be to prioritize youth who are referred for the pilot that do not otherwise meet criteria for the ISA. This is because by continuing to refer ISA eligible youth to the ISA allows for increased capacity in the pilot. This will likely have the outcome of serving pilot youth who have primarily behavioral disorders, delinquency and / or substance use as their primary treatment need, at least in the first phase.

Other criteria that will be used to guide our prioritization of youth referred to the pilot will include:

- There is an imminent risk of the youth losing their current placement.
- The youth is involved in another system (in addition to MH and CAF) or at risk for involvement in the juvenile justice system due to delinquent behavior.
- There is a recent history of suspension or expulsion from school, or placement outside of the youth's home school.
- There has been chronic truancy or absenteeism.

The CASII/ ECSII level of service intensity will be used as decision support, but will not be a primary criterion.

As the pilot develops, the Advisory Council may choose to refine or further develop the eligibility criteria in consultation with the Review Committee.

3. Review Committee

WCMH, in consultation with our system partners, has identified the following members of the committee that will review entry into and transition from the pilot program:

Family Member
WCMH Program Supervisor
Child Welfare Beaverton Program Manager
Child Welfare Hillsboro Program Manager
Representative from a local provider agency
Washington County Juvenile Department Supervisor

This committee will be convened and facilitated by the WCMH Program Supervisor and will meet at a frequency to be determined. As the guardian for children eligible for this pilot cohort, child welfare staff will ensure that appropriate releases of information are signed and available during the review committees. Our experience is that we are able in a variety of settings with various system partners to have productive case consultations within the confines of HIPAA and FERPA (when applicable). It is our explicit intent that

when the review committee will be reviewing any personal health information or medical records, that releases of information for all members will be in place.

4. Wraparound Planning Process

WCMH is fortunate to have developed an in-house care coordination program in response to the CSCI in 2005. Our rationale for developing this program internally rather than contracting it to a community provider was to enable the funding and authorization decisions to happen in the most efficient manner. By having Care Coordinators employed by WCMH, they are able to authorize treatment services and other flexible services in the child and family team meeting as the plan is being developed and revised. As we have developed and expanded our ISA program over time, we have continued to refine our policies and practices in order to provide the best possible services to the youth and families we serve. We hire master level clinicians with experience in wraparound planning, and provide ongoing training in the wraparound process. With only one staff turnover since the program's inception, we attribute the longevity of our staff to our organizational culture of putting the child and family first, as well as the cohesiveness and collaborative nature of the team. The Care Coordination program is supervised by Mary Baker, LPC and receives psychiatric consultation from Bennett Garner, a child and adolescent psychiatrist, both of whom are integral members of this highly skilled team of clinicians.

We intend to incorporate our existing service planning process used in the ISA to the pilot cohort. Prior to the initial child and family team meeting, the assigned Care Coordinator meets with the family to introduce the care coordination role and wraparound planning process, begin developing a relationship, hear the family's story, and address any immediate safety concerns. The Care Coordinator also takes this opportunity to assist the family in identifying members of their child and family team.

At the first child and family team meeting, the Care Coordinator facilitates a discussion of the family's strengths, as identified by each team member, as well as identification of needs across the various life domains. This is often facilitated with a deck of laminated cards that have life domains printed in English and Spanish. Family members have remarked to us that this process, including the cards, is tremendously eye opening and that they appreciate the focus on the entire family system. This typically elicits the basis for the development of the service plan.

From our most recent ISA Family Satisfaction Questionnaire in response to what was most helpful:

> *"Listening to me as a parent and letting me be a part of her treatment and validate my concerns. (Care Coordinator) was a great support for our family because she validated my daughters wants and needs and also made her be responsible for her own consequences. Having the support of this program made my daughter successful."*

The initial service plan is then developed, with the family having the "loudest voice" with regard to what will best meet their needs. Each member of the child and family team is

aware of what their role and commitment is to the plan, and receives a copy of the plan. During ongoing child and family team meetings after the plan has been implemented, the Care Coordinator facilitates a discussion about how it is working and the team revises the plan as needed. It is seen as a living document and keeps team members focused on the client and family's vision and goals.

Our Care Coordinators often begin the dialogue about transition at the very first meeting. They are clear with the family that their role is to help the family reach a point where they are able to meet their needs without the ongoing involvement of professionals, but rather through their own community support system. For example, to enable parents to attend visits and treatment appointments, one Care Coordinator purchased a baby carrier so that one parent could ride the bus with her children and driving lessons for another parent. Transition planning is ongoing, and progress toward goals is acknowledged at every opportunity. When families have achieved their goals and a period of relative stability (which looks different for each child and family), they graduate from Care Coordination services. Our mission is to empower families with the skills to navigate the system on their own as things come up in the future. We knew we had succeeded when we heard back from a parent a year after discharge who had pulled together her own child and family team to address some of her son's educational needs.

5. Family Member and Youth Involvement

As stated above, youth and family members are given the primary authority in the child and family team, with input from other team members. We encourage family members and youth to invite friends or other supports to their meetings, and refer families to NAMI for support and advocacy when appropriate. Our Family Partners will be a significant resource in this area, offering peer support and guidance, as well as assisting teams in understanding the family's perspective. They will also be available to provide training to system partners on meaningful family participation and family driven treatment.

WCMH currently has a cadre of family members and advocates on our Children's Intensive Services Advisory Council who have been through the OFSN training, Parents as Policy Partners. This group of family members meets every other month with the WCMH Program Coordinator, Jill Archer, MSW, to discuss current system issues and the agenda for the Advisory Council meetings. Most recently this group was instrumental in ensuring that the revision of our ISA eligibility criteria for 0-5 year olds was inclusive enough and recognized some specific family dynamics. Our Advisory Council members, inclusive of all the current family members, have agreed to serve on the Pilot Advisory Council and provide the same type of oversight and guidance as we develop the program.

As stated earlier, we intend to provide a Youth as Policy Partners training this year and recruit youth leaders to serve on our Advisory Council. Ultimately we would like to develop a peer mentor program for youth and see this as an opportunity to partner with child welfare and perhaps Portland State University in this endeavor.

6. Provider Network and Array of Services

WCMH intends to provide care coordination services in house, as the CMO. As stated previously, we believe this model to be the most efficient in that it allows payment authorization decisions to be made in the moment in the child and family team. In addition, having the entire program within a single organization allows for consistency in policy, practice and philosophy, for which our contracted providers have expressed their appreciation.

As the ASO, WCMH would continue to subcontract with community providers for a full array of treatment services. Pilot youth would have access to this same array of services. Our current contracts include:

Prevention

- Early Childhood Mental Health Consultation – Morrison
- Promotora/ Early Childhood Latino Outreach – LifeWorks NW

Respite

- Boys and Girls Aid

Outpatient Services

- LifeWorks NW, Youth Contact, Western Psychological, Morrison
- Kerr Cornelius Group Homes
- St Mary's Home for Boys
- Chehalem Youth and Family Services

Intensive Home and Community Based Services

- Home Based Stabilization – LifeWorks NW, Catholic Community Services
- Transition Age Youth Intensive Services – LifeWorks NW
  - Supported Housing
  - Supported Education/ Employment
- Early Psychosis Program (EASA) – LifeWorks NW
  - Supported Housing
  - Supported Education/ Employment
  - Occupational Therapy

Treatment Foster Care

- LifeWorks NW

Psychiatric Day Treatment Services

- Trillium, LifeWorks NW (3 sites), Morrison Hand in Hand

Psychiatric Residential Treatment Services

- Trillium, ChristieCare

Acute/ Subacute

- Providence Portland, Trillium, Kerr, ChristieCare

Exceptional Needs Providers

- Variety of providers serving our youth in BRS placements statewide
- Local private practitioners with various specialties
- OHSU Intercultural Psychiatric Program
- Family Skill Builders

Having the Care Coordination provided out of the same organization that contracts for services allows for increased communication about barriers youth and families face in regard to access, quality of clinical care, transitions, etc. This provides the opportunity for timely continuous improvement processes between WCMH and contracted providers.

7. Service Array Available to Phase 1 Cohort

WCMH works closely with our local child welfare program to coordinate access to services, and collaborate on decision making around the best service type and clinical fit for a particular child. Child Welfare currently funds and offers access to the following services, which would be available to youth in the pilot cohort:

- Family Finding services
- Regular foster care
- Relative foster care
- Group home foster care - ECSI
- Regional BRS shelter – BGA Safe Place, Catholic Community Services
- Regional BRS Treatment Foster Care – Kerr, Maple Star, Morrison
- Out of Region BRS Treatment Foster Care – Trillium, Kerr, Maple Star, etc.
- BRS Intensive Community Care – Kerr, Morrison
- BRS Group Homes – Chehalem Youth and Family Services, White Shields, Janus
- BRS Residential - St. Mary's Home for Boys, Rosemont

WCMH and Washington County Child Welfare, in collaboration with local providers, have identified opportunities for local innovation to BRS services. For example, we have discussed with St. Mary's Home for Boys the idea of developing a Day Residential service, where clients could attend the treatment activities in the morning and evening, attend the day treatment program, and still maintain their current living situation in their home community. In addition, our child welfare program has identified that Washington County has a disproportionate number of referrals to the Target committee. We hope to collaborate with CAF to permit local management of Target funds to allow for more timeliness and flexibility in the usage of these funds to maintain placements that might otherwise have failed by providing enhanced services with local providers. One of our mutual goals is to avoid disruption of placements that are successful by titrating the amount and type of services rather than moving clients due to contractual issues.

Services funded through Oregon Health Plan and State General Funds via contracts with AMH are described above in #6, and will be available to youth in the Pilot cohort. In addition, WCMH intends to offer flexible and non-traditional services to youth in the pilot. Examples of flexible services purchased by WCMH include: registration fees for

therapeutic activities and camps, a hygienic mattress for a client with pronounced enuresis, food handler's permit for a client applying for jobs, public pool membership for a family to engage in healthy family activities, payment to a neighbor or church member to provide respite, etc. In the event that a particular service identified on a service plan by a child and family team is not an allowable service under Medicaid, WCMH uses general funds to ensure the plan can be implemented.

WCMH is pleased to have a provider system that values and supports evidence-based practices. In 2006 we offered grants to all of our contracted providers to implement new evidence-based treatment models that included ongoing fidelity monitoring. In addition we were successfully awarded funds from AMH to implement Parent Child Interaction Therapy (PCIT) in 2008. Currently, WCMH contracts with local child-serving providers who implement the following practices to fidelity:

- PCIT (LifeWorks NW, Morrison, Youth Contact)
- Trauma Focused Cognitive Behavioral Therapy (Morrison)
- Solution Focused Brief Therapy (LifeWorks NW)
- Collaborative Problem Solving (LifeWorks NW)
- Brief Strategic Family Therapy (Youth Contact)
- Dialectical Behavior Therapy (Trillium)
- Supported Employment (LifeWorks NW)
- Incredible Years (Morrison, LifeWorks NW, Youth Contact)

Each contracted provider agency has internal mechanisms for fidelity monitoring, which are reviewed by WCMH.

In addition to services funded by Child Welfare and WCMH, youth in the pilot cohort will have access to physical health and addiction services funded by DMAP and coordinated by the WCMH Care Coordinators. In Washington County, Youth Contact, LifeWorks NW and Western Psychological and Counseling offer addictions treatment services to OHP eligible youth and families. Youth Contact currently offers integrated dual-diagnosis treatment, and WCMH intends to partner with the Fully Capitated Health Plans to pursue additional integrated treatment options.

Finally, it is important to mention services offered by other system partners that will be available to youth in the pilot cohort. Washington County Juvenile Justice is a critical partner for both adjudicated and non-adjudicated youth. In addition to early intervention and prevention services such as Sky's the Limit for gang prevention, they offer treatment for adjudicated sex offenders through local outpatient and private providers. They operate the Harkins House shelter in Hillsboro, which provides assessment and case planning recommendations for youth with pending charges. WCMH funds mental health assessment and treatment for these youth which is provided by Youth Contact, one of our contracted outpatient provider agencies. Again, there is significant coordination both at the case level and system level between agencies in Washington County, which will enhance our ability to expand this work to a cohort of pilot youth.

Washington County has seven school districts, and an Education Services District. Each district has a unique array of services available to their students. For example, both Hillsboro and Tigard-Tualatin School Districts are recipients of federal Safe Schools/ Healthy Students grants, which have resulted in significantly more services targeted at high risk and high needs youth. WCMH recently added a School Based Services Liaison position in order to improve coordination at both a case specific level as well as at a larger system level. This will be another integral part of the pilot project in Washington County.

8. Crisis/ Emergency Services

With regard to crisis mental health services, WCMH has an array of options that would be available to pilot youth. For youth in any of our intensive home and community based services, those providers are available to respond to crisis 24 hours per day, 7 days per week, with a clinician who is familiar with the child and their family. This also includes Treatment Foster Care at LifeWorks NW, as well as all of our Psychiatric Day Treatment programs. If the crisis is such that the placement is unsafe for the child or family, the treatment provider will work with the guardian to find a safe and appropriate alternative. This could include crisis respite, use of natural supports to provide respite, or assessment for subacute or inpatient stabilization. For Intensive Community Care (ICC) programs, the BRS and mental health providers have an established triage system to determine who responds in various situations.

For youth in outpatient services in the community, their treating provider responds to crises 24 hours per day, seven days per week, and if need be will contact the guardian or Washington County Mobile Capable Crisis Team for assistance in accessing additional services or supports after hours. The crisis team is available to offer crisis response to any resident of Washington County who is having a mental health crisis and can offer same-day appointments or on-site assessments in the community. This team is considered a safety net service and is a backup to all other mental health crisis services when necessary. Again, this team would coordinate and follow up with other involved providers and guardians as soon as possible.

Clients served in BRS programs will have access to crisis support from the programs, as well as from the treating mental health provider. In most situations, crisis support will be provided by the existing systems with increased communication between members of the child and family team.

WCMH and Washington County Child Welfare propose to maintain the crisis/ emergency placement responsibility with child welfare for the first phase of the pilot. It is our mutual belief that child welfare staff has expertise in facilitating emergency placements, familiarity with the available resources, and existing infrastructure to do so. In the event that a pilot youth is in need of an emergency placement, after exhausting any possible resources to maintain the existing placement, the WCMH Care Coordinator will consult with the assigned Child Welfare worker about the situation and continue to be available for collaboration as a placement is identified. As we gain expertise during phase one, we intend to include our Regional Resource Consultant in regular planning and

development meetings to ensure we are developing an emergency placement system for the long-term that can meet everyone's needs.

9. Culturally Competent Services

As stated previously, WCMH places a high value on ensuring the delivery of culturally and linguistically competent services. In order to meet the needs of our clients from minority cultures who may not be fluent in English, we have Spanish-speaking clinicians at all of our outpatient provider agencies, and in both of our home-based stabilization programs. We also have bilingual skills trainers in several of our programs. Whenever possible we strive to offer families a primary clinician that is bi-cultural as well as bilingual. In addition to serving the Latino population, WCMH also contracts with Asian Health and Services and OHSU Intercultural Psychiatric Program to serve clients of Asian, Eastern European and some African cultures in a culturally and linguistically competent manner. All of our contracted provider agencies have access to interpreter services and are able to be reimbursed for that cost on a fee-for-service basis.

As stated in our letter of intent, if awarded the pilot WCMH would seek to hire at least one bilingual and/ or bicultural Care Coordinator and a bilingual Team Support Specialist. We would also continue our current practice of using interpreters when needed for child and family teams and other client and family contact. One of the first projects assigned to the WCMH Cultural Competency Coordinator will be to coordinate a system wide training for clinicians on how to provide treatment using an interpreter that is respectful to the client and as minimally intrusive to the treatment as possible. This training will also be made available to our system partners as appropriate during the pilot.

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

WCMH intends to utilize our existing ISA Advisory Council membership to serve on the ASO Advisory Council. This group has experience over the past five years of evaluating program data, informing policy decisions, and giving input on decisions around funding. Membership is currently comprised of six family members and advocates, Child Welfare District Manager, OYA Regional Supervisor, Director of Juvenile Justice, Executive Directors of ChristieCare and LifeWorks NW. There is a recently vacated seat for a representative from the education system, for which we are currently recruiting.

Demographically, Washington County includes a rich mixture of diversity, not only ethnically but also socio-economically. High tech industry with a highly educated workforce coexists with small family owned farms and orchards reminiscent of the County's agrarian roots. Our Advisory Council reflects this range by including parents of children with commercial as well as public health insurance, all of whom have been served in the ISA. In addition we have representation from the Latino community among our family members, which is our highest minority population in the County and in the ISA.

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Lynne Saxton

February 22, 2010

To Whom It May Concern:

ChristieCare supports the proposal of Washington County Mental Health to provide a comprehensive array of wraparound services and supports to an initial cohort of 60 pilot youth. We understand all direct treatment services will be subcontracted to qualified community mental health providers, like ChristieCare. We have served on the Advisory Council for Washington County for the past four years and value their professionalism, focus on outcome data, commitment to integrated services and family-driven child and family teams.

ChristieCare has been involved in this statewide initiative since its inception, providing financial analysis, market assessment, information technology and social marketing supports. It has been a privilege to work with policy leaders at the state and county level as well as national leaders in wraparound service delivery. Washington County will bring significant professional resources, and disciplined administration to this effort, advancing the initiative statewide through their efforts.

We are pleased to submit this Letter of Support for Washington County. Please do not hesitate to contact me if you have any questions. Thank you.

Sincerely,

Lynne Saxton

Lynne Saxton
Chief Executive Officer

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ACCREDITED: The Joint Commission
MEMBER: American Re-EDucation Association (AREA)

MEMORANDUM OF UNDERSTANDING

This Agreement between the Washington County Service District Area #16 of Department of Human Services-Child Welfare (DHS) and Washington County Health and Human Services-Mental Health (WCHHS) defines and clarifies the operating procedures, policies, and responsibilities of each agency in the management of children and adolescents in DHS custody with mental health disorders.

WCHHS and DHS recognize that we share responsibility for the well being of youth in DHS custody with mental health disorders. Only through communication, cooperation and commitment of all programs involved in the youth's care can we assure that all of the youth and families' needs are being met without duplication of service.

Guiding Principles

- The Child and Adolescent Service System Principles (CASSP) will guide the planning, management and delivery mental health services.

- The planning and delivery of mental health services to youth in DHS custody with emotional disorders will be individualized, collaborative, well coordinated, comprehensive and multi-systemic.

- To the extent allowable by our individual mandates, we will work to reduce duplicative or uncoordinated processes that can discourage and create barriers to families and youth in need of our services.

- When possible, DHS and WCHHS may pool funding to develop resources for children and families or provide comprehensive services for youth.

Communication and Coordination

To ensure close collaboration between DHS and WCHHS, regular avenues of communication are maintained and include:

1. The Children's Intensive Services Advisory Council
   This Council is contractually required by the WCHHS OHP Mental Health Organization (MHO) Agreement. The Advisory Council will meet quarterly at a minimum. The purpose of the Advisory Council is system oversight, planning and evaluation, identifying needs and establishing priorities, recommending system improvements, and providing a forum for advocacy.

The SDA #16 Manager or his/her designee will represent DHS in this Council. WCHHS will staff this meeting.

2. Children's Intensive Services Coordinating Committee
   This committee is also mandated by the WCHHS Oregon Health Plan (OHP) MHO Agreement and meets monthly.

   The purpose of the Coordinating Committee is to manage coordination issues between systems, joint planning and policy making, system monitoring and problem solving, identifying and committing existing and/or new resources, developing/revising working agreements and dispute resolution. DHS Program Managers from the Hillsboro and Beaverton/Tigard districts and the Children, Adults, and Families Program Analyst will attend the Coordinating Committee representing DHS. WCHHS will staff this meeting.

3. Alternate Care Committee
   This is a DHS/Oregon Youth Authority (OYA) committee that meets weekly to review children in the custody of these agencies referred for out-of-home placement for the treatment of behavioral issues.

   Representatives from DHS and OYA staff this meeting. A WCHHS Child and Adolescent Care Coordinator will represent WCHHS at this meeting.

4. Complex Case Consultation Committee
   The purpose of this committee is to provide a forum for clinical consultation, and case-specific problem solving for unsuccessful Plans of Care, complex cases with co-morbidities, or multi- problem youth and families. Child and Family Teams, DHS caseworkers and/or supervisors, or a representative from any other system involved in the youth's care may present a case at this meeting.

   This meeting will meet monthly at a minimum and ad hoc meetings may be convened as necessary. The Regional Resource Coordinator and DHS Supervisors from the Hillsboro and Beaverton/Tigard districts will represent DHS. WCHHS will staff this meeting.

5. Child and Family Team
   The WCHHS Care Coordinator will develop a Child and Family Team for each youth found eligible for the Intensive Service Array (ISA), unless an existing team has already been established. The Clinical Care Coordinator may become a member of an already existing team or expand an existing team.

   For youth in DHS custody, the assigned DHS caseworker will be a member of the Child and Family Team. The Child and Family Team will meet as often as necessary but no less than quarterly.

Responsibilities of DHS

The following describes the responsibilities of DHS for youth in their custody under this agreement:

DHS will be represented on the Children's Intensive Services Advisory Council, the Children's Intensive Services Coordinating Committee, the Complex Case Consultation Committee, and Child and Family Teams for youth in DHS custody

DHS will participate in the WCHHS quality improvement process, including QI committee participation.

DHS is responsible for protecting children in the community from abuse and neglect and assuming the obligations and duties of guardianship and legal custody when DHS assesses that youth are unable to remain in their current home.

DHS is responsible for locating and financing substitute homes for youth in DHS custody who require removal from their living situation due to protective service risks such as abuse, neglect, safety issues, caregiver incapacity or behavioral, conduct or substance use problems.

DHS is responsible for locating and financing service needs for youth with no covered OHP diagnosis.

If a child in DHS custody requires admission to a non-outpatient mental health treatment program, such as respite care, sub-acute care, inpatient care or residential care, DHS will work collaboratively with WCHHS to coordinate guardianship issues associated with admission and consent to treat.

Responsibilities of WCHHS

WCHHS is responsible for contracting with a panel of mental health treatment providers adequate to serve the mental health needs of OHP members and eligible uninsured youth who reside in Washington County. Criteria for uninsured youth are defined in Exhibit A.

WCHHS is responsible for managing a continuum of mental health treatment services including but not limited to outpatient, intensive community and home based services, respite, sub-acute, mental health day treatment, psychiatric residential treatment services and hospital care.

WCHHS is financially responsible for the provision of all authorized mental health treatment services within this continuum.

WCHHS is responsible for payment of psychiatric residential treatment services, respite, sub-acute and hospital care, when a youth is authorized by WCHHS for entry into the specified treatment program, as long as the level of treatment is medically necessary. Some costs of facility based care may be the responsibility of the youth's medical Fully Capitated Health Plan.

WCHHS is responsible for assessing that medically appropriate criteria are met for each level of mental health services on the continuum. Levels of Care criteria are defined further in Exhibit A.

WCHHS is responsible for authorizing admission and/or entry into all of the levels of mental health care on the continuum for which is receives capitation from the Office of Mental Health and Addiction Services (OMHAS).

WCHHS is responsible for assessing all children referred by their DHS caseworker for ISA eligibility determination in accordance with the procedures described later in this Agreement.

It is the responsibility of WCHHS to issue of Notice of Action and inform their OHP members of their due process rights any time a service or benefit will be terminated, suspended or reduced without agreement of the guardian; each time a request for service authorization is denied or limited; or a request for claim payment is denied in whole or in part. WCHHS will send this Notice to DHS when the action relates to a youth in DHS custody.

In no circumstances does WCHHS assume guardianship or custody or the responsibilities of these roles for any youth.

WCHHS is not responsible for locating or financing substitute homes for youth in DHS custody who have been removed from their living situation due to child protective service risks.

WCHHS will be responsible for collecting and analyzing data required by OMHAS for youth referred for ISA screening and level of care.

WCHHS will be responsible for quality improvement activities related to the Children's Mental Health Change Initiative and the ISA.

WCHHS will assist DHS to obtain mental health assessments for all youth referred into DHS custody within the mandatory 60-day time period.

In accordance with DHS's status as legal guardian for youth in their custody, WCHHS will provide DHS with documents in WCHHS's possession as requested by DHS.

Intensive Service Array (ISA)

The ISA is a range of service components that are coordinated, comprehensive, culturally competent, family-focused and child centered, and include intensive and individualized facility, home and community-based services for children and adolescents with severe mental or emotional disorders who meet criteria outlined in Exhibit A. Care is integrated in a way that ensures that youth and adolescents are served in the most natural environment and least restrictive possible.

Services in the ISA include but are not limited to WCHHS-based care coordination, psychiatric residential treatment services, day treatment, inpatient care, respite, therapeutic foster care, and intensive community based services, such as intensive wraparound and home based services. The intensity, frequency, blend, and venue in which the services take place are based on the mental health needs of the child.

The Child and Adolescent Service Intensity Instrument (CASII) will be used as a decision support tool but a CASII score of 19 or above is not the sole determiner of eligibility for the ISA. Eligibility criteria for ISA is further defined in Appendix A. Each level of the CASII describes a recommended array of services, programming options, and the type and intensity of services or resources, rather than a specific treatment intervention or program.

Procedure for ISA Eligibility Determination Assessment:

1. DHS caseworkers, in consultation with their Supervisors, may refer children and adolescents in their custody suspected of having a significant mental or emotional disorder to the WCHHS Child and Family Care Coordination Team for assessment to determine that youth's eligibility for ISA. Referrals may also be made through the DHS Alternate Care Committee.

2. When DHS refers a child in their custody for an ISA eligibility screening, the DHS caseworker is responsible for providing the WCHHS Care Coordinator with the youth's social and medical history, placement history, and any mental health assessments or psychological testing that may have been conducted if these documents are in possession of the DHS branch office.

3. The WCHHS Care Coordinator may request additional information such as school records and/or mental health treatment records to assist in making the eligibility determination. The WCHHS Care Coordinator is responsible for requesting and obtaining these records and any Releases of Information that might be required.

4. The Child and Adolescent and Adolescent Service Intensity Instrument (CASII) will be used as a decision support tool for children age 6 and over.

5. If the youth is new to DHS custody and/or the mental health system a face-to-face appointment may need to be scheduled with the youth and their family. This may be completed by a member of the WCHHS Care Coordination Team or a contracted mental health provider.

6. The WCHHS Care Coordinator will assess and make decisions regarding ISA eligibility and referrals to service within three (3) business days of the receipt of requested DHS documentation, other records that may have been requested, and/or appointments required to make an adequate assessment.

7. As a part of the eligibility assessment, the WCHHS Care Coordinator will evaluate whether the youth is in need of routine, urgent or emergency services. Services will provided within the response time frames outlined in the MHO Agreement:

   - Routine: no more than two calendar (2) weeks.
   - Urgent: 48 hours
   - Emergent: no more than 24 hours

8. Emergency situations are defined in the 2004-2005 Oregon Health Plan Mental Health Organization Agreement as "a mental health condition manifesting itself by acute symptoms of sufficient severity such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of the OHP member, (2) serious impairment of bodily function, or (3) serious dysfunction of any bodily organ or part".

   Urgent situations are defined as "a situation requiring attention within 48 hours to prevent a serious deterioration in an OHP member's mental health". (2004-2005 Oregon Health Plan Mental Health Organization Agreement).

9. The appropriate level of service will be provided within these time frames whether or not the Child and Family Team has been completely formed or convened or has completed the individualized Plan of Care.

10. When a determination has been made, the WCHHS Care Coordinator will communicate the decision to the DHS caseworker within 24 hours or no later than the next business day.

Intensive Service Array Plans of Care and Payment Decisions

A Plan of Care will be developed for all youth who are determined to be eligible for the Intensive Service Array by the WCHHS MHO. Each Plan of Care will serve to authorize services and will assign responsibilities for tasks and payment. Decisions of each Plan of Care will be made jointly by members of the Child and Family Team. Membership in the Team will always include both DHS and WCHHS for any family with DHS involvement, and is described fully below.

Plan of Care decisions will be aligned with medical appropriateness, safety, the youth's and family's needs, and will consider the family's wishes and strengths.

If the Plan of Care for an ISA eligible youth includes the provision of psychiatric residential treatment, inpatient care, sub-acute care, or respite care; it will be the responsibility of WCHHS to locate, coordinate referral, and finance these services. If the Plan of Care of an ISA eligible youth includes intensive community-based wraparound services, intensive outpatient services, day treatment services, or other outpatient services, WCHHS will be responsible to locate, coordinate referral, and finance these services while DHS will be responsible for locating, coordinating referral and financing any substitute care needed due to protective service risks.

Treatment Foster Care costs will be shared, as they are now, with DHS financing the cost of the substitute care and WCHHS financing all mental health treatment costs. Treatment Foster Care will not be considered for families with no protective service risks. There are no current plans to expand current Treatment Foster Care capacity in Washington County and any future planning for these services will be done collaboratively between Washington County and DHS.

Responsibility for the costs of flexible services included in the Plan of Care will be shared. DHS staff representatives to the Child and Family Team will have authority to commit DHS System of Care funds up to an identified limit. DHS will typically pay for flexible services that relate to the youth's global well-being or safety. WCHHS will typically pay for flexible services that relate to interventions directed at alleviating signs and symptoms of the covered diagnosis.

Training in System of Care, Strengths-Needs Assessment, and Wraparound for both DHS and WCHHS staff will be critical in insuring positive outcomes. DHS and WCHHS will collaborate in the planning, coordination and cost of training.

If safety risks prevent a youth in DHS custody from successfully participating in an outpatient mental health assessment to determine whether an eligible diagnosis exists and all other means of obtaining an assessment have been exhausted, WCHHS agrees to cover the cost of admission to a secure facility or other out-of-home placement for the amount of time needed to complete the assessment. DHS will work collaboratively with WCHHS to coordinate guardianship issues associated with admission and consent to treat.

If after the assessment is completed the youth is **not** found to have a mental health diagnosis covered by the OHP Prioritized List of Integrated Mental Health Conditions, or if it is determined that facility-based level of care is not medically necessary to treat the condition, WCHHS will no longer pay for the cost of the program. If DHS chooses to keep a youth under these circumstances in the facility or placement, DHS will assume responsibility for the cost once the mental health assessment is complete, including any time required to find an alternate placement. DHS will be responsible for locating this alternate placement.

Child and Family Team

Each youth found eligible for the ISA will be assigned a WCHHS Care Coordinator who will assist in the development of a Child and Family Team, develop an ongoing, supportive relationship with the family, monitor and coordinate services from multiple providers, and create linkages to and facilitate transitions between levels or care.

The child and family team consists at a minimum the youth, when appropriate, family members (parents, caregivers, or legal guardians), DHS staff for all families involved with DHS and the WCHHS Care Coordinator. Other team members can include involved public and private youth serving agencies, school personnel, and natural community supports identified by the family.

The team works collaboratively and shares responsibility for developing, implementing, monitoring and evaluating a single Plan of Care. This Plan of Care will include:

- A combination of existing or modified services, newly created services, informal, formal and natural supports, and community resources;
- Identification of the strengths/needs across life domains (family, home, safety, educational/vocational, behavioral/emotional, health, legal cultural, social/recreational, etc.);
- Short- and long-term goals;
- Formulation of a crisis/safety plan and transition criteria.

The youth's CASII score indicates the intensity of mental health services that are needed but not how or where the services are delivered or which services are required to meet this intensity level. The level of care agreed upon by the child and family team may be lower than that indicated by the CASII score, as long as a lower level is agreed upon by all members of the team and can provide for the safety of the youth and/or the safety of others. Together the team will come to agreement on the variety of services that will be implemented and the venue for treatment provision. The team may choose community based in-home services, day treatment, or different types of facility based care as long as those services are medically appropriate.

Crisis Response

When a youth or family in DHS custody is in crisis due to the youth's mental health diagnosis, the DHS caseworker or the family should call the Washington County Crisis Line at 503-291-9111 or the OHP Call Center at 503-291-1155. Master's level clinicians will then assess the crisis and recommend a course of action based on the acuity of the crisis. Recommendations may include but are not limited to the following: the mobile Crisis Team may be deployed to the home to attempt to stabilize the situation; the family may be directed to take the youth to the nearest Emergency Room to be evaluated for admission to a psychiatric unit; or respite or sub-acute services may be found to divert a hospital admission. If a youth is presenting an imminent danger to self or others, 911 should be called to send the local law enforcement agency to protect the youth and their family. Law enforcement also works with both the crisis call centers and the mobile Crisis Team.

All youth eligible for ISA services will have a crisis response plan developed, as part of the Plan of Care and this crisis plan will be forwarded to the appropriate crisis call center.

WCHHS Outpatient Levels of Care for Children and Families

WCHHS endeavors to develop a comprehensive, coordinated, community-based system of care for children and families which utilize available funding to serve the greatest number of eligible families with effective services whose type and intensity is matched to the individualized needs of the family. To this end, community-based service intensity is determined through a Level of Care Utilization System.

There are three Levels of Care within the outpatient system Brief Treatment/Recovery Maintenance; Outpatient Services, and Intensive Outpatient Services. These correspond to Levels 1 through 3 of the Child and Adolescent Service Intensity Instrument (CASII). WCHHS contracts with five mental health agencies to provide these three Levels of Care. Criteria for admission and service description are fully described in Exhibit A.

The three outpatient Levels of Care may be accessed directly. The DHS caseworker can call any of the contracted agencies on behalf of the youth to schedule an intake. The agency will assess the youth, conduct a CASII, and submit a request to a WCHHS Care Coordinator for either the appropriate Level of Care. The WCHHS Care Coordinator must authorize the Level of Care before treatment can continue. The request for one of these three Levels of Care must come from a mental health provider.

Case Management and Care Coordination

Outpatient

Case Management is included in the services WCHHS sub-contracts to its outpatient (CASII levels one through three) providers. Thus, coordination of care and communication for youth in these three treatment levels would primarily occur between the DHS caseworker and the outpatient therapist/case manager.

In the event of disagreement between the DHS caseworker and the outpatient provider, the DHS caseworker can file a complaint with the agency, a WCHHS Care Coordinator, Quality Improvement Coordinator, WCHHS Member Services, Access Triage, or another WCHHS administrator. WCHHS Care Coordinators are available to facilitate complaint resolution in the rare occurrence when a complaint cannot be resolved at the provider level. The WCHHS complaint policy is attached as Exhibit B.

ISA Levels of Care

WCHHS:

1. All children and adolescents eligible for ISA will be assigned a WCHHS Care Coordinator who will be responsible for coordinating with all of the various systems responsible for the care, treatment, and education of the youth throughout the youth's eligibility for ISA and during transition between levels of care.

2. The WCHHS Care Coordinator is not necessarily the primary contact for the family. The primary contact and/or facilitator for the Child and Family Team will be agreed upon by the members of that team.

3. The WCHHS Care Coordinator does not replace the DHS caseworker, therapist, probation officer or education representative involved in the child or adolescent's care. Each of these people are responsible for developing their system's part of the Plan of Care and other requirements of the system they represent.

4. The WCHHS Care Coordinator is responsible for assessing youth referred by DHS for ISA eligibly.

5. The WCHHS Care Coordinator has responsibility for coordinating and authorizing mental health services appropriate to the identified intensity level.

6. The WCHHS Care Coordinator is responsible for obtaining releases of information for all agencies providing services to the eligible youth.

7. The WCHHS is responsible for the formation of a Child and Family Team, unless there is a pre-existing Child and Family Team.

8. It is the responsibility of the WCHHS Care Coordinator to inform the DHS caseworker in a timely manner of the time and place of any Child and Family Team meetings for a youth in DHS custody.

9. The WCHHS Care Coordinator is responsible for documenting the Plan of Care developed in the Child and Family Team. This Plan of Care will incorporate the plans and responsibilities of all other systems involved in the youth's care. The plan of care does not replace each system's treatment or service plan. All members of the Child and Family Team will be provided with copies of the Plan of Care.

10. If the mental health services incorporated in the Plan of Care are at a lower level than indicated by the CASII score, the reasons determining the use of a lower service level and the agreement of the entire team will be documented by the WCHHS Care Coordinator.

11. The WCHHS Care Coordinator assigned to a youth in DHS custody or another WCHHS representative will make every effort to attend any DHS meetings pertaining to that youth, as requested by DHS. These should include, at a minimum, Family Decision meetings and/or team meetings focusing on the youth.

12. The WCHHS Care Coordinator will facilitate the transition of youth to a lower level of mental health care when the child or adolescent is no longer eligible for the ISA. The Care Coordinator will also assist in transitioning youth into the adult mental health system, when appropriate.

13. The WCHHS Care Coordinator will also assist in planning continuing mental health services if a youth loses eligibility for the Oregon Health Plan (OHP).

DHS

1. The DHS caseworker will continue to be responsible for the safety, protection and all other obligations and duties of guardianship for youth in DHS custody.

2. If the WCHHS Care Coordinator's attendance is requested at any DHS meetings (e.g. Family Decision meetings, Team meetings) it will be the DHS caseworker's responsibility to communicate the time and place these meetings.

3. The DHS caseworker retains primary responsibility for judicial proceedings involving the child/adolescent and their family and permanency decisions. A WCHHS Care Coordinator or Supervisor will make every effort attend judicial proceedings as requested by DHS. If a WCHHS Care Coordinator or representative does not attend, the DHS caseworker will inform WCHHS of any court orders pertaining to mental health treatment.

4. The DHS caseworker or their representative for a youth in DHS custody will make every effort to attend Child and Family Team meetings and any other meetings pertaining to that child as requested.

5. The DHS caseworker is responsible for assisting youth in DHS custody to find housing when the youth transitions to independent living.

Problem Resolution

Clinical and systems consultation is available to all members of the Child and Family Team at the Complex Case Consultation Committee and the Children's Intensive Services Coordinating Committee. This consultation may assist the Child and Family Team in coming to a common understanding and agreement as to how to proceed forward in meeting the goals of the Plan of Care.

It may happen that WCHHS and DHS disagree from time to time regarding the eligibility of a youth for a particular level of care, service provision and payment responsibility, plan of care, or other issues pertaining to the mental health treatment of a youth in DHS custody.

DHS and WCHHS have agreed to the following recommended procedures for the resolution of such disagreements before the initiation of the formal grievance and appeal procedure. However, nothing in the following procedures prohibits DHS initiating of a formal grievance or appeal at any time.

1. Level of Care

   If the DHS caseworker disagrees with the Level of Care authorized by the WCHHS Care Coordinator, contact should be made with that Care Coordinator and/or the System of Care Coordinator to discuss the rationale for the assigned level. The case will be reviewed by the System of Care Coordinator and the WCHHS Medical Director.

2. ISA Plan of Care

   Ideally, disagreement in Plans of Care should be resolved within the Child and Family team. When agreement on a Plan of Care or provision of treatment (e.g. out-of-home placement) cannot be reached within the Child and Family team, the team should seek consultation through the Complex Case Consultation Committee.

   If the dispute cannot be resolved after consultation, the WCHHS Care Coordinator or DHS Service Coordinator will present the case to the Children's Intensive Services Coordinating Committee..

In the event that the dispute cannot be settled by the Coordinating Committee, the member, the family, a member representative, or a DHS caseworker or supervisor may file a grievance with the WCHHS System of Care Coordinator.

3. DHS and WCHHS Responsibilities
   DHS and WCHHS may disagree on payment or case management responsibilities, which are defined in another part of this Agreement.
   If both parties are willing, the dispute will be discussed at the Children's Intensive Services Coordinating Committee or DHS may submit a grievance by following the procedures described below.

4. Quality of Clinical Care, Quality of Service, Consumer Rights, Interaction with MHO, Provider, or Staff.
   Complaints in the above domains should be submitted to the WCHHS Quality Improvement Coordinator.

Dispute Resolution and Grievance and Appeal Procedures

Any youth or their family, youth or family representative, provider, or DHS caseworker, representative or supervisor may file a grievance or appeal within 90 days from the date of the Notice of Action.

A grievance is the initial expression of a disagreement and request for resolution. An appeal requests a review of a previously made decision. Grievances and appeals may be submitted either orally or in writing. An oral appeal must be followed by a written document unless an expedited appeal is requested, and the case meets the criteria for an expedited appeal.

A youth is only entitled to an expedited appeal process if the mental status of the youth meets the definition of an emergent or urgent situation and the situation cannot wait to be addressed within the time frames associated within the regular appeal process. The youth, their family or representative, provider or DHS representative must indicate that the request is for an expedited appeal and explain why a decision is needed right away.

WCHHS must resolve each appeal and provide notice of the resolution of the appeal as expeditiously as the youth's mental health condition requires, not to exceed 45 days from the date WCHHS receives the appeal. An expedited appeal must be resolved and notification provided as expeditiously as the youth's mental health condition requires, not to exceed three (3) working days after WCHHS receives the request for an expedited appeal.

Notification will be provided to the youth and their family or representative, provider and DHS representative. For OHP members, notification to uphold a denial will be accompanied by information regarding Administrative Hearing Rights.

All appeals will be decided by persons not involved in the original eligibility determination. Any decision to uphold a denial of eligibility or treatment service must be approved by the WCHHS Medical Director.

If an appeal is regarding a decision to discontinue or limit previously authorized mental health treatment services currently being provided to the youth and/or their family, the youth and/or their family or representative, provider, or DHS representative may request that the treatment service or level of care that is the subject of the appeal continue until the appeal has been resolved. WCHHS must continue services if the appeal was filed in a timely manner, previous services were authorized, and the original authorization has not expired.

Sharing of Resources

WCHHS will fund mental health assessment and treatment services for youth eligible for ISA, when an OHP covered, DSM IV, non-substance use, diagnosis is the focus of the needed mental health treatment. That is, treatment is not directed primarily to resolve placement issues related to abuse, neglect or caregiver incapacity OR behavior, conduct or substance abuse problems.

To the extent possible, based on available funding, and allowable by our individual mandates, DHS and WCHHS may pool or share funding to create services or augment existing services which could serve the needs for both systems, even when cases do not overlap. This may be to develop resources in the community that do not currently exist or to supplement services on an individual case basis.

Agreement

The protocols for cooperation between the Department of Human Services-Child (DHS) Welfare and Washington County Health and Human Services-Mental Health (WCHHS) are in effect and will be the operating procedures between the two agencies. It is understood that the procedures and protocols DHS and WCHHS will continue as outlined above until modified by agreement.

WASHINGTON COUNTY
OREGON

February 22, 2010

To whom it may concern:

The Washington County Juvenile Department enthusiastically supports the efforts of the Washington County Mental Health Department in its efforts to pilot a demonstration site for the Statewide Children's Wraparound initiative.

The Mental Health Department has demonstrated time and again a commitment to quality service delivered efficaciously whether in its children's programs such as the ISA or its overall successful efforts with the Children's System Change Initiative in general; these examples have set the standard for collaborative problem solving and focus on youth mental health needs.

In my prior employment with the Oregon Youth Authority I had Administrative responsibility for NW Oregon as the Field Services Manager and without fail the Washington County Mental Health Department was responsive and creative in meeting the needs of our challenging population.

The Washington County Juvenile Department is equally committed to the project and supports the Washington County Mental Health Department in its application for the opportunity to pilot the Statewide Children's Wraparound initiative.

Sincerely,

Dennis Kenna, Director
Washington County Juvenile Department

Juvenile Department
222 North First Avenue, MS 47, Hillsboro, OR 97124-3000
Phone: (503) 846-8861 • Fax: (503) 846-8886

Oregon
Theodore R. Kulongoski, Governor

Department of Human Services
Washington County, District 16
Administration Office
Tigard Multi-Services Center
10777 SW Cascade Avenue
Tigard, OR 97223
(503) 598-3100
Fax (503) 598-7948

February 23, 2010

To Whom It May Concern:

I have had the opportunity to work closely with Washington County Mental Health (WCMH) for the last eight years, and have been very pleased with the highest level of collaboration and coordination between our agencies. Needless to say, our partnership with WCMH has been of tremendous benefit to the children and families we serve. I have found WCMH's approach to be one that puts the needs of the youth first and I continue to be impressed with how their staff maintains close contact and coordination with our DHS case workers.

As we have worked together on various initiatives, such as the Casey Project and the CANS Foster Payment System Pilot, I have seen the commitment of WCMH, and their contracted providers, to improving services and decreasing barriers to youth and families. I am confident that this level of system-wide collaboration will continue as we implement the Wraparound Pilot in our community.

On behalf of my DHS-District 16 staff, I am pleased and proud to support our community's application for the Statewide Children's Wraparound Initiative. I look forward to the many improved opportunities this initiative will bring to our community's youth by the further strengthening and enriching of our services.

Please contact me with any questions you may have at (503) 598-3101.

Sincerely,

Kevin Aguirre
District 16 Manager
DHS/CAF – Washington County

One Year Budget (10-11)						
Resources to serve 60 Pilot Youth in phase one	Funding Source					
	WCMH OHP	WCMH (MHS 22)	Local CAF	AMH Pilot	AMH	Other
4 FTE Care Coordinators	$ 51,160			$ 392,400		
1 FTE Team Support Specialist	$ 88,712					
1 FTE (2 staff) Family Partners	$ 70,000					
Program Coordinator (.2 FTE)	$ 15,246	$ 6,653				
Program Supervisor (.2 FTE)	$ 15,246	$ 6,653				
CAF CaseWorker 1 FTE (split among staff)			$ 98,100			
CAF Program Managers			$ 66,215			
CAF office space			$ 12,360			
Family Finding program				$ 30,000		$ 45,000
Treatment Foster Care at LifeWorks NW - 7 beds	$ 142,400		$ 118,188		$ 213,245	
Non-medicaid covered flexible services		$ 10,000				
Juvenile Department Staff on Review Committee						$ 1,200
Family Member Stipends for Review Committee	$ 1,200					
TOTAL	$ 383,964	$ 23,306	$ 294,863	$ 422,400	$ 213,245	$ 46,200

Of Washington County
18680 SW Shaw Street
Aloha, OR 97007
(503) 356-6835

February 16, 2010

To Whom It May Concern:

NAMI of Washington County wishes to express our support for Washington County Mental Health's application to be a Wraparound Pilot site. Given their strong commitment to work in partnership with provider agencies, advocacy groups, and families, we feel that they are well-positioned to take on such a project.

Washington County Mental Health has demonstrated that they value the family member by their willingness to partner with and offer support to family advocates as equal contributors in the Intensive Service Array Advisory Council. While developing the Family Partner program, Washington County worked with and were responsive to feedback from family advocates. Through collaborating with Washington County, NAMI has been able to develop youth programming such as a youth support group, a family support group, a family information evening, and Family Mentors.

When providing support to families in Intensive Services, we frequently hear positive feedback about the Care Coordinator's dedication to providing quality services and support of families. We have been able to establish a positive working relationship with the Care Coordinators improving the family support we offer.

We applaud Washington County Mental Health's collaborative approach to problem-solving in meeting the needs of children and families. NAMI looks forward to working with Washington County as they develop the program.

Sincerely,

Laura K O'Neill

Laura K. O'Neill
Executive Director
NAMI of Washington County