Statewide Children's
Wraparound Initiative

Subcommittee and Team Assignments to
Refine the Recommendations
August 29, 2007

Finance

Assignments

1. Refine recommendation on "market assessment" to address concerns about:
   - Need for fair and equitable compensation for providers.
   - Timing of agency and Governor's request budgets (process begins spring 2008).
   - Timing related to legislative decisions (January 2008).
   - Roll out of wraparound projects and the data needed from market assessment (Statewide? Pilots?).
   - Roll out should include the concept of "community readiness". And, community readiness should include financial participation from local communities. How will we define and determine this?

2. Of the committee's recommendations, what can be done immediately (either in total or steps toward accomplishing the recommendations)?

3. Define the specific steps necessary to get to blended funding (the "how" or "process" necessary).
   - Provide for audit safeguards.
   - Consider the possibilities of a private payor pool of funds.
   - Consider including a school-district pool of funds.
   - Please provide a diagram of how the process would work.

Recommendations

Project startup team:

Create project startup Implementation team – must include family members (10/31/07 deadline):

- Governor established budget and team, **or**
- Percentage taken from agency budgets to fund startup, **or**
- SAMHSA grant funding.

Project Team's Responsibilities:

1. Complete market assessment (2/14/08 deadline)
   - Population prevalence.
   - Percentage of target population in K-12 population.
   - Identify existing budget and populations serves as well as projected budgets and populations served, as much as is possible
   - Compare results of market assessment with current funding for these services to identify and quantify the gap.

2. Identify MIS/IT system for billing and outcomes tracking (5/26/08 deadline)

3. Using data from market assessment, calculate size of system contributions and overall size of blended funding pool, based upon size of population, prevalence of need, and cost to provide services in benefit package. (5/26/08 deadline)

4. Identify/resolve Medicaid Issues (11/20/08 deadline for identification; resolution plan developed within specific time period)
   - Roles of organizations.
   - Eligibility/access.
   - Desired services and outcomes.
   - Transition between services.

5. Develop a protocol and rationale for moving funds into the funding pool.

6. If there are critical barriers, propose any required legislative modifications and Oregon Administrative Rule (OAR) revisions if necessary.

7. Identify statewide strategies to encourage local investment.

8. Identify levels of community readiness, appropriate resource requirements and propose a phase-in schedule.

Project team should include mix of experts who possess:

- Experience developing systems of care, utilizing wraparound or similar approaches.
- Experience setting up and successfully initiating large projects (ultimate budgets in excess of $500 million).
- In-depth knowledge of Medicaid financing and the context for Medicaid in Oregon.

- Knowledge of payment systems and data systems (demographics, outcomes, outputs, reporting as needed to funding sources, and others as needed).
- Experience in working with diverse stakeholder groups.
- Knowledge of evidence-based services and service system development.

How the process will work

The following diagram describes the Steering Committee's recommended funding approach for the children served in the Statewide Children's Wraparound Initiative. At the top of the funding model is the State Funding or Purchasing Collaborative, made up of key state agencies including: Department of Human Services, Oregon Youth Authority, State Department of Education, Commission on Children and Families, Vocational Rehabilitation and Oregon Employment Department, who would allocate funding to a "blended pool" based on either an overall percentage of overall total expenditures for the target populations or some other methodology that would equitably allocate money.

Local education, juvenile justice and other local agencies would contribute funds to the pool to be used as matching funds to draw down additional federal monies. This would be accomplished using the Medicaid Rehabilitation Service option, New (1915i) Home and Community based Waiver Program or other yet to be determined federal source.

A Systems Administrator will oversee the various management responsibilities, includeing: allocation of funds to local systems of care that will ensure uniform standards of service provision; and development of a statewide information system for establishing audit safeguards and for monitoring program outcomes. This role could be performed by a designated state agency, contracted Administrative Services Organization (ASO), or a locally based administrative entity.

Finally, it is envisioned in the diagram on the next page that the actual service delivery be focused at the local level utilizing a wraparound approach and System of Care design. That design features a local Care Management Organization (CMO) employing care coordinators to facilitate coordinated care planning teams.

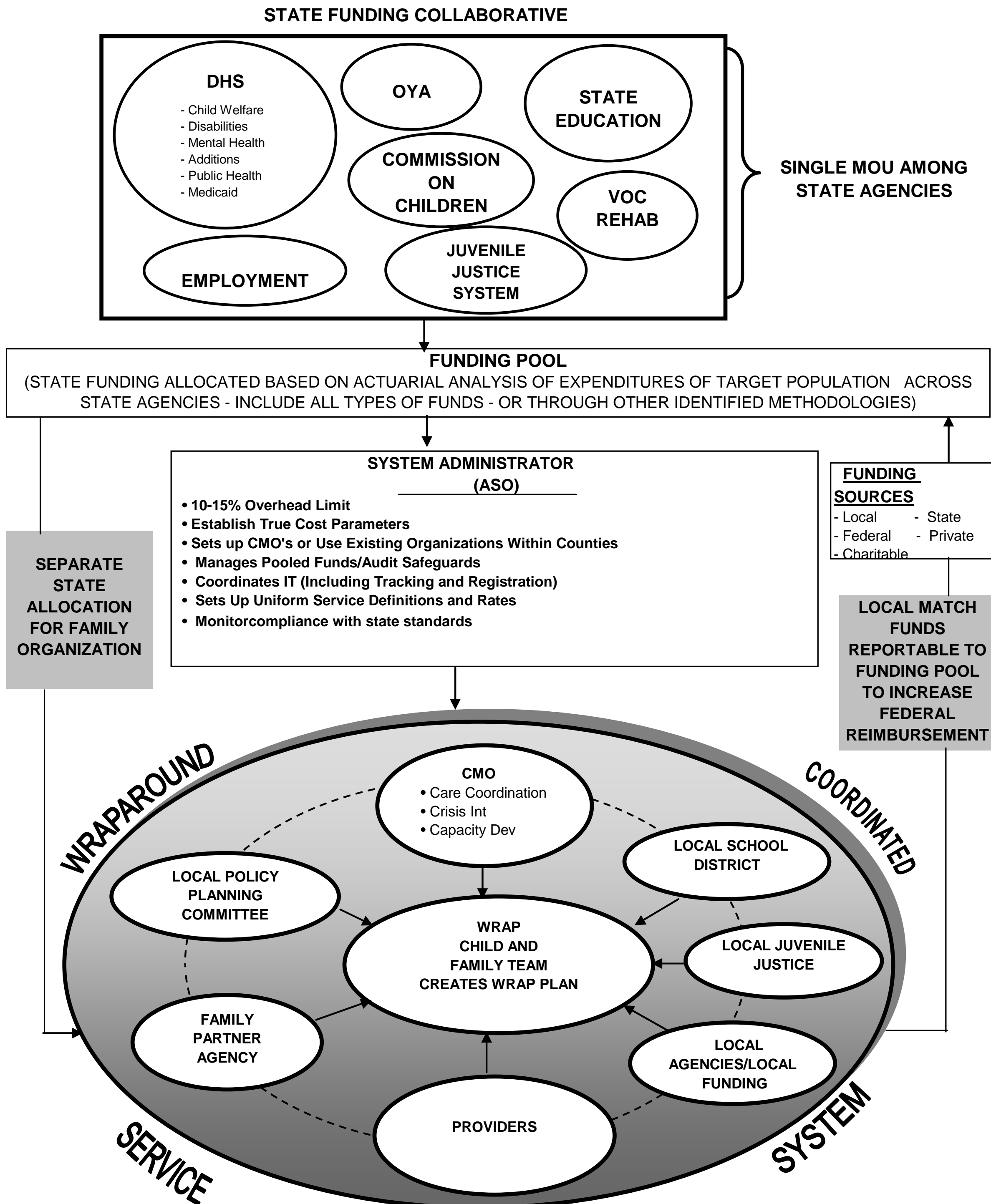
Those teams would be made up of families, local providers, child service agency, staff and informal family community supports, all working with a very flexible pool of monies. Pictured in the diagram, each community would also have a family partner agency to support and advocate for families and collaborate with the local CMO.

While there can be variations on the diagram, the Steering Committee is committed to the creation of a finance model that is flexible and accessible to families and consistent with the principals and values of Systems of Care.

Please see the diagram on the next page.

REVISION 4

OREGON'S STATEWIDE WRAPAROUND INITIATIVE FUNDING MODEL



Local Implementation

Assignments

1. Recommend a "benefit package" for statewide wraparound.
   - How is physical health included or linked?
   - What is the role/link of addictions?
   - What about triage and crisis prevention?
   - Should local communities be able to expand the benefit package in their communities?
   - If so, how would they do so?
   - What are the criteria for expansion of the basic package?

2. Please create a template for local execution of the model and benefit package (including planning, service coordination, etc.).
   - Consider creating options that communities could apply to their circumstance (e.g. urban, rural, sub-urban).
   - Provide for an increased presence and link to education.

3. Please diagram how you envision this looking at a local level (may need to include more than one option). Picture should begin with youth/family (not with service provider or state).

Recommendations

Benefit Package for Statewide Wraparound:

Eligibility	Universal access for all children in Target Population. Eligibility is based on behavioral health need and multi-system involvement, regardless of a child's eligibility for categorical benefit programs (e.g., Medicaid, Title IV-E, special education, etc.). Each local system is responsible to serve all children in target population, i.e., "no reject, no eject."
Benefit Plan	Comprehensive plan to include culturally-competent **behavioral health (which encompasses mental health and substance abuse) and non-traditional services**, including but not limited to: developmentally appropriate screenings, assessments (which can include mental health, developmental, adaptive and intellectual functioning, substance abuse and addiction, and behavioral risk factors); prevention/early intervention services; services provided by families and young people; outpatient therapies; family therapies; parent-child therapies; case management; mobile crisis response; intensive in-home services; behavioral aides; medication management; psychosocial education and training; mental health consultation; behavioral support for child care; treatment and other foster homes; culturally-specific services; treatment services for substance abuse and addiction; day treatment; residential treatment; sub-acute; in-patient hospitalization; and mentors, independent living;

	respite; tutors; job coaches; treatments designed for children and youth with externalizing behaviors (such as, delinquent behaviors, aggression, sexualized behavior and/or fire setting); transition services for older teens; and discretionary flex funds. **Supports specific to school success**, including but not limited to: early childhood behavioral supports, early childhood mental health consultation, behavioral aides, behavior specialists, school-based health services, school-based crisis response and management, behavioral support for extracurricular activities, other supported classroom services, special school placements and discretionary flex funds. ***Individualized services from the benefit package will be authorized based upon the coordinated services and support plan developed by a child and family team.***

Behavioral Health	**Psychiatric**	**Mentor**	**Respite**
• Crisis intervention • Day treatment • Family Assessment • Family preservation • Family therapy • Group therapy • Individual therapy • Parenting/family skills training • Substance abuse therapy, individual and group • Special therapy, i.e. sex offender treatment	• Assessment • Medication follow-up/psychiatric review • Nursing services	• Case aide • Clinical mentor • Education mentor • Life coach/independent living skills mentor • Parent and family mentor • Recreational/social mentor • Tutor • Community supervision	• Crisis respite (daily or hourly) • Planned respite (daily or hourly) • Residential respite
Service Coordination • Case management • Service coordination • Intensive case management	**Discretionary** • Activities • Automobile repair • Child care/supervision • Clothing • Education expenses • Furnishings/appliances • Housing (rent, security deposits) • Medication • Supplies/groceries • Utilities • Incentive money	**Other** Camp Team meeting Consultation with other professionals Transportation Interpretive services	**Supports** • Family Groups • Youth Groups • Peer to Peer Supports • Youth Leadership Development • Trainings • Advocacy • System navigation • Resources/ Directory

- Linkage to physical health occurs through outreach to primary care settings, 'no wrong door' approach to referrals. Mental health and addiction services staff will be encouraged to co-locate within Oregon Health Plan (OHP) primary care settings. Oregon Administrative Rules (OARs) will require medical charts to be inclusive of multiple service elements, including mental health and addiction services. Incentives will reward mental health and addiction services providers who are creative about inclusion across health settings. Single plans of care will incorporate children's health needs and strengths into the overall plan.
- Addiction services provided and contracted for by Health Maintenance Organizations (HMOs), will be incentivized to work closely with mental health organizations. Those organizations with dual certified providers (A&D and Mental Health) will be incentivized. Family organizations will be encouraged to participate in peer-to-peer and self-help processes, including the ability to bill for such services.
- Triage and Crisis Prevention will be a service provided at the local level. Entities that can demonstrate inclusion within HMOs and that provide services throughout emergency departments at local hospitals will be rewarded through a series of incentives, including a percentage advantage in rate structure. Child and Family Teams work closely with families and children to identify crisis "triggers" and plan for preventing and handling crises when they occur.
- Local communities may expand the benefit package to suit their local needs by: (1) raising additional resources through local contributions of general fund dollars. Funds could come from education, juvenile justice, business and philanthropy. These dollars may be blended at the state level and leveraged with federal dollars and then returned to be used locally. (2) Tailor benefits to "fit" the needs of their families through using existing resources and through in-kind contributions of community assets.
- Criteria for expansion of the basic package:
    1. Access to local general fund dollars.
    2. Memorandum of Understanding from local contributors to participate, inclusive of acceptance of the Oregon System of Care Values and Principals.
    3. Adherence to the spirit of the Governor's Executive Order.
    4. Expanded ability to serve populations meeting the eligibility guidelines.

Template for Local Execution of model and benefit package, inclusive of urban, suburban, frontier and rural settings:

Elements to be assessed:

- Leadership
- Staffing
- Meeting time and place
- Stakeholder involvement (families, youth, local governmental leadership, child serving agencies, volunteer groups, faith based groups, philanthropy, business, etc)
- Ability to form work groups and committees
- Ability to communicate and disseminate information
- Outreach to broad community, inclusive of dominant and non-dominant cultures
- Linkage to Statewide Initiative efforts
- Resources—both human and fiscal (e.g. in-kind and dollars)

Minimum standard regarding local funding (inclusive of dollars and in-kind):
Local standards for receiving state funding will have to be met for participation. The Local Implementation Committee has developed a number of criteria to be met in terms of governance structure and administrative structure. The criteria are inclusive of elements such as: minimum size (one county), authority to create local policy, community assets, partnerships, diverse membership with families, child-serving agencies, business, philanthropy, faith/culture communities, government leadership, etc. Communities need to demonstrate nimble decision-making, capacity for financial/policy/data management, relationships with state entities, ability to make budgetary decisions under the purview of agents contributing to the blended pool

The state could set a minimal standard such as the federal government does that requires a 1:4 match for years one and two and increases incrementally, inclusive of in-kind dollars. This does involve a lot of administrative tracking to submit information but meets *the pay to play philosophy.*

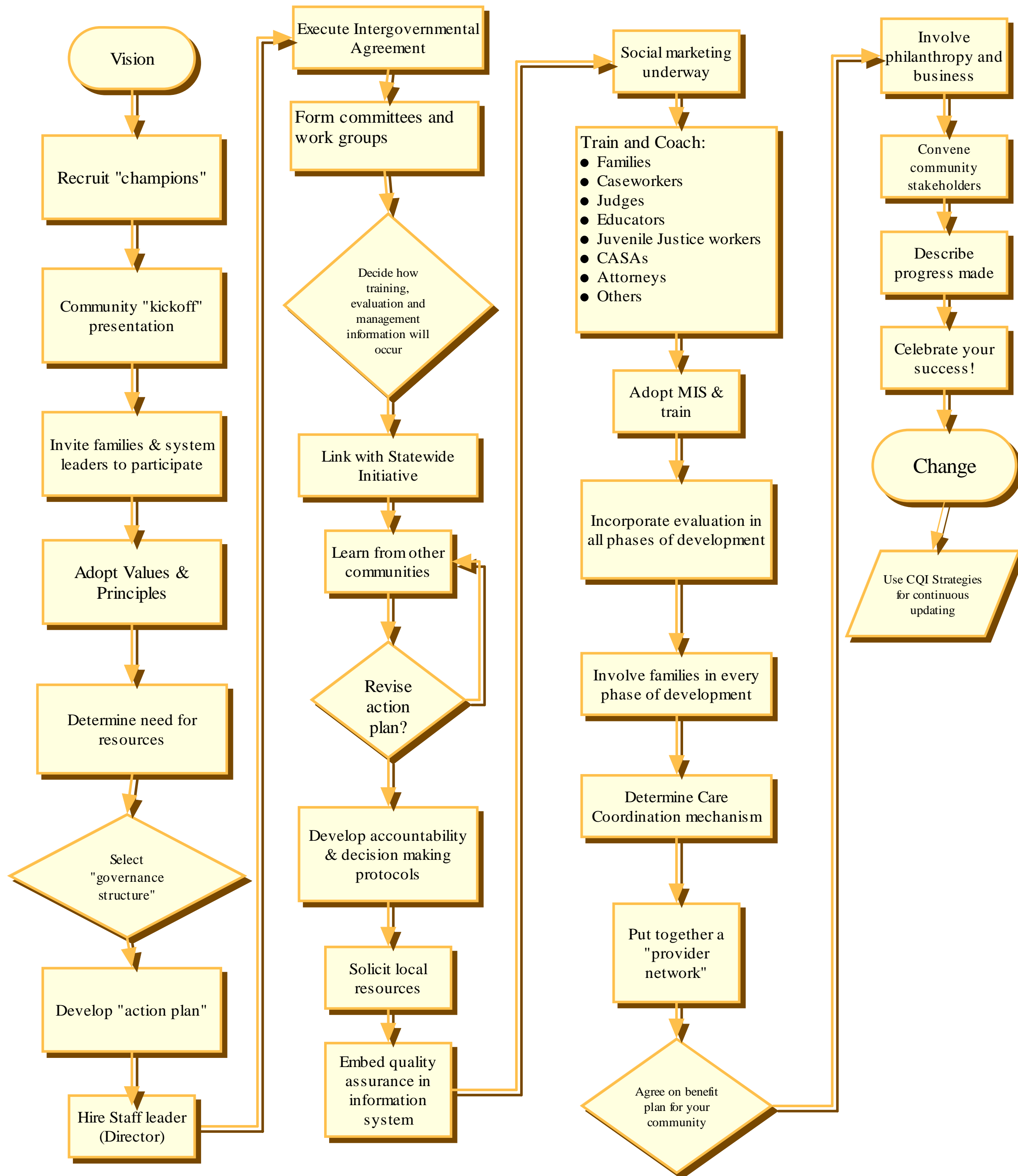
Recommendations for incentivizing local participation:
Local participation is incentivized by access to the state blended funds. We need to also provide administrative costs that will realistically allow the development of the structures to support the governance and local implementation.

Suggestion: if the local community achieves the top 25 percent in meeting outcomes, then they can receive a percentage increase in dollars for following for a program development year. This could be increased further if communities meet the top 10 percent in achievement of outcomes. A report card can be created that provides this information quarterly and annually as well as the dollars received for incentives across communities.

The above elements are inclusive of local school districts, early childhood education settings with outreach and sponsorship by superintendents, special education directors and local school boards. Three successful local initiatives will be integrated into the final report, both with visual and narrative descriptions.

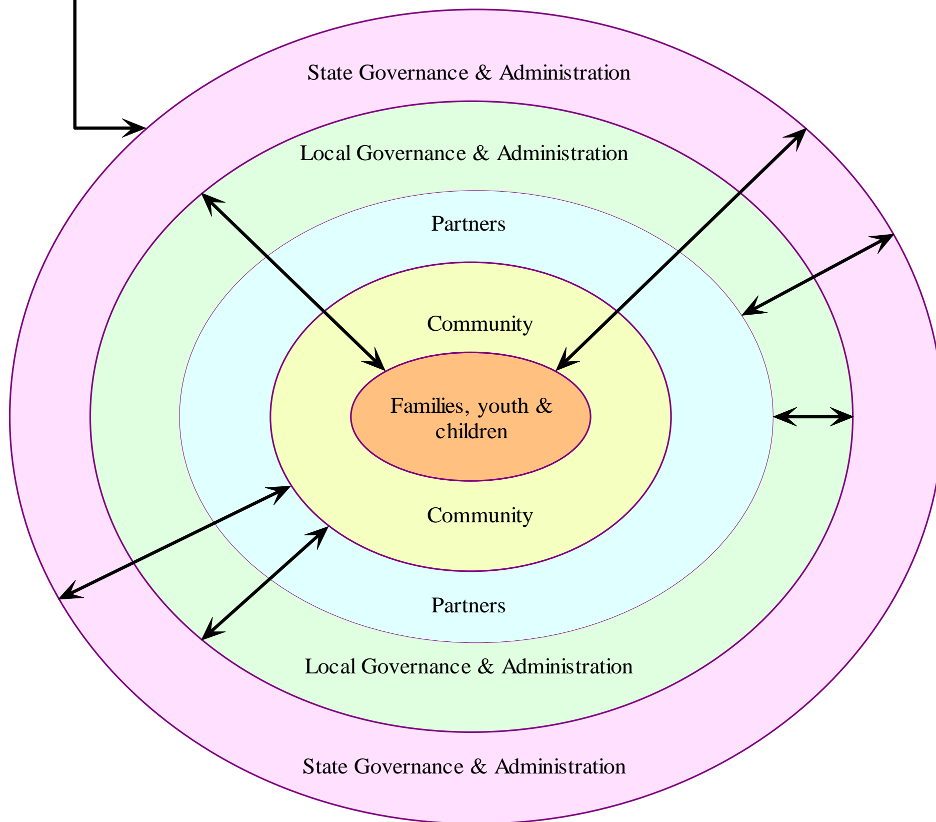
Please see the diagram on the next page for a “map” of local implementation steps.

Tips on Local SOC Implementation 8-20-07



Local level diagram:

Statewide Children's Wraparound Initiative
Local Implementation Committee
Local Level Design
REVISED August 20,2007 - 2



Families: Advocacy/support groups; peer supports & services; system navigators; resource development; membership services; workforce training for family, youth and professionals; outreach, prevention and education; membership on local and state committees; social marketing

Community: Formal and informal resources such as business, friends, faith-based organizaitons, recreation, housing, etc.

Partners: Services and supports for families, youth and children including: schools, colleges, mental health providers, addiction services, child welfare supports, early childhood resources, health and public health, juvenile justice, etc.

Local Governance & Administration: Administration of state/local funding; authorize and account for funding; real-time payment system/contracts; workforce training; IS/data management; local outcomes tracking and reporting; CARE COORDINATION -- facilitate wraparound process; support family teams, rapid access/authorize funds.: Local service delivery systems; building collaboratives; social marketing; policy and bylaws; quality and outcome oversight; local resource development.

State Governance & Administration: Administration of funding (blended); administration of benefits; service array; provider certification/contracts/ RFPs; state IS development/maintenance; outcomes tracking and reporting; electronic medical record (web-based); workforce training; social marketing. Resource/requirements development; oversight of systems development; quality and outcome oversight; system integration -- OAR, ORS, waiver submission.

Cultural Competency

Assignment

Members will "embed" themselves in other committees to ensure the cultural competency standards are reflected in recommendations coming forward.

Data and Evaluation

Assignments

1. Provide a plan to develop the shared data system, including how (not what) the following could be accomplished:
   - Should information technology be centralized?
   - Define what should be in and out of the "electronic record."
   - Address any HIPPA concerns
   - How should system infrastructure be funded?

2. Provide a diagram of how the shared data system would look and function at and between state and local levels.

3. Identify top level of outcomes to be shared by state and local agencies.
   - Include how agencies would be jointly accountability for outcomes.
   - Include a diagram of how the joint accountability would work.

Recommendations

Centralized IT, electronic records, and funding:
The subcommittee does not recommend that all data be maintained in a centralized MIS system. Instead, the subcommittee recommends a two-tiered data system (see diagram below):

First, at the local level, the local entities implementing the project would maintain "real time" data systems. The electronic records contained in these local data systems would include information that enables the local entity to:

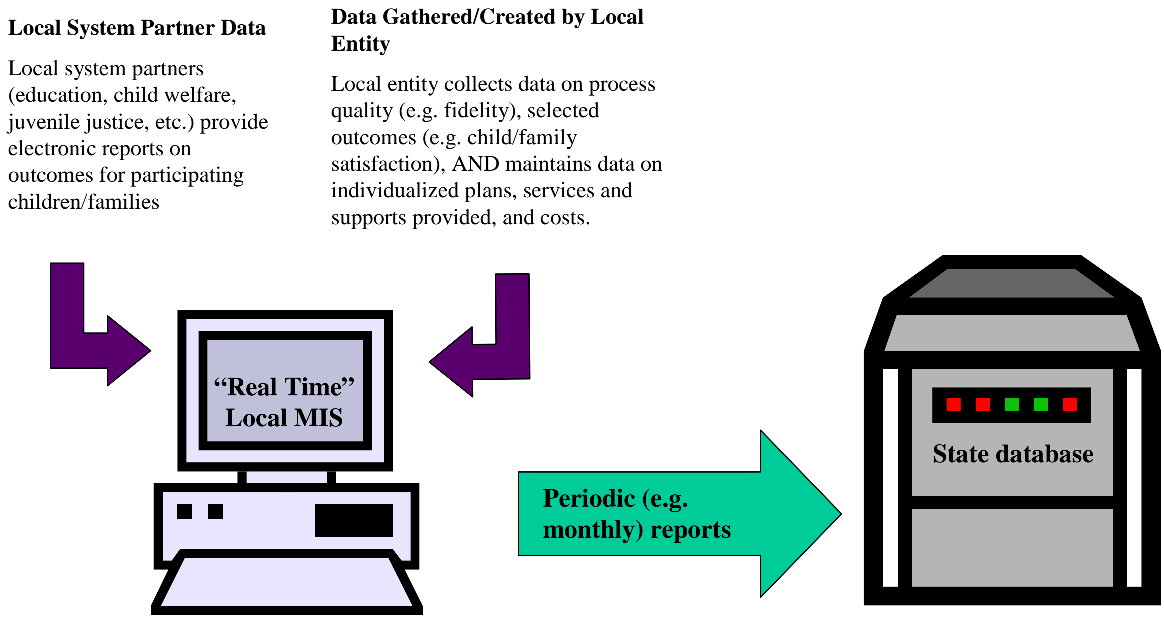
- Track family/youth outcome and process data in real time and coordinate with local-level system partners to receive relevant data (e.g. get data on safety from child welfare; education data, juvenile justice data, etc.).
- Track services and supports included in the plan and when/whether they are provided.
- Track costs and do billing.
- Report key cost/utilization and outcome data to the state as required.
- Meet federal reporting requirements.

Second, the state would maintain a database to receive summary or abstracted data from the local MIS systems, including data on costs, utilization, child/family outcomes, and process outcomes. This would not be a "real time" system and would be primarily used for evaluating the quality and success of both local implementation and the project as a whole.

To plan the specifics of how the local and centralized MIS systems would be developed, the subcommittee recommends convening a committee of MIS/data system experts from the collaborating public and local agencies to work out the details. This would happen only after the outcome selection and review committee had selected specific outcomes to be measured. This committee would also provide information on the costs of maintaining the centralized database.

HIPPA concerns:
The subcommittee recommends that, once the MIS committee described above has described the proposed local and state MIS systems, the lead state agency, with support from collaborating agencies at the state level, will seek legal consultation from the state and will seek guidance from the relevant federal agencies in developing releases and data sharing agreements that can be used across the state to ensure that the data sharing process is legal and that it protects the rights of children and families.

How the shared data system will look and function at and between state and local levels:



"Real time" local MIS exists in each community and is similar to what Wraparound Milwaukee or Dawn currently uses.

•Contains data that allow teams and local agencies to track plans and progress. Electronic records

- •hold individualized plans
- •Include child/family outcome data (including data from local system partners AND gathered by the local entity), process quality data, utilization
- •Allow tracking of billing and costs of services/supports provided

State Database is not real time and is intended primarily for evaluation purposes.

•Receives and aggregates data from periodic reports from each local entity implementing the project

•Holds data gathered by the lead state agency on local system readiness and local system development

Top level of outcomes:

Service level – child/youth and family: The outcome selection committee will choose key indicators in the following areas according to the criteria laid out by the subcommittee in recommendation #1:

1. **Educational/vocational progress** (i.e. measures that indicate child/youth is attending/engaged at school and progressing toward educational and/or vocational goals).
2. **Stable, home-like environment** (i.e. need is to assess whether project is realizing the goal of decreasing disruptions in placement (and those disruptions that do occur are related to child needs rather than other considerations) moving youth/children toward a permanent situation, community living and most home-like environment feasible).
3. **Safety** (Child/youth and family feel safe and do not experience abuse, neglect, trauma, etc.)
4. **Out of trouble** (i.e. child/youth does not have or reduces delinquent behavior)
5. **Social/Interpersonal support:** (Child/youth and family have positive and healthy attachments to each other and in the community; child/youth and family have the opportunity to engage in positive social/recreational activities)
6. **Mental/behavioral health**: (Mental health/Substance use outcome measures)
7. **Needs met**: Individualized needs as identified in the care/treatment planning process are met to at least a satisfactory level

Process level: The committee will choose process quality indicators including measures of planning process fidelity, child/family satisfaction, and cost/ financial/ utilization indicators such as:

1. Child/youth placements and services reflect needs not other considerations (eg kids placed in foster care to access services; kids stay in residential because there is no local foster home or inadequate community services to support the child in the community).
2. Services/supports received and costs, length of delay, time in services.
3. Cost per child per day; reduced rate of use of more restrictive placements.
4. Length of time in program.
5. Availability of array of services—i.e. minimum array is available; wait time is tracked.
6. Utilization of natural supports and individualized services/supports as identified in plans.

Accountability for outcomes:

Accountability for outcomes does not seem to be within the purview of the data and evaluation subcommittee. Of course, agencies should be accountable for providing necessary data. In other successful wraparound programs, the local entity that implements the project is often accountable for outcomes. But this is usually when they are provided a capitated (and possibly tiered) case rate and assume risk. How accountability works depends ultimately on the financing model that is developed and the local implementation model, particularly on how risk is distributed.

Project Team

Assignments

1. Recommend/clarify local/state accountability structure, addressing the following issues:
   - Governance for the shared system

- Administration of the shared system
- A defined role for family/youth and an accountability mechanism for that role
- Opportunities to consolidate or build on existing governance/administrative structures

2. Provide a diagram of the structure (state and local).

3. Develop a specific recommendation that honors SB 267 mandate for agencies/funding and the need for culturally validated approaches

Recommendations

Clarify a role for family/youth and an accountability mechanism for that role:

The State Steering Committee has articulated a value that: *"The system of care should be child guided and family driven, with the needs of the child and family dictating the types and mix of services provided."*

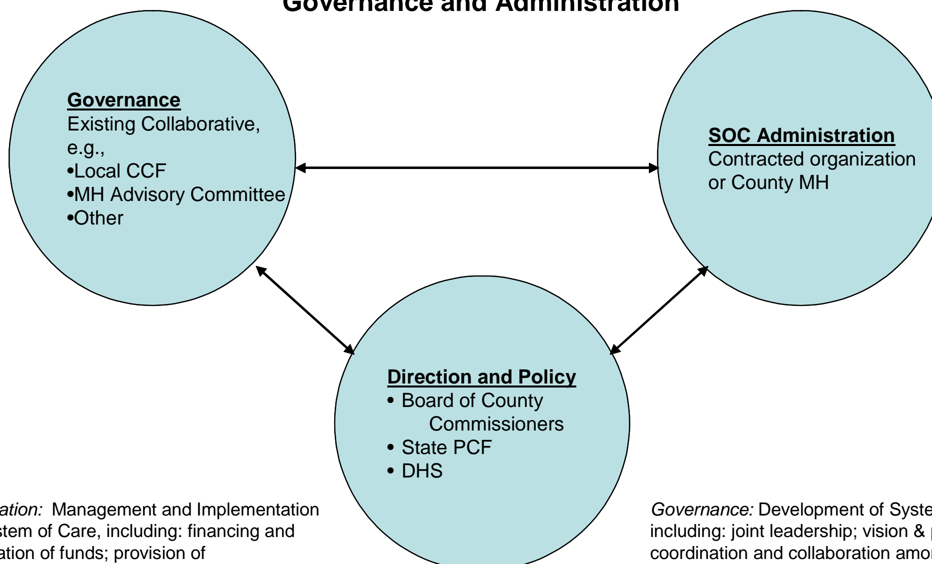
Putting this value into operation means that family members are involved in the planning, delivery and evaluation of their child's care. As such, family members should be included and supported in participating in these activities (including education, training and assistance as necessary). Families and family organizations should also be held to the same standards and accountability mechanisms as others who plan, deliver and evaluate services to children in the System of Care.

Diagram of the state/local structure:

System of Care Governance and Administration

Local Level

Governance and Administration



Administration: Management and Implementation of the System of Care, including: financing and administration of funds; provision of services/benefits; accountability for service and system performance measures; professional development and education; utilization of electronic records; implementation of IS systems; care coordination; and family involvement.

Governance: Development of System of Care, including: joint leadership; vision & policy setting; coordination and collaboration among partners; quality and outcome oversight; continuous learning; resource development & growth; and system marketing.

Recommendation that honors SB 267 mandate for agencies funding and the need for culturally validated approaches:

State agencies should revise definitions of "evidence based" under SB 267 to include the following components (or similar):

- "Evidence based" recognizes that many aspects of care depend on individual factors, such as cultural formation (DSM-IV, 2000; 0-3 Criteria) quality and value of life judgments, which are only partially subject to scientific methods. Using the evidence base means identifying the parts of care that are subject to scientific methods and applying them in combination with individual factors to ensure the best prediction of desired outcomes.
- Make available skills-based training on effective culturally and linguistically competent approaches to policy development, program management, service provision.
- Evaluate culturally and linguistically competent approaches for organizing, managing and delivering services to determine their efficacy.
- Compile information on promising ethnic-specific practices and encourage funded programs to adapt strategies for use.