2018

Oregon's Child, Youth & Family Continuum of Care

A SYSTEM IN CRISIS – PROPOSED SYSTEMIC SOLUTIONS

March 6, 2018

In DRAFT for Partner/Stakeholder Revisions

Oregon Health Authority

DHS Oregon Department of Human Services

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OREGON'S CHILD, YOUTH & FAMILY CONTINUUM OF CARE

A System in Crisis – Proposed Systemic Solutions

March 6, 2018

EXECUTIVE SUMMARY

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Problem Statement

Oregon's children's system is in crisis and is failing to serve children, youth and families who are involved with multiple systems and have complex needs. State agencies and service systems are disconnected, siloed and do not collectively manage the continuum of care. This has resulted in a system within which children and youth languish in inappropriate settings such as emergency departments and institutions, providers and caregivers do not feel supported therefore are not retained within the system and child, youth and family safety and health needs are not met.

Goal Statement

Oregon will meet the safety and health needs of children and youth who are involved with multiple systems and who have complex needs. Through infrastructure, Oregon will collectively ensure care coordination and access to appropriate levels of care and safe placements, at the right time and for the appropriate duration.

Proposal Objective

The objective is to explore potential solutions to address current system issues and Oregon's unintended failure in meeting the needs of children and youth impacted by multiple systems who have complex needs.

Identified Population of Focus

Children and youth ages 0-21, impacted by two or more systems and have complex needs which require intensive services and supports and are at risk for or require out of home placements.

Primary Recommendations

1. **Ensure sustainable capacity that meets the needs of children and youth involved with multiple systems.** In sustaining Oregon's commitment to serving families within their communities, ensure services and safe placements are available to meet child and youth needs in the right place, at the right time and for the appropriate duration.

2. **Establish executive leadership support of the System of Care infrastructure** through the development of an empowered State System of Care Steering Committee (charged with policy analysis and direction focused on multi-system involved youth and their families) and an executive level Children's Leadership Council.

3. **Implement improvements within the behavioral health system** to ensure the complex needs of children and youth involved with multiple systems are met. Ensure state policies and funding empower the service system to offer high quality community-based intensive services.

4. **Become Trauma Informed state agencies** by collectively adopting trauma informed care policies and ensuring state agency leadership and employees have access to training and consultation.

Anticipated Next Steps

- OHA and DHS Leadership will determine proposed solutions which align with strategic priorities and approve those concepts to be moved forward to stakeholders for feedback and meaningful engagement.

- OHA and DHS will organize the collection of stakeholder feedback by engaging families, state agencies, local System of Care governance structures, advisories, providers, associations etc. in meaningful conversation to ensure agreement and collective commitment to system improvements and reform.

- OHA and DHS will work to align efforts with the work being done within the Youth with Specialized Needs Workgroup (Governor's office, legislative, judicial, state agency and provider membership).

BACKGROUND

This proposal is the collective work of the Oregon Health Authority (OHA) - Health Systems Division and the Department of Human Services (DHS) Child Welfare and Developmental Disability Services (DDS) programs with the goal of partnering together to consider identified systemic barriers and propose a range of potential solutions which may be expected to address issues experienced across Oregon's child and youth continuum of care. Barriers and systemic issues of consideration are those which have led to cross system capacity decline and a failure to appropriately serve multi-system involved, intensive needs children and youth.

This effort originated from the project work of the DHS Unified Child and Youth Safety Implementation Plan - Continuum of Care Project, the project will now ensure equal partnership with and participation of OHA. The project is being sponsored by OHA Director Pat Allen and DHS Director Fariborz Pakseresht. The two agencies are committed to the development of a goal statement and proposed solutions to ensure a collective approach to system improvements.

DHS and OHA have distinct **roles and responsibilities** which are important to define -

DHS provides services for at risk and high needs populations including children, youth and families involved with Child Welfare (guardianship and service provision) and those eligible for Intellectual and Developmental (I/DD) services.

- Child Welfare has primary responsibility for child safety and response to abuse. The services which child welfare may provide are focused on child safety, permanency, well-being and safe placements. Child Welfare does build some types of services, including placements (congregate care and foster care), but is not responsible to develop mental or physical health services or placements. However, DHS does accept responsibility for ensuring youth receive needed services.

- Oregon Developmental Disabilities Services (ODDS) and works with County-run Community Developmental Disabilities Programs (CDDPs) to determine eligibility and provide case management for children who meet specific eligibility criteria. The DD system supports individuals across the life span, birth to death, rather than for a limited duration of service delivery. ODDS is not a placement agency and does not have children and youth in its custody.

- Additionally, DHS – Oregon Adult Abuse Prevention and Investigation (OAPPI) oversees the following areas for children services:
  - Licensing of Child Caring Agencies (CCAs) is a responsibility within DHS. These include (name the settings). Licensing activities include site and desk auditing, technical assistance, on-going oversight……

- Investigations of alleged or suspected abuse, including neglect in licensed CCAs is also a DHS responsibility.

OHA's primary purpose is to help people and communities achieve optimum physical, mental and social well-being. Many of its programs serve children, youth and their families, such as:

- The Oregon Health Plan (OHP) program which children and youth in Child Welfare custody are eligible. OHA is the state's Medicaid authority.
- OHA certifies programs to provide clinical services, including psychiatric residential and day treatment, OHA also certifies and grants funds to the 31 Community Mental Health Programs. OHA also awards Letters of Approval endorsing to program providing addictions treatment.
- Public Health programs
- Integrated health care delivery (physical, behavioral and dental health)
- Contracting and oversite of the 15 Coordinated Care Organizations (CCO)

The children, youth and families at the center of this proposal are those with co-occurring and complex needs who interface with multiple systems. Children and youth who are involved with Child Welfare, I/DD, Oregon Youth Authority, Juvenile Justice, special education and/or major medical services commonly engage with two or more of these systems at any time. We know that while placements and services available to this population continue to decline, there is a systemic and complex crisis occurring causing us to fall short on our commitment to partners, caregivers and most importantly Oregon families. While there continues to be lack of consensus on what the solutions are, all agree that what we are doing is not working.

Nationally, up to 80 percent of children in foster care have significant mental health issues. Additionally, children who qualify for I/DD services often have co-occurring mental health needs. The prevalence of psychiatric disorders among children and youth with intellectual disability is estimated to be between 30-50% (Einfeld, et. al, 2011). Families describe barriers to appropriate assessments, medical evaluations or treatment, while public agencies or providers state their children have the "wrong "diagnosis or the wrong IQ (either too high or too low) or they have the "wrong" insurance.

Einfeld, S. L., Ellis, L. A., Emerson, E. (2011). Comorbidity of intellectual disability and mental disorder in children and adolescents: A systematic review. J Intellect Dev Disabilities, 36 (2), 137-43.

Fragmented services commonly result in multiple coordinators and separate plans in each system (Georgetown Effective Strategies Checklist, 2014). We know when children and youth with serious mental health needs receive coordinated and appropriate services, their functioning substantially improves. Oregon needs an integrated system of care to meet the critical health and safety needs of multi-system involved children and youth. The infrastructure is siloed and structured in such a way that limits us in delivering care and ensuring access.

Historical assumptions suggest Oregon is required to be structured by its federal funding. Oregon must overcome barriers presented by our disparate mandates and funding requirements to better serve our youth and families. With new leadership in place and a shared commitment to system improvement, Oregon has an opportunity to make significant gains both within service delivery and cross system coordination by implementing creative and innovative solutions as well as embarking on broad system change for children, youth and families.

Below are four categories of recommendations for consideration. The concepts vary in that there are short term fixes expected to enhance the service delivery system and capacity, while others are macro system change proposals which would need further project work, would require research and consultation from experts and would be longer term ventures.

The categories are, Create Sustainable Capacity, System of Care Infrastructure, Behavioral Health Enhancements, and Become Trauma Informed State Agencies.

PRIMARY RECOMMENDATIONS

1. Create Sustainable Capacity

This section outlines creative ideas to ensure system-wide and appropriate capacity is maintained over time. This includes the service array managed by Oregon Health Authority/CCOs, I/DD and Child Welfare.

Oregon needs a collective state agency commitment to fund programming across multiple jurisdictions and state agencies to end hoteling and to return children and youth (who are placed out of state) to Oregon. This will require an adequate and collective approach to funding appropriate services. Most youth without placements are youth with intensive needs, who struggle to a detriment in existing services and placements and are involved with multiple systems.

For over three years, state agencies, providers, CCOs, stakeholders and others have grappled with the question of capacity and whether more residential beds are needed. Little action has been taken due to the lack of agreement and fear that increasing the number of residential

beds will move our system away from our values which include serving children and youth in their communities. Current state data systems do not have the capability of measuring required capacity and cannot look at youth involvement across systems. While long term and preventive solutions are critical, children and youth who are in crisis and who are in temporary placements cannot continue to wait.

As of March 6th, 2018:

- Child Welfare has 18 children and youth in hotels due to lack of placements across the continuum.
- Child Welfare has 15 children and youth in hotel diversion programs, which are not long term strategies for serving youth.
- Child Welfare has 50 children and youth placed in residential programs in other states as Oregon does not have safe and appropriate placements for them.
- Child Welfare has 11 additional children and youth on referral lists for out of state placements.

Capacity Declines:

Since 2015, Oregon's Psychiatric Residential Treatment Services (PRTS) capacity has decreased by at least **67** beds. This equates to a 50% loss of the PRTS capacity in Oregon which has disappeared in the last two and a half years with no capacity recovered or added.

- The closure of Youth Villages PRTS in 2016 resulted in the loss of **35** beds.
- The closure of Looking Glass PRTS resulted in the loss of **12** beds in 2016.
- Through restructuring, Trillium Family Services reduced capacity by **20** beds.
- The remaining capacity in the PRTS system is around **70** (not counting Jasper Mountain Residential since they primarily serve out of state kids – **90** if you count them).

Additional Capacity Loss:

- Oregon entered its current foster care crisis with estimated 2016/2017 reports of a loss of 400 caregivers.
- In 2014 the I/DD system discontinued its use of proctor care which reduced placements by 60.
- In 2015 and 2016 there was a Behavioral Rehabilitative Services (BRS) decline of approximately 100 placements within both therapeutic foster care and residential settings.

Safe and Appropriate Placements

The following concepts are in line with discussions occurring within the Youth with Specialized Needs Workgroup convened by the Governor's Office and Legislators. **The Governor's office has requested cost estimates for the following concepts.**

1. Regional Crisis Assessment Centers –
   These centers are expected to largely address hoteling, kids placed out of state and inappropriate use of BRS levels of care. The recommendation is for four crisis centers. These programs would:
   - Become the high end of the continuum (after hospitals).
   - Potentially be a partnership with hospitals.
   - Include Psychiatry, physical health services, nursing and line staff in line with subacute staffing models
   - Have short lengths of stay, average of 30 days
   - Provide intensive assessment, evaluation, and stabilization.
   - Identify and secure all resources for youth to move into appropriate levels of care, or return to community with a comprehensive care plan.

   Funding:
   - Medicaid and private insurance will cover much of the service costs
   - Would require a GF offset for operations assuming the program doesn't operate at 100% capacity always.
   - Requires funding for "sticks and bricks," start up, and ongoing operations.

2. Receiving Centers-
   These centers are specific to children and youth who are coming into Child Welfare care and custody for the first time. A decade ago in Multnomah County this model was known as the Children's Receiving Center. The program folded due to funding issues even though it had good outcomes and met an enormous need within the Child Welfare continuum. The receiving centers would:
   - Conduct comprehensive assessment
   - Maintain youth in current school settings
   - Provide time to ensure the child is placed in a foster home or other placement that meets the child's needs.
   - Reduces number of placements overall by reducing crisis decisions

   Funding:
   - Requires funding for "stick and bricks," start up and ongoing operations
   - Medicaid and private insurance won't cover this
   - Funded with GF and local partnerships

   This model is recommended for the metro area to meet the immediate needs described above. For rural and frontier areas, a receiving center could potentially be provided in a smaller home-based setting.

In addition to the immediate needs described above, the following are longer term solutions to create sustainability and improvements across the system long term.

Create System Improvement and Expansion

Addressing the capacity crisis alone will not create a sustainable system. New approaches are needed to improve service delivery.

Approach legislature to use a "caseload growth" model to fund new programs and innovations (currently used by OHA to meet needs of civil commitment population in the community). This could be managed by OHA and DHS jointly and awarded to CCOs (possibly CMHPs and providers) to develop new programming, invest in workforce recruitment and retention, adopt new services, build facilities, etc. in response to the growing need for intensive behavioral health services. A grant process would allow DHS and OHA to review and approve funding, target specific programs and populations, and ensure funding is being used in a manner consistent with other statewide efforts.

Managed Care Approaches to Serving Youth in State Custody

Due to the complex needs of youth in Child Welfare custody and guardianship, other states have created managed care strategies to ensure focus on specific outcomes and ensure quality services. The recommendation is for OHA and DHS to explore and invite creative ideas, within the CCO model, for providing care coordination and integrated health care for state custody youth. Other states with managed care health systems have implemented strategies and administrative functions to deliver health care to youth in state custody given the populations complex and individualized needs. Examples from other states include:

- Contract with one statewide entity to manage all children and youth in state custody (Child Welfare and Oregon Youth Authority)
- Create incentives for desired outcomes in meeting the complex health needs of youth in foster care
- Fund prevention services for children and youth in foster care and those at risk of out of home placements

Stabilize Placements

DHS and OHA could develop creative funding strategies through a payment structure that flexes the general fund contribution with the Medicaid contribution based on a youth's individualized needs. As an individual's behavioral health (psychiatric) acuity decreases, the Medicaid contribution decreases. As the need for safety and security increases, the general fund contribution increases. This model ensures that CCOs are only responsible for reimbursing medically appropriate services, while DHS and OHA pay for services that will stabilize a youth's placement until they are truly ready to transition out of the program (home or to a different placement) and no longer meet medical necessity criteria.

Allow providers to render different "levels of care" within the same facility. Currently, Trillium Family Services provides subacute and PRTS to the same child in the same facility. They simply

adjust the type, intensity, and frequency of services to differentiate the levels of care. This allows a youth to remain with the same treatment provider during their treatment experience. DHS and OHA could explore using this model for all facility-based care (including BRS). Reducing the number of placements for a youth reduces trauma and therefore improving outcomes.

Service Array for Co-Occurring Needs

Oregon does not adequately meet the service needs of children and youth with co-occurring I/DD and behavioral health needs. Currently, behavioral health benefits are managed through medical necessity criteria which do not allow for modifications to meet the needs of youth with I/DD. Recommended service delivery enhancement for children and youth with I/DD are:

- Increased intensive services to meet behavioral health needs of youth who qualify for I/DD services.
- Require providers to hold a National Association of the Dually Diagnosed (NADD) certification requirement. This would ensure expertise in co-occurring service delivery.
- Equivalent to Secure Children's Inpatient Program (SCIP) and Secure Adolescent Inpatient Program (SAIP) services modified to meet the needs if I/DD youth
- Payment mechanism for behavioral health treatment, evidence based practices that are delivered on a timeline appropriate for I/DD youth (appropriate reimbursement). Appropriate durations of service are not currently reimbursed.
- Investment in Train the Trainer model for the State of Oregon on mental health treatment for children and youth with I/DD.
- On-going OHA and DHS sponsorship and support for the Mental Health/IDD annual Summit and maturing of existing learning communities.

2. System of Care Infrastructure

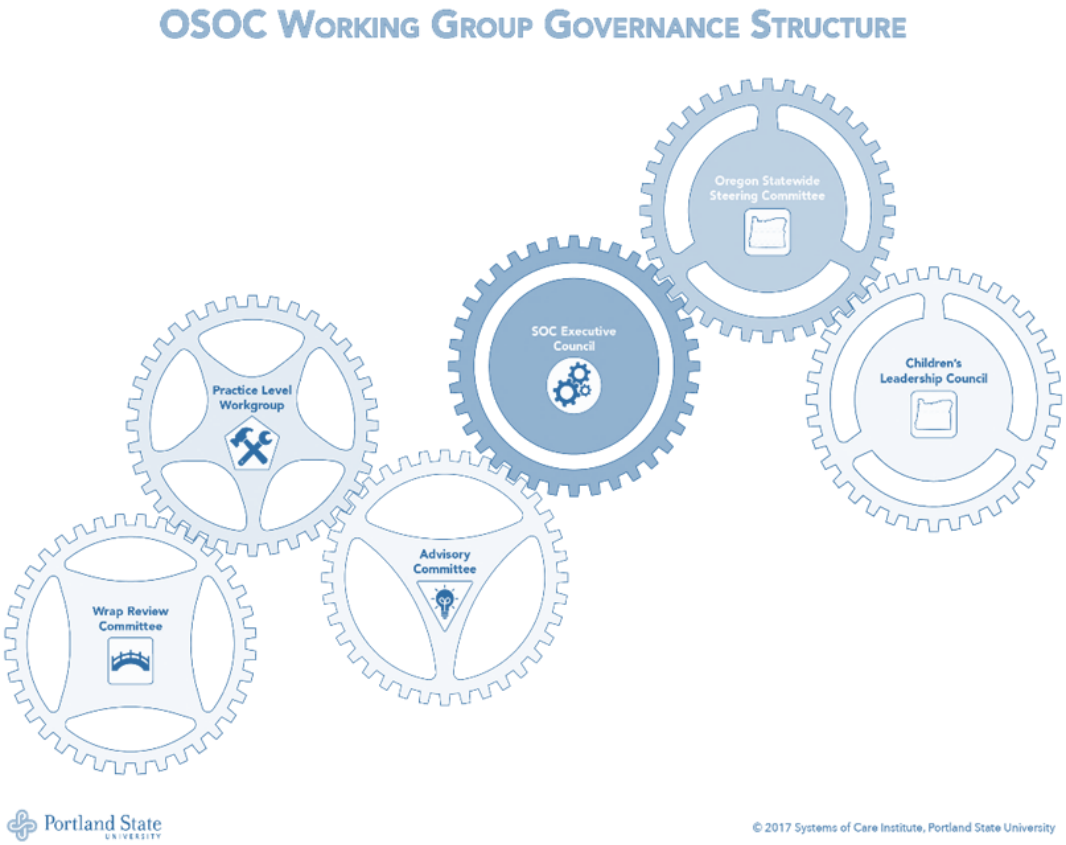
A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, to help them to function better at home, in school, in the community and throughout life.

System of Care Governance

The already-existing System of Care (SOC) governance infrastructure was launched in 2014 and continues to mature and develop. OHA contractually requires Coordinated Care Organizations (CCOs) to have local SOC structures in place and these have been developed and maintained with consultation from Portland State University's (PSU) System of Care Institute. The Institute is funded jointly, through an interagency agreement between DHS – Child Welfare, OHA and PSU.

While local governance structures are in varying stages of development and maturing, state agencies have not had success in creating state level governance to support local efforts and respond to needs. While state agencies are convening and slowly developing, successful implementation will require the following:

- State structure to include an Executive Children's Council to include: Directors of OHA, DHS, ODE, OYA. Executive Leadership would be provided with metrics on a regular basis to make informed decisions about system interventions, resource requests that come from the local SOC infrastructure, and strategic investments to address gaps in the continuum of care.
- Executive leadership empowerment of the current System of Care governance structure is required by setting an expectation across OHA and DHS child serving programs and working with other state agency leadership to create buy-in and equal accountability
    - Empower State SOC Steering Committee. This group to be charged with;
        - Responding to local SOC governance barriers and needs
        - Communicating state efforts to the local SOC governance groups
            - Report up to the Executive Children's Council regarding legislative needs, funding barriers, etc.
            - To include child serving state agency management, providers, youth, family, stakeholders, etc.
    - Fund the State System of Care Steering committee with existing GF (consider policy option package for legislative session, see below) from each child serving state agency for multi-agency needs and development of shared services and supports. This will reflect values and principles to the local governance structure.
- System of Care training for state agency leadership (Directors and Managers) provided by the PSU System of Care Institute (currently contracted) and program subject matter experts.
- Clarify Advisory Council (CSAC, CWAC, CSAG, SACSE, etc.) roles and responsibilities as they relate to the broader System of Care Governance structure. Utilize the advisory bodies to address single system issues and ask that they report multi-system needs to the System of Care State Steering Committee.



POTENTIAL POLICY OPTION PACKAGE:

Request funding for the State System of Care Steering Committee to utilize in investing in multi system, state wide improvements. No one agency would hold the funding but would be managed by the collective membership. Current Governor's office and legislative focus on multi-agency or whole system solutions and approaches to address issues present an opportunity.

In addition, OHA and DHS are recommended to consider whether the responsibility for upholding local SOC infrastructure is best to remain with the CCOs. While some CCOs have had success, and have implemented SOC principles and values, many governance structures across the state remain heavily weighted by CCO direction and authority. The goal of local governance structures is to ensure equal voice across child serving systems to best meet the needs of multi system involved children and families.

Remove Systemic Barriers

In 2011, legislature developed OHA which removed health care programs from DHS. This change was necessary to successfully implement healthcare transformation and oversee the CCO model for health care delivery. Having OHA manage health programs such as OHP, CCOs, Public Health and others has been beneficial, however many children's system experts may argue, that by moving children's behavioral health to OHA it further siloed the children's system separating programs that serve complex needs youth. The anecdotal experience and system-wide discussion continues to be that the children's system seems to have become more divided over recent years. Child serving systems and providers express greater frustration than ever regarding the reality in navigating systems and frustration while working to meet the needs of children and families.

Oregon needs to develop strategies to reduce the burden of child serving state agency siloes which cause funding, policy and access barriers. There are several strategies worthy of consideration which may enable state agencies to come together to better serve this population:

1. Develop an administrative structure for oversight of services and coordination for children, youth and families who are involved with multiple systems and who have complex needs related to health and safety. Child and youth serving agencies need to establish and honor shared priorities, shared responsibilities and shared desired outcomes. This might be operationalized within a joint program/unit made up of Child Welfare, Behavioral Health and I/DD professionals focused on meeting the needs of this population through funding and policy. Recommendation would be to create this team by repurposing unfilled FTE, one from each agency.
2. Further develop and mature the System of Care governance infrastructure as proposed above.
3. Consider a macro approach to structural system reform by bringing child and youth serving programs together to reduce cross system complexities. The Casey Family Programs has offered to connect OHA/DHS with system change architects in states that have adapted state government structures and implemented system of care models to better serve children and youth across service systems. The recommendation is to explore whether Oregon would benefit from expansive state government structural changes to increase alignment.

Create a Data Informed System

Currently Oregon's data systems enable and contribute to non-coordinated approaches to service delivery. When children and youth are involved in two or more systems, there is no current way to track intersections or cross system involvement. This results in lack of outcome data, redundancy, lack of coordination, disconnected service delivery, duplication of efforts and

unneeded expense. The recommendation is to create a shared data system which would allow state agencies to:

- Use data to drive services
- Document cost benefits
- Develop and track outcome metrics
- Provide ongoing feedback for quality improvement
- Sustain funding support
- Analyze costs and service utilization
- Track satisfaction of youth and families

Some of the above goals can be met through completion and executive sponsorship of a current project. OHA began a data system project in 2014 to collect data across the behavioral health intensive services array. The goal is to purchase eCANS, an external vendor data solution, which analyzes outcomes from the Child and Adolescent Needs and Strengths (CANS) screening tool. Several factors have delayed the project leaving the children's behavioral health system without a mechanism for monitoring outcomes. The CANS is used statewide within Child Welfare (foster care rate setting), mental health and for Wraparound intensive care coordination. Recommendations for implementation success include:

- Executive Director led prioritization of eCANS procurement and implementation with removal of barriers due to DAS and OIS policy and procedure, using project management.
- Consideration for use of CANS and eCANS (does not require changes to existing data systems) as a shared, cross system data and reporting solution and universal care planning tool for youth involved in multiple systems to assist in identifying and meeting needs.
- Analysis of the system impact of Child Welfare use of CANs for foster care rate setting with consideration of modifying policies and procedures. This would entail exploration of other states who utilize CANS within child welfare service delivery however do not reimburse foster care solely based on CANS outcomes alone. Consider best practice recommendations from the Praed Foundation (CANS developer). Praed offers free consultation for statewide and comprehensive implementation.

Develop State Level Blended Funding Strategies

This would be the work of the State System of Care Steering Committee as described prior in this section. The membership of the committee consists of all child and youth serving state agencies. Each agency would contribute general fund dollars which the steering body would then collectively invest in local systems of care creative and innovative solutions for delivering care to children and youth who are multi-system involved with complex needs. In addition, the committee would develop and propose strategies for local blending of funds which might require policy change or creative funding streams.

3. Behavioral Health Enhancements

This section describes short range potential enhancements to the child and youth behavioral health system. Many of these items were present prior to the CCO implementation and need to be reintroduced within the CCO structure. Others are enhancements expected to increase the quality of programs and service delivery.

Behavioral Health Intensive In-Home & Community Based Services

Prior to the implementation of health systems transformation, and the creation of the Coordinated Care Organizations (CCOs), OHA contracted with Mental Health Organizations (MHOs) to manage the Medicaid benefit for individuals on the Oregon Health Plan (OHP). Along with the community-based structure, Oregon Health Authority supported a center of excellence model, where best practices were funded, explored, or cascaded out to the communities. This initiative, along with the central structure and supports, successfully decreased the heavy reliance on long term residential programs by creating intensive community based treatment services as an alternative. The capacity for Psychiatric Residential Treatment Services (PRTS) was greatly reduced, length of stay was reduced, and less restrictive community based alternatives were introduced and incentivized. Very few children were sent out of state for behavioral health services.

The state is experiencing large scale negative impacts in behavioral health capacity overall causing a compression of the entire system. This impacts all children and families with cross-system needs. The state needs to support a sustainable forum to discuss system barriers, successes, or best or promising practices on a regular basis.

The goal has always been to allow the local flexibility to address local communities. One recommendation for OHA is to be more specific in its contracts with CCOs regarding the types of services that need to be offered to members. For example, there is nothing in the current CCO contracts that would require a CCO to provide “Intensive Outpatient Services”, “In Home supports”, “mobile crisis services”, “crisis respite” or “Partial Hospitalization.” While some CCOs are utilizing the flexibility allowed within their contracts to reimburse for these services, not all CCOs have embraced these approaches. OHA would need to evaluate its State Medicaid Plan, Oregon Administrative Rules, regulatory structures, and contracts to implement this change. OHA might also explore updating its rules and update its fee schedules for the Fee-For-Service (Open Card) population.

Recommendations –
Amend the state plan to add Intensive Outpatient Services and Supports (IOSS). Specifically, intensive in-home services with 24/7 crisis support and access to mental health and Psychiatric services This allows OHA to define this level of care, set standards and pay for the services in both FFS and CCO structure.

1. Create FFS rate structure for intensive outpatient services, intensive in home and therapeutic/treatment foster care
2. Require a specific array of services to be provided as a baseline within the CCO service array

CCO Roles, Responsibilities, Accountability, Contracting and Oversight

Recommendations:

- Recognition by CCOs and state agencies of foster youth and youth with specialized needs being a prioritized population for the state of Oregon and strategize operationalizing this across CCOs.
- OHA increase oversight of CCO contract as it pertains to care coordination and children's mental health service delivery.
- Participation from providers, CCOs and stakeholders to develop language for the 2020 CCO contract specific to children's mental health, the system of care and serving children and youth who are involved with multiple system and who have complex needs.
- OHA and DHS to work collaboratively to document a shared understanding of the contract expectations for CCOs regarding the children's continuum of care. This document should be developed with meaningful input from key stakeholders including but not limited to CCOs, CMHPs, and providers, youth and families. Once this guidance document is completed, all CCOs, CMHPs, and providers should receive training on the expectations. OHA and DHS should review CCO performance based on this document collaboratively, and on an ongoing basis.

4. Become Trauma Informed State Agencies

A Trauma Informed System realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in client's families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices and seeks to actively resist re-traumatization. (SAMHSA's Concept of Trauma and guidance for a Trauma-Informed Approach, 2014 http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf)

Statewide Trauma Informed Care Policy

OHA currently has a trauma informed care policy. The recommendation is for each child serving state agency to create a trauma informed care policy or to consider a collective state agency policy and approach to creating trauma informed state agencies and therefore policy development and program development.

Training, Technical Assistance and Consultation

Trauma Informed Oregon (TIO) is a statewide collaborative aimed at preventing and lessoning the impact of adverse experiences on children, adults and families. TIO works in partnership to promote and sustain trauma informed policies and practices across physical and behavioral health systems and to disseminate promising strategies to support wellness and resilience.

OHA funds TIO now. DHS, OYA and ODE would become equal partners and ensure training and support across all state child serving state agencies. Recommend leadership, Directors and Program Managers to be trained together in Trauma Informed Care and agency approaches to implementation.

SUMMARY

Oregon is experiencing system paralysis within its children's service system. Several assessments, program closures, loss of foster parents, overwhelmed emergency rooms, frustrated providers, audits, use of hotels as placement, sending children out of state prove our system is broken and yet we have not come together to create and implement solutions.

The crisis is not a 2018 crisis. The severe downturn began in 2015 and now in 2018 we are at the breaking point. While other states in this situation have had forced system change through legislation or class action law suits, DHS and OHA children's system experts want to correct the system for children and families, not in response to a mandate. What is different in 2018 is professionals, advocates, legislators, stakeholders and many others have come to an agreement that something must be done and it needs to happen now.

We would like to acknowledge that this proposal does not address all needs across the continuum of care which include but are not limited to, prevention of children entering systems, consideration of protective factors, supporting and serving families early to ensure success, prenatal and early childhood programs, substance use disorders and treatment, early learning, trauma informed approaches to build resiliency in youth, the need for true integrated health care delivery, work force development, the lack of child Psychiatrists state wide and so many other needs we know contribute to or could alleviate children and youth becoming involved with multiple systems.

DHS and OHA know it is necessary to begin somewhere to end the system paralysis. We value a holistic approach to serving children and youth and believe that we all, government and community, share responsibility for this population. As state agencies, we want to and are committed to doing better. We hope these recommendations will assist in moving us forward and anticipate the opportunity to work with children, youth, families, state agencies, providers, caregivers, CCOs and other stakeholders to ensure we make improvements through transparency and shared commitment.

PARTNER REVISION LOG

Entity/Partner	Date of Engagement	Revision Request Description	Date Revision Completed
Coordinated Care Organization CEOs	March 15, 2018		
Oregon Youth Authority			
Oregon Department of Education			
Youth with Specialized Needs Work Group			
State System of Care Steering Committee			
Local/regional System of Care Executive Councils			
AOCMHP			
Children's System Advisory Council CSAC (BH)			
Child Welfare Advisory Council CWAC			
Children's System Advisory Group CSAG (DD)			