Oregon's Statewide Children's Wraparound Initiative

STEERING COMMITTEE REPORT TO GOVERNOR TED KULONGOSKI

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Statewide Children's Wraparound Initiative Steering Committee

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- Columbia River WrapAround, funded by SAMHSA
- CareOregon, a managed care health plan

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Executive summary

"Long ago, I wrote an essay for our school's PTA newsletter as a way to focus my feelings about my little boy's struggles at school. He is now 16 years old, and as I look back on my thoughts at the time, I cannot help but notice that what our family needed then is not so dissimilar to what we still need nearly 10 years later. I have great hope and expectation that Oregon's concept of 'wraparound' will provide what splintered education and mental health systems have failed to deliver."

~An Oregon mother

Caring for children with complex physical and mental health needs

Oregon's state and local agencies, public and private organizations, care providers, advocates and many others have worked tirelessly for years to provide the services and supports needed by children with developmental and behavioral disorders. While these efforts have had some success, progress has been hindered by the "splintered" delivery systems mentioned above. Services historically have been provided independently by an array of specialized providers, rather than as part of an integrated and holistic approach. This has resulted in occasional duplication of services as well as gaps in service delivery, particularly for children and youth with the most complex needs and multiple diagnoses.

ACTION

In recognition that Oregon must develop a better way to deliver services that more effectively help children and families who have complex needs, Oregon Governor Ted Kulongoski signed an executive order March 27, 2007, to transform how behavioral health services are delivered to Oregon's children, youth and their families. The order created the Statewide Children's Wraparound Steering Committee, and charged the Committee to create a plan that would:

- Provide services and supports as early as possible so that children can be successful in their homes, schools and communities;
- Make services available based on the individual needs of the child and family, rather than on system requirements; and
- Maximize the resources available to serve children and families across systems, to most appropriately and effectively meet the physical and mental health needs of Oregon's children.

TARGET POPULATION

The wraparound initiative is designed to reach children and youth from birth to age 18 who have emotional, behavioral or substance abuse related needs, and who touch at least two systems. This population includes children and youth who are at risk of developing problems, as well as those who already have a diagnosed problem.

CORE VALUES

The Steering Committee developed a list of recommendations built upon a framework of values and principles for Oregon's system of care and for culturally

appropriate service delivery. The core values adopted by the Steering Committee to guide development of the recommendations were:

- The goal of Oregon's system of care is a community of support for each child and family that honors the family's sense of its own culture.
- The system of care will be child guided and family driven, with the needs of the child and family driving the types and mix of services provided.
- The system of care will be community based, with the focus of services and supports as well as management and decision-making responsibility resting at the community level.
- The system of care will ensure individuals are treated respectfully, compassionately and effectively in a manner that recognizes, affirms and values the worth of children, individuals, families and communities – protecting and preserving the dignity of each.

Recommendations

OVERALL INITIATIVE

- Serve all children in the target population.
- Generate family-driven and youth-guided individual plans developed through a high-quality wraparound process.
- Include culturally competent mental health, substance abuse and non-traditional services in the benefit plan.
- Blend funds at the state and local levels for target population services.
- Monitor outcomes and provide accountability through local real-time, Web-based, electronic records that inform the larger statewide system about certain key indicators.

FINANCING

- Develop a statewide purchasing collaborative to create a mechanism to pool funds across state agencies.
- Conduct a market assessment to determine population need and service cost, and to invest resources strategically.
- Determine current barriers to, and opportunities for, maximizing state, local and federal funds.
- Create a strategic financing plan establishing an infrastructure that supports system design.
- Develop incentives to encourage local financial participation.

IMPLEMENTATION

- Connect services and supports across lifespan and developmental stages.
- Build local governance structures to implement systems of care at the local level.
- Manage care through care coordination at the local level.
- Store coordinated service-related information in an electronic record.
- Establish a basic benefit package that is universally accessible for the target population.
- Authorize services and supports from the benefit plan based on individual plans of care.
- Allow communities to expand the benefit plan to suit local needs.
- Establish a work force development process to translate policy into practice through service delivery.
- Support the establishment of, and key roles and responsibilities for, family and youth organizations.

CULTURAL COMPETENCY

- Adopt a uniform standard across state and local agencies to describe culturally appropriate services and supports in a system of care context.
- Ensure that children, youth and families receive understandable and effective care provided in a manner compatible with their cultural beliefs, practices and language.
- Develop and implement a process to review traditional practices accepted by diverse communities.
- Identify ways to continually improve culturally appropriate care and implementation of a statewide system that reflects culturally competent practices.

DATA AND EVALUATION

- Create one or more committees to review and select outcome/performance measures and benchmarks for the initiative.

- Develop mechanisms to evaluate state agencies' (and their local representatives') collaboration on the data needs of the project.
- Create standard data-sharing agreements.
- Develop and maintain a two-tiered data system that allows local entities to share "real time" data and the state to evaluate the quality and success of local implementation and the initiative as a whole.
- Implement workforce development strategies designed to achieve identified outcomes and performance measures.

Next steps

The Steering Committee recommends establishing an Implementation Team to advance the priority issues identified in this report and move Oregon toward statewide implementation of the initiative. The Implementation Team would be accountable to the Governor's Office and responsible for completing the market assessment; defining outcome/performance measures; making recommendations for creating an integrated Management Information System; developing a protocol for moving agency funds into a blended funding "pool;" analyzing administrative rules and statutes; and identifying criteria for community readiness. The Implementation Team would be charged to complete the majority of its work in time for consideration by the 2009 Legislative Assembly.

Results

When implemented, Oregon will have a system of care for children and youth in which:

- There is a single point of contact for obtaining a comprehensive array of child, youth and family services and supports in homes and communities.
- Families and youth work with service providers to develop, manage, deliver and evaluate policies and programs.
- Services and supports are delivered in the least restrictive, most natural environment appropriate for the needs of children, youth and families.
- Child-, youth- and family-serving agencies establish partnerships to coordinate services and supports.
- Resources are blended at the state and local levels.
- The infrastructure is in place to support the system of care, including financial management and performance/outcome tracking.
- Care management ensures that planned services and supports are delivered and continue to help children, youth and families move through the system as their needs change.
- Evidence-based treatments and interventions are included and appropriately used.
- All services and supports are selected and designed in ways that are responsive to families' beliefs, traditions, values, cultures and languages.
- Agencies and organizations are accountable for evaluating the outcomes of services and supports for children, youth and families.

One family's story

This is a story told by a grandmother from Multnomah County.

I lost contact with my two grandsons in late 2004 when they left Oregon bound for an adoptive placement in Oklahoma. As any grandmother can imagine, this was a very bleak time for our family. This is the story of one of my grandsons. I will call him "Jason."

As I later learned, Jason disrupted out of the adoptive placement in January 2005. In his short life, Jason experienced domestic violence, neglect, parent's drug abuse, and sex abuse by his mother's boyfriend. He had a laundry list of diagnoses, including Post Traumatic Stress Disorder, Reactive Attachment Disorder, and Oppositional Defiant Disorder. Unknown to me and my family, Jason returned to Oregon and was placed in residential care. Shortly after his return, Judge Nan Waller recommended him for Wraparound Oregon. This, in my mind, was a turning point for Jason and for me.

Although I was just two blocks away from the residential center, I didn't know Jason was back in Oregon. In fact, due to the pending adoption, my family was disconnected and lost all hope of ever seeing him or his brother again. But one day I received a letter from Jan Lacy, a Parent Partner for Wraparound Oregon. She was asking if I wanted to reconnect with Jason and participate in his child and family team. I was not only shocked, but thrilled to finally see Jason again and be part of his life.

Jason's child and family team worked together to help him achieve his goals of going to "regular" school and playing baseball. Soon, Jason was out of residential care and into a foster home. We got him on a baseball team and before long he had his "All Star" jacket! Next was school. Jason's team and his family worked closely with the local school district to enroll him in an elementary school with a comprehensive safety plan.

Today, Jason is a happy 10-year-old who is doing what every 10-year-old should be doing – going to school, living in a happy home, and playing baseball. Soon, he will be adopted by his foster dad. And, Jason is a talented and gifted (TAG) student.

This story happens to have a happy ending due to the dedication and hard work of so many great people who came together in a wraparound team to help one boy achieve his dream. I can't thank Wraparound Oregon enough for seeking me out and including me and my family in our grandson's life.

Caring for children with complex mental health needs

Oregon's state and local agencies, public and private organizations, care providers, advocates and many others have worked tirelessly for years to provide the services and supports needed by children with developmental and behavioral disorders. While these efforts have had some success, most services have been provided independently by an array of specialized providers, rather than as part of a holistic approach. This has resulted in occasional duplication of services as well as gaps in service delivery, particularly for children and youth with the most complex needs and multiple diagnoses.

In recent years a number of groups at the state and local levels have proposed solutions that might better meet the needs of children with complex mental health issues and their families. But to date, no solution has been entirely successful in creating the kind of "systems change" envisioned. When the available child and family service systems are fragmented and duplicative, children often are served in more restrictive environments that also tend to be relatively high cost. These more restrictive environments include extended psychiatric residential treatment or hospitalization, long-term foster care placements, extended use of detention facilities, and highly restrictive educational settings. Historically, cost and outcome data regarding services and supports to this population are tracked in multiple information systems that do not link with each other. This often results in public policymaking that is not well informed, that does not provide optimum service efficiency and that has not stimulated effective system improvements.

It is well understood by those involved in providing mental health care for children that children with complex needs require highly individualized plans. Ideally these plans integrate and coordinate services delivered by providers, as well as supports and activities provided by community organizations and individuals in the family's network of interpersonal relationships. However, existing planning and funding mechanisms usually are not flexible enough to fund the array of service and support strategies that often appear in highly individualized, complex care and treatment plans.

New, interdependent partnerships between families, neighborhoods (particularly within communities of color), public sector service systems, non-profits, businesses and philanthropic communities must occur if we are to create and sustain the kind of flexibility needed to: (1) provide individualized, community-based care for children with complex needs; and (2) reach and sustain healthier outcomes for children, youth and their families. The Statewide Children's Wraparound Initiative will build capacity to effectively serve children, youth and their families through a governance structure that will oversee coordinated policy development, comprehensive planning, and collaborative budgeting for services for children.

Governor's Executive Order

Nationally, the term used for children's behavioral health system transformation has become known as a "system of care." A system of care results in a process, or philosophy, for the delivery of behavioral health services and supports known as "wraparound." (See the Glossary of Terms in the Appendices Section, pages A11-A16, for definitions of system of care and wraparound.)

Oregon Governor Ted Kulongoski signed an executive order March 27, 2007, to transform how behavioral health services are delivered to Oregon's children, youth and their families. The order created the Statewide Children's Wraparound Steering Committee. The Steering Committee was asked to create a plan that will transform child- and family-serving systems so they can: (1) provide services and supports as early as possible to enable children to succeed in their homes, schools and communities; (2) make services and supports available based on the individual needs of the child and family, rather than on system requirements; and (3) maximize the resources available to serve children and families across systems, so the mental health needs of Oregon's children are appropriately and effectively met. The Steering Committee also was asked to plan strategies that would be used to hold systems accountable for outcomes consistent with this vision. The systems referenced in the report minimally include education (inclusive of early care through high school), child care, child welfare, public health, primary care, pediatrics, juvenile justice, mental health, substance abuse and developmental disabilities.

Target population

The wraparound initiative is designed to reach children and youth from birth to age 18 who have emotional, behavioral or substance abuse related needs, and who touch at least two systems. This population includes children and youth who are at risk of developing significant difficulties including drug and alcohol abuse, mental health problems and other emotional challenges, as well as those who already have a diagnosed problem.

Steering Committee

The Governor appointed a 16-member Steering Committee representing families, youth, providers, state agencies, early childhood, local systems of care and the Legislature. Steering Committee co-chairs were Erinn Kelley-Siel, Human Services Policy Director for Governor Kulongoski, and Mary Lou Johnson, Special Education Director for Centennial School District in Portland. The Steering Committee met in Salem four times between April and September 2007. Members also met twice via teleconference during this time.

The Steering Committee was charged with developing a plan to finance and provide accountability for statewide emotional and behavioral health services for children, youth and their families. The requested plan was expected to incorporate system of care values, wraparound principles, and incentives that enable and encourage:

- Knowing the true cost of providing emotional and behavioral health care to children across systems;
- Tracking outcomes of system of care and wraparound implementation;
- Providing efficient, effective and coordinated resources to meet child and family needs and to promote positive development; and
- Planning that is individualized to fit specific children and their families, and that emphasizes early intervention and community-based service and support approaches.

In addition, the plan specifically was expected to include:

- A multi-year action plan to implement necessary policies, statutory changes and federal waivers;
- Strategies to address:
  - State and local financing,
  - Local implementation and roll out,
  - Culturally appropriate services and supports,
  - Measurement of service, support and finance outcomes, and
  - Coordination across and between state and local services and supports;
- Methods to overcome barriers; and
- Statewide vision and principles sensitive to Oregon's diversity.

Subcommittees

Steering Committee members also participated in and co-chaired four issue-specific subcommittees formed to study and make recommendations in the areas of finance, local implementation, cultural competency, and data and evaluation. The subcommittees were asked to produce detailed recommendations that responded to charges defined by the Steering Committee. (See the Appendices Section, pages A9-A10, for membership rosters and subcommittee charges.)

More than 130 Oregonians from all sectors and regions of the state participated in these subcommittees. Family members were actively recruited so each subcommittee would have as many family voices as possible. Subcommittee membership included representatives from government, nonprofit organizations, the courts, businesses, advocates, education and others. Each subcommittee had two chairs, with at least one chair coming from the Steering Committee. Each subcommittee met at least four times between April and September 2007.

Through a collaborative process involving the various project subcommittees, the Steering Committee adopted values and operating principles to guide development of the wraparound initiative. These were based on national system of care values and principles, and were used as a foundation for all recommendations.

Core values

1. The goal of Oregon's system of care is a **community of support** for each child and family that honors the family's sense of its own culture.
2. The system of care will be **child guided and family driven**, with the needs of the child and family driving the types and mix of services provided.
3. The system of care will be **community based**, with the focus of services and supports as well as management and decision-making responsibility resting at the community level.
4. The system of care will ensure individuals are **treated respectfully, compassionately and effectively** in a manner that recognizes, affirms and values the worth of children, individuals, families and communities – protecting and preserving the dignity of each.

Operating principles – services and supports

1. Children and youth with emotional, behavioral or substance abuse related needs will have access to a seamless and comprehensive array of services and supports that address the child's physical, emotional, safety, social and educational needs.
2. Children and youth with emotional, behavioral or substance abuse related needs will receive individualized services and supports in accordance with the unique needs and potential of each child, guided by an individualized service plan.
3. Children and youth with emotional, behavioral or substance abuse related needs will receive services and supports within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional, behavioral or substance abuse related needs will be full participants in all aspects of the planning and delivery of services and supports.
5. Children and youth with emotional, behavioral or substance abuse related needs will receive services and supports that are integrated with linkages between child-serving agencies, programs and mechanisms for planning, developing and coordinating services and supports.
6. Children and youth with emotional, behavioral or substance abuse related needs will be provided with case management or a similar mechanism to ensure that multiple services and supports are delivered in a coordinated and therapeutic manner, brought to the child, and delivered in accordance with the child's changing needs.

7. Early identification and intervention for children with emotional, behavioral or substance abuse related needs will be promoted by the system of care to enhance the likelihood of positive outcomes.
8. Children and youth with emotional, behavioral or substance abuse related needs will be ensured continuity of service and supports to meet their needs from birth to maturity.
9. The rights of children and youth with emotional, behavioral or substance abuse related needs will be protected, and effective advocacy efforts for children and youth with emotional, behavioral or substance abuse related needs will be promoted.
10. Children and youth with emotional, behavioral or substance abuse related needs will receive services and supports without regard to race, religion, national origin, sex, physical disability or other characteristics, delivered in a manner that is sensitive and responsive to cultural differences and special needs.

Operating principles – system of care

11. Agencies providing behavioral health services and supports to children and youth with emotional, behavioral or substance abused related needs will be held accountable for providing culturally competent services and supports.
12. Services, supports and the system will be oriented toward outcomes that are supported by the child, youth and family, and continuously monitored.
13. State and local agencies and families will have a common understanding of success for children, youth and families, and will share data and information to support that understanding.
14. The system of care will be supported by a sustainable financing system.
15. Resources will focus on and follow the child, youth and family.
16. The system of care will provide common, continuous and comprehensive workforce development and training.
17. Youth, children and families will have access to culturally validated approaches based upon the principles, laws and values of specific communities.

Cultural standards

In addition to adopting the core set of values and principles, the Steering Committee also endorsed a set of cultural standards. Families and persons of color guided the Steering Committee as it focused on how to better serve all Oregonians. The Cultural Competency Subcommittee identified a guiding statement and a set of standards to influence the development and implementation of a system of services and supports that serves all individuals with compassion and respect. The standards are embedded in the subcommittee recommendations:

1. Organizations/agencies will implement strategies to recruit, retain, develop and promote at all levels of the organization a diverse staff and leadership representative of the demographic characteristics of the services, support area and population.
2. Organizations/agencies will ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate services and support delivery.
3. Organizations/agencies will offer and provide language assistance services and supports, including bilingual staff and interpreter services and supports, and alternative formats at no cost to each individual and family with limited English proficiency, including hearing impairment, at all points of contact in a timely manner during all hours of operation. Family and friends will not be used to provide interpretation services except upon request by a patient or consumer.
4. Organizations/agencies will display signage and provide individuals and families in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services and supports.
5. Organizations/agencies will make available easily understood individual and family-related materials, and will post signage in the languages

(including Braille) of the commonly served or represented groups in the service area.

6. Organizations/agencies will use a needs assessment and integrate the practice of cultural competence in their written strategic plans that outline clear goals, policies, operational plans and management accountability/oversight mechanisms reflecting culturally and linguistically appropriate services and supports.
7. Organizations/agencies will provide human and financial resources and supports to achieve culturally effective practices as identified in their strategic plans.
8. Organizations/agencies will conduct initial and ongoing organizational self-assessments of CLAS (Culturally and Linguistically Appropriate Services) activities and will integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, individual and family satisfaction assessments, and outcomes-based evaluations.
9. Organizations/agencies will ensure that data on the individual and families' gender(s), race, ethnicity and primary language are collected in records, integrated into the organization's management information systems, and periodically updated.
10. Organizations/agencies will maintain a current demographic, cultural and gender-specific epidemiological profile of each community served as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
11. Organizations/agencies will develop participatory, collaborative partnerships with communities and use a variety of formal and informal mechanisms to facilitate community and patient/consumer/family/youth involvement in designing and implementing CLAS-related activities.
12. Organizations/agencies will ensure that conflict and grievance resolution processes are culturally and linguistically sensitive to the individuals and families, and are capable of identifying, preventing and resolving conflicts or complaints by individuals and families without fear of reprisal. This includes accepting anonymous grievances.
13. Organizations/agencies will regularly make available public information about their progress and successful innovations in implementing the standards, and will inform staff and the public about the availability of this information.

Information about the Steering Committee's progress was distributed regularly through Internet list-serves, a project Web site, and a twice-monthly news bulletin. The news bulletin, *News at a Glance*, was sent to e-mail lists provided by the participating systems. Requests for individuals to participate on subcommittees and in family feedback groups were made through local and state public and private organizations. Everyone who asked to participate on a subcommittee was given the opportunity to do so. At its third meeting, "responder panels," including more than 50 individuals representing local agencies, families and youth, government and providers, met with the Steering Committee and gave feedback on the draft set of recommendations. Finally, each of the Steering Committee meetings had time set aside for public feedback, which was documented and considered as each subcommittee made recommendations.

Public testimony and responder panel themes

VALUES AND PRINCIPLES: All participating entities must affirm these values, inclusive of the culturally competent standards, and embed them within their infrastructure.

ACCOUNTABILITY: The data system and the families must hold the system and providers accountable through selected outcome measures.

TIMELINE: The proposed timeline appears to be very ambitious; this process has taken other states four to five years to fully institute.

FAMILY AND YOUTH: Families and youth receiving services need to be involved and supported through the development of a formalized family and youth support and advocacy organization at the state and local levels.

TARGET POPULATION: Services must be designed to serve not only older youth, but also the very young and those at risk of very serious difficulties.

WORKFORCE DEVELOPMENT: Involvement of higher education and credit for on-the-job-training and life experience need to be part of the process to move this effort forward.

SIMPLICITY OF DESIGN: The system changes must enhance the work to be done, must emphasize flexibility and nimbleness, and must not create more burdens for families and providers.

FINANCIAL SUCCESS: An assessment of readiness must be completed prior to full implementation by looking at actual costs, numbers currently served and available resources, inclusive of adequate compensation for those involved with providing services and, where possible, private payers. Funding should be flexible, blended and inclusive of local contributions.

DATA SYSTEMS: Data systems need to be Web-based, secure and easily shared when appropriate.

COMMUNITY READINESS: This plan needs to use a phased-in approach that incorporates the strengths of communities where the process has started.

CODIFY THE CHANGES: The Legislature and state administrators need to amend the statutes and rules required to institutionalize these changes.

Family feedback

Five family feedback focus groups were held throughout Oregon September 5, 2007. Fifty-five families were connected via video conferencing convened by the Oregon Family Support Network and the Native American Rehabilitation Association. Committee co-chairs Erinn Kelley-Siel and Mary Lou Johnson attended the teleconference. A pre-meeting provided information on the initiative and recommendations. Families were asked four questions:

1. When considering evaluation, is there anything missing that you think should be measured?
2. What concerns do you want project leaders to consider as the change process moves forward?
3. Should anything be added to the list of culturally appropriate services?
4. What's most important about this initiative in your mind? What's missing?

There were many specific recommendations that came through each discussion relative to each subcommittee area. The following themes captured general principles and recommendations:

ACCOUNTABILITY AND COMPLIANCE: The evaluation process needs to involve families.

FAMILY VOICE: Families need to be involved in system design, evaluation and record-keeping.

WHOLE FAMILY APPROACH: Parents and siblings must be included in the array of services and supports if the goal is a strengths-based, wraparound approach.

LIFE SPAN APPROACH: Help must be available on and off when needed.

WORKFORCE DEVELOPMENT: Employee training must focus across disciplines and communities, especially for frontier and rural communities where distance makes access difficult.

FLEXIBILITY: Implementation must include flexibility in funding, community-specific designs and family-driven, needs-based services.

BROAD SYSTEM INTEGRATION: Private payers and the education community need to be involved in this design through a communication strategy developed to bring them in; transition-aged youth must not be forgotten.

MEDICAL COMMUNITY: There is strong support for inclusion of the family practice and pediatric community; an equal focus must be placed on integration of physical and mental health.

PEER-TO-PEER SUPPORTS: Supports are necessary for youth or parent mentors in roles such as "family navigators" and "parent partners."

Recommendations were made regarding the overall initiative as well as in the areas of financing, local implementation, cultural competency, and data and evaluation.

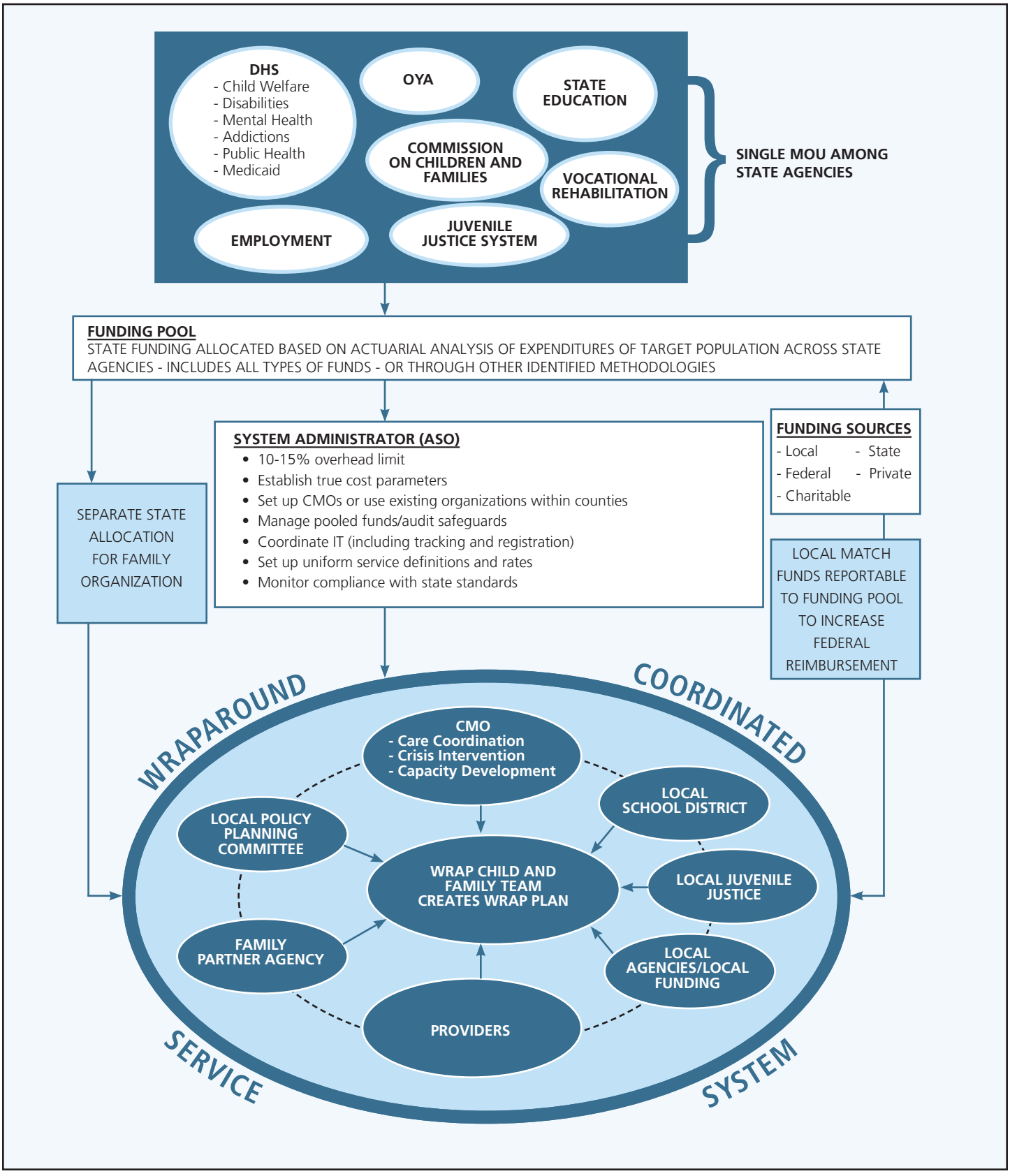
Overall initiative recommendations

1. **Serve all children in the target population.**
2. **Generate family-driven and youth-guided individual plans developed through a high-quality wraparound process.**
3. **Include culturally competent mental health, substance abuse and non-traditional services in the benefit plan.**
4. **Blend funds at the state and local levels for target population services.**
5. **Monitor outcomes and provide accountability through local real-time, Web-based, electronic records that inform the larger statewide system about certain key indicators.**

Funding recommendations

1. **Develop a statewide purchasing collaborative to create a mechanism to pool funds across state agencies.**
2. **Conduct a market assessment to determine population-need service costs and invest resources strategically to fully fund stages of implementation and core infrastructure for system design.**
3. **Determine current barriers to, and opportunities for, maximizing state, local and federal funds.** This will ensure that services reflect each community's demographics – who's in the community compared with who's getting the services.
4. **Create a strategic financing plan establishing an infrastructure that supports system design.** This will result in a core infrastructure that is adequately funded and adheres to the cultural competency standards.
5. **Create legislation to codify the components of the initiative.** This will identify policies, fiscal investments and partner involvement in system change within a defined timeline, and ensure that cultural competency standards and practices are embedded in legislation.
6. **Integrate these recommendations into an overall funding approach for target population children served in Oregon** (as illustrated in the diagram on page 15). This funding approach needs to include the following components:
   - A state funding or purchasing collaborative would be created, made up of key state agencies to allocate funding to a "blended pool" based upon either a percentage of 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 state pool to be used as matching funds to draw

OREGON'S STATEWIDE WRAPAROUND INITIATIVE FUNDING MODEL



down additional federal moneys. This could be accomplished using the Medicaid Rehabilitation Service option or new (1915i) Home and Community-Based Services Option created under the federal 2005 Deficit Reduction Act. This would require help from the Centers for Medicare and Medicaid Services to modify Oregon's State Medicaid Plan.

- A systems administrator would oversee the various management responsibilities, including 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 monitoring program outcomes. This role could be performed by a designated state agency, contracted Administrative Services Organization (ASO) or a locally based entity.
- A local Care Management Organization (CMO) would employ care coordinators to facilitate coordinated care wraparound planning teams. (Note: Not every child or youth in the target population will require the wraparound approach.)
- Support would be in place for family organization(s) functioning on the state and local levels to support and advocate for families, as well as provide some services and supports such as peer-to-peer and other non-traditional services supported through some type of allocation. Specific support would be provided for family and youth through local parent partners, youth partners, family navigators and support organizations.

7. **Develop incentives to encourage local financial participation.** In the same way that the state would blend funds, local communities would be provided incentives to create similar structures and opportunities to pool resources. Options could include:
   - Provide communities that achieve a certain percent of outcomes a percentage increase in dollars for program development the following year.
   - Set minimal standards (as does the federal government) requiring a match of local resources.
   - Develop some number of standards that have to be met before a community can participate. These criteria could include minimum size (one county), authority to create local policy, community assets, partnerships, diverse membership with families, child-serving agencies, businesses, philanthropic organizations, faith/culture communities, and government leadership. In addition to local human services agencies and other behavioral health service providers, the above elements would be inclusive of local school districts, early childhood education settings with outreach and sponsorship by superintendents, special education directors, and local school boards.

Local implementation recommendations

1. **Adopt the values and principles contained in this report statewide.** Change Oregon statutes as necessary to reflect the values and principles developed by the Steering Committee. Require partner communities to develop local memoranda of understanding signed by key stakeholders that reflect these values and principles.
2. **Use a lifespan system of care approach to service provision and care coordination.** Connect services and supports across the developmental stages of an individual. Change Oregon statutes as required.
3. **Amend Oregon Administrative Rules (OARs) to encourage service provision and care coordination at the local level.** For example, require medical charts to include multiple service elements, including mental health and addiction services and supports. Establish incentives to encourage mental health and addiction services providers to be creative about inclusion across health services settings. In addition, incorporate children's health needs and strengths into the single plans of care. Establish relationships with the child or youth's medical home (pediatric provider). Incentivize addiction services and supports provided and contracted for by Health Maintenance Organizations (HMOs), Fully Capitated Health

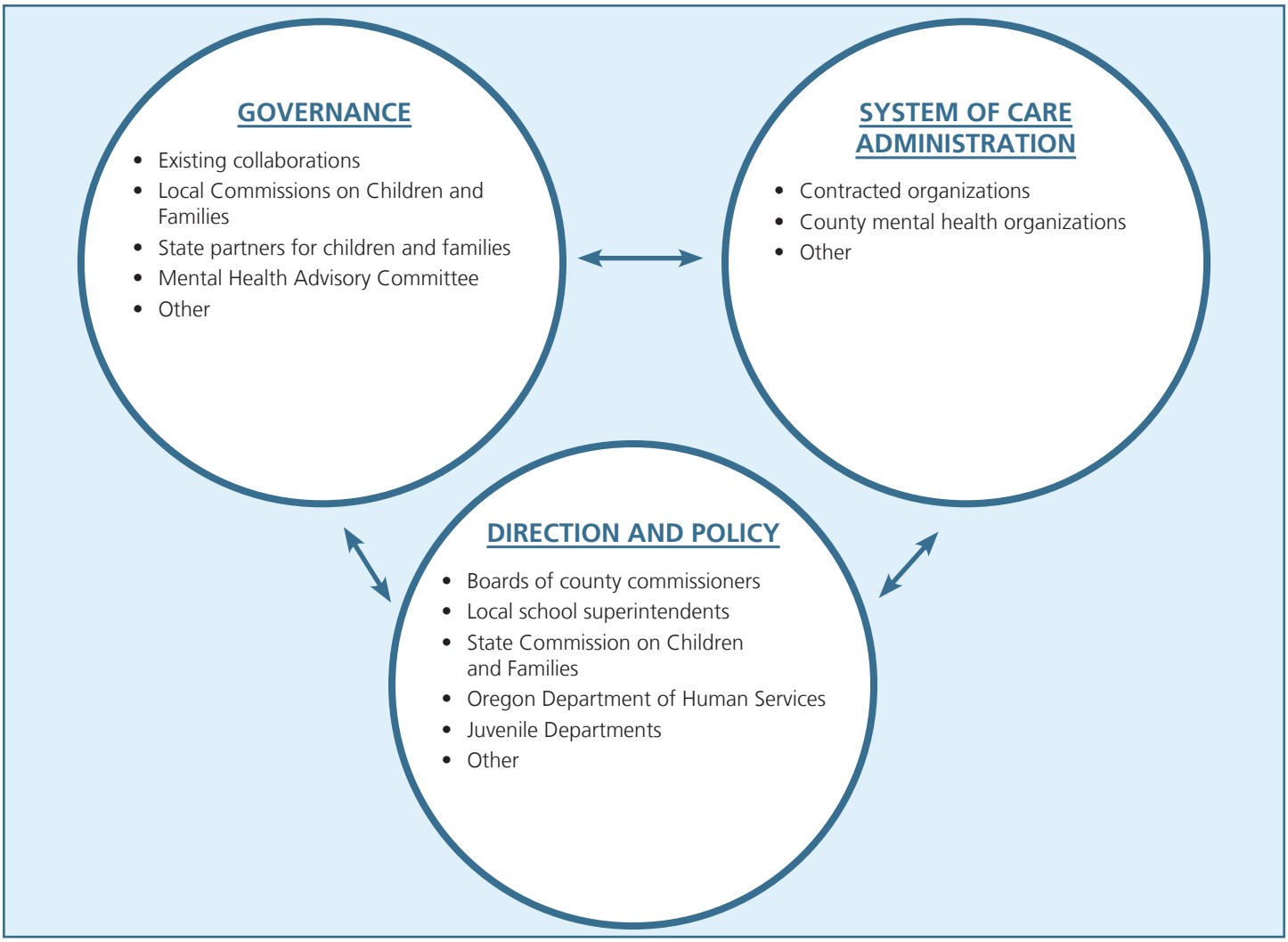
Plans (FCHPs) and/or private insurance, to work closely with mental health organizations. Those organizations with dual certified providers (alcohol and drug and mental health) also need to be incentivized to participate. Encourage family organizations to participate in peer-to-peer and self-help processes, including the ability to bill for such services and supports.

Similarly, reward entities that can demonstrate inclusion within managed care coordinated service-delivery settings and that provide services and supports throughout emergency departments at local hospitals through a series of incentives that include a percentage advantage in rate structure.

4. **Require adoption of a local governance structure to implement a local system of care.** The participants in this structure would develop an implementation plan to address how implementation, administration and governance are to be addressed at the local level. Critical components for local governance include significant representation from family members; a commitment to culturally validated approaches; and the capacity to meet funding, data and outcome requirements.

The following diagram shows the governance and administrative structure for a local system of care.

SYSTEM OF CARE GOVERNANCE AND ADMINISTRATION - LOCAL LEVEL



5. **Manage care through care coordination at the local level – one facilitator for each child and family team.** Provide an integrated single plan of care for every child or youth who is eligible for services and supports. This would produce single integrated plans developed through a high fidelity and culturally validated wraparound process including family and youth recommendations. Child and family teams would work closely with families and children to identify crisis "triggers" and plan for preventing and handling crises when they occur.
6. **Store coordinated service-related information in an electronic record.** This needs to be a Web-based electronic record with shared investment at state and local levels.
7. **Establish a basic benefit package that is universally accessible for all children in the target population.** Base eligibility on emotional, behavioral or substance abuse related health needs and multi-system involvement, regardless of a child's eligibility for categorical benefit programs (e.g., Medicaid, Title IV-E and special education). Each local system would be responsible to serve and support all children in the target population. Individualized services and supports from the benefit package would be authorized based upon the coordinated services and support plan developed by a child and family team.
8. **Authorize individualized services from the benefit plan based upon the coordinated services and support plan developed by a child and family team.** The basic benefit plan recommendations can be viewed in their entirety in the Appendices Section, pages A24-A25.
9. **Expand the benefit package to suit local needs.** Communities could expand the benefit package by 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, leveraged with federal dollars and then returned to be used locally. Additionally, the local community would tailor benefits to fit the needs of its families through the use of existing resources and through in-kind contributions of community assets.

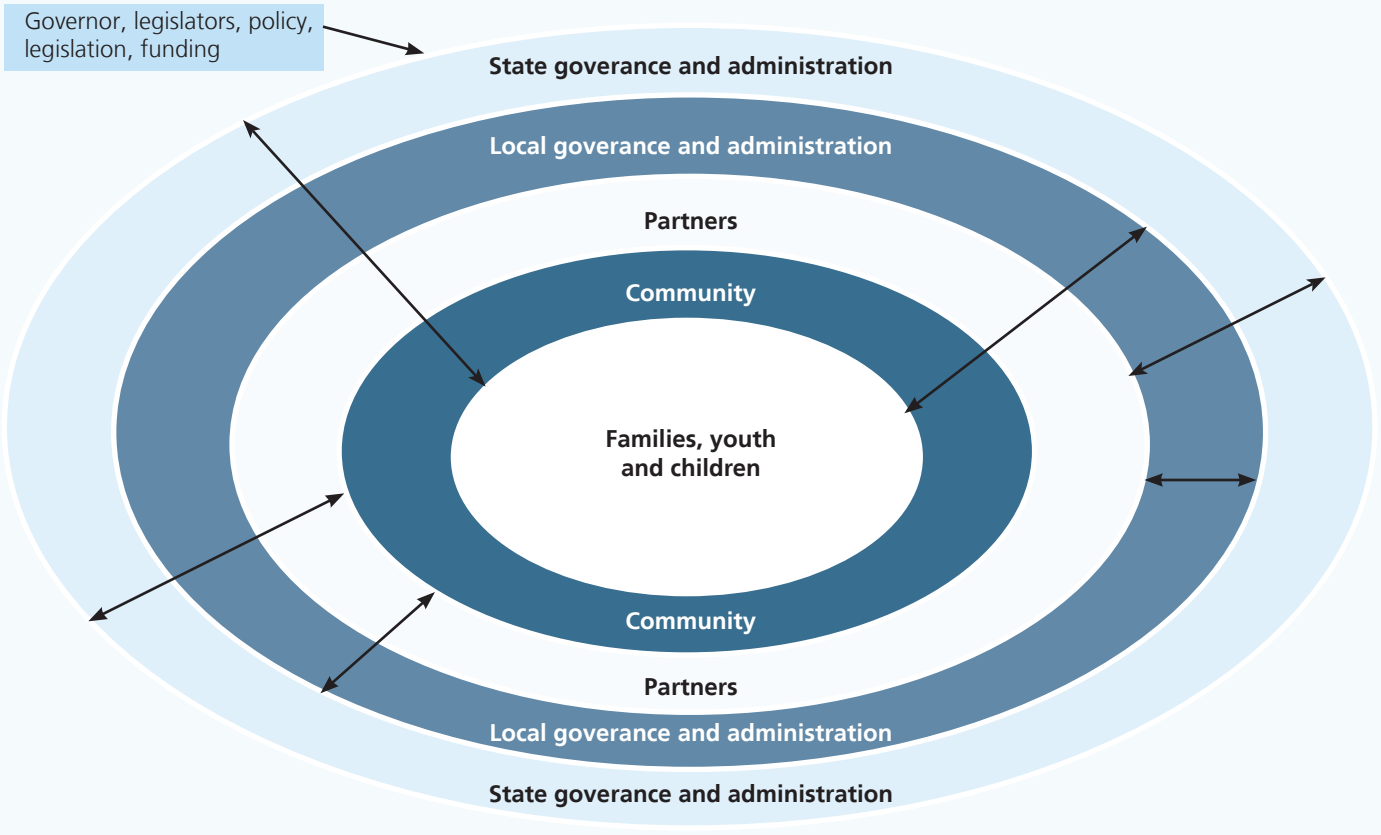
   Criteria need to be established for local expansion of the basic package to avoid cost shifting and other unintended consequences. Criteria include:
   - Access to local general fund dollars.
   - Memoranda of understanding (MOU) from local contributors to participate, inclusive of acceptance of the Oregon system of care values and principles, and the cultural competency statement and standards.
   - Adherence to the spirit of the Governor's Executive Order.
   - Expanded ability to serve populations meeting the eligibility guidelines.
10. **Establish a work force development process that can assist local communities and providers to practice wraparound in a system of care environment.** This would require cross-system training and work with higher education, community colleges and other institutions of learning.
11. **Put resources into establishing a Family and Youth Organization that provides for the following:**
    - Inclusion of family members and youth in all aspects of development, implementation and service provision of the system of care.
    - Training and education about how to navigate the system and participate in child and family teams.
    - Training and education for professionals on how to partner with families and youth.
    - Recruitment, training and support for parent and youth partners and family navigators.
    - Peer-to-peer supports that could be reimbursed by Medicaid or other funds to help support the family organization.
    - Sustainability through contracts with state and local governments, grants from foundations and fee-for-service opportunities.

12. **Create accountability mechanisms for youth, families and family organizations.**
13. **Involve family members and youth in the planning, delivery and evaluation of their or their child's care.** Youth and family members must be included and supported in participating in these activities (including education, training and assistance as necessary). Youth, families and family organizations would be held to the same standards and accountability mechanisms as others who plan, deliver and evaluate services to children in the system of care.

The following diagram provides an illustration of how the local integrated service system would interact with the local governance structure, funding mechanisms and state governance/administration.

There are several examples of effective application of a system of care approach in Oregon communities and

LOCAL IMPLEMENTATION COMMITTEE - LOCAL LEVEL DESIGN



Families: Advocacy/support groups; peer supports and 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 information resources such as businesses, friends, faith-based organizations, recreation and housing

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 agencies, and juvenile justice

Local governance and 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 to facilitate wraparound process; support family teams; rapid access/authorize funds; or local service delivery systems; building collaboratives; social marketing; policy and bylaws; quality and outcome oversight; local resource development

State governance and administration: Administration of funding (blended); administration of benefits; service array; provider clarification/contracts/RFPs; state IS development/maintenance; outcomes tracking and reporting; electronic medical records (Web-based); workforce training; social marketing; resource/requirements document; oversight of systems development; quality and outcome oversight; system integration; OAR, ORS, waiver submission

elsewhere around the country. (See Oregon and other successful models in the Appendices Section, pages A26-A30) The experience and strengths of these communities were used as a foundation for the recommendations in this report regarding the construction of a statewide model for community-based services.

Cultural competency recommendations

The following recommendations were reviewed by the subcommittees to ensure embedding of culturally competent practices in all facets of the system redesign going forward:

1. **Adopt the following statement across state and local agencies to describe culturally appropriate services and supports in a system of care context:** Individuals are treated respectfully, compassionately and effectively in a manner that recognizes, affirms and values the worth of children, individuals, families and communities, protecting and preserving the dignity of each. This includes culture, language, national origin, class, race, age, ethnic background, disability, stage of development, religion, gender, sexual orientation and other differences/diversity factors.
2. **Ensure that children, youth and families receive from all agencies and organizations effective, understandable and respectful care provided in a manner compatible with their cultural beliefs, practices and preferred language.** See the information on cultural standards on pages 10-11.
3. **Develop and implement a process to review traditional practices accepted by racial/ethnic and diverse populations receiving services and supports.**
4. **Provide for state-level evaluation of adherence to the cultural standards.** This will allow the state system administrator to use local data to assess whether services and supports are:
   - Being delivered to the intended population,
   - Reflecting the philosophy of the system of care and wraparound, and
   - Achieving intended outcomes.
5. **Develop, implement and evaluate planning and policies with advisory groups and family members in proportion to the racial/ethnic and diverse populations receiving services and supports.**
6. **Identify ways to continually improve culturally appropriate care through the implementation of a statewide system that reflects an embedding of culturally competent practices.**
7. **Develop, implement, evaluate and coordinate provider specialties including culturally and linguistically qualified staff, use of translators and interpreters, use of cultural specialists, and consultants and related indicators.**

Data and evaluation recommendations

1. **Create one or more committees at the state level to review and select outcome/performance measures and benchmarks for state policy and funding, and local service delivery.**

   This committee needs to coordinate with similar efforts, such as the Oregon Progress Board and state legislative direction relative to agency performance measures.

   Use outcome/performance measures across state agencies to report on the initiative. The committee needs to take the following into account in considering which measures to adopt:
   - Base evaluations of "candidate" measures or assessments to the extent to which they conform to the Oregon system of care principles and the definitions laid out in the National Wraparound Initiative (NWI) document on the 10 wraparound principles. (See the Appendices Section, page A21.)
   - Focus strategies for data collection and evaluation on what is feasible and practical, maximizing use of existing data systems and elements, and measures/assessments that present the least burden to the family/youth/child and other stakeholders.
   - Ensure data requested for evaluation have a

direct nexus to the overall vision of the initiative (i.e., ensuring that services and supports are being delivered to the intended population, reflect the philosophy of system of care and wraparound, and are achieving intended outcomes).

– Data collection and evaluation must include youth and families, as well as representation from state and local agencies.

The committee needs to choose key indicators in the following areas (many of these data needs can be met through existing data currently gathered in various systems) by developing measures that monitor:

- **Educational/vocational progress:** Indicate whether children and youth are attending/engaged at school and progressing toward educational and/or vocational goals.
- **Stable, homelike environment:** Monitor whether changes in living situation are minimized and are the result of the child's needs, with the goal of finding the most permanent community-based situation and most home-like environment feasible.
- **Safety:** Determine whether the child/youth and family feel safe and do not experience abuse, neglect or trauma.
- **Problematic behavior:** Track whether the child/youth has or reduces delinquent behavior.
- **Social/interpersonal support:** Determine whether the child/youth and family have positive and healthy attachments to each other and in the community, and whether the child/youth and family have the opportunity to engage in positive social/recreational activities.
- **Mental/behavioral health:** Monitor mental health/substance use outcomes.
- **Needs met:** Determine whether individualized needs as identified in the care/treatment planning process are met to at least a satisfactory level.

In addition, the committee is expected to choose process quality indicators including measures of planning process fidelity, child/family satisfaction, and cost/financial/use indicators that measure:

- Whether child/youth placements and services and supports reflect the child's needs, rather than other considerations.
- Community services to support the child in the community.
- Services/supports received and the costs, length of delay, and time in services.
- Cost per child per day, with the goal of reducing the rate of use of more restrictive placements.
- Length of time in the program.
- Availability of array of services and supports (i.e., minimum array is available; wait time is tracked).
- Use of natural supports and individualized services/supports as identified in plans.

It also is worth noting that Portland State University's Regional Training Center has created a foundation of workaround indicators that assess whether services and supports are being delivered in a manner that reflects system of care and wraparound principles. Following are some examples of those indicators:

- Planning process reflects "voice and choice."
- Youth and family are empowered.
- Families and youth are satisfied.
- The service planning or coordination process (wraparound for families who need it) reflects fidelity to practice models and the system of care/wraparound values including "voice and choice," "strength based," "culturally competent," and "natural supports."
- The child/family have a single service/support plan. Services/supports in the plan are received without excessive delay.
- Services/supports that are determined to be needed are provided, and funding is flexible enough to pay for what's determined to be needed.

2. **Develop a mechanism to evaluate state agencies' (and their local representatives') collaboration with the data needs of the project.** After outcomes/assessments/indicators have been chosen, state agencies must work with staff at the local level to provide needed data to the local entities implementing the initiative. Using feedback from this process, state agencies would consider implications for their data gathering efforts and work to harmonize the needs of both. Desegregated data and evaluations would be collected by race, ethnicity, gender and primary language.

3. **Create standard data-sharing agreements.** State agencies must collaborate to develop standard agreements around how to share needed data while preserving youth/family privacy rights, and meeting federal and state legal obligations.

4. **Collect data to allow the state to assess the extent to which the local entity administering the project:**
   - – Demonstrates readiness to manage the project by putting structures/processes into place, developing capacity as identified by the Local Implementation Subcommittee, and by developing the MIS/data capacity described below. A local entity would not receive state funds until readiness is demonstrated.
   - – Implements system of care principles at the community level (e.g., by having required levels of family/youth participation on decision-making bodies). This would demonstrate readiness to manage the project by putting structures/processes into place and developing capacity.

5. **Reflect a lifespan approach in data systems.** Family/youth/child data would persist across one's lifespan (from pre-natal through adulthood) and would not be "closed out," so that if/when families need to re-engage in services, either in the same locality or elsewhere in the state, or when they need to move from one part of the state to another, needed information can be accessed. This may require creating some kind of unique identifier for a child/youth, and also may require mechanisms for local entities to share data with each other. Although probably a more long-term goal, short-term actions need to be taken with this in mind, and a strategy for reaching this long-term objective needs to be identified early in data systems development. Data gathering needs to be efficient, targeted on shared goals and culturally relevant to providers and communities of color.

6. **As a foundation for implementation of the initiative, state and local entities must develop and maintain a two-tiered data system (see the diagram on page 15).** After specific outcomes are selected, and taking into account the recommendations relating to data collection above, the state would convene a committee of MIS/data system experts from the collaborating public and local agencies to work out the details outlined below. This committee also would provide information on the costs of maintaining the centralized database.
   - • 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 outcomes, 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 and juvenile justice systems).
     - – Track services and supports included in the plan and when/whether they are provided.
     - – Track costs and do billing.
     - – Report key cost/use and outcome data to the state as required.
     - – Meet federal reporting requirements.
   - • The state would maintain a database to receive summary or abstracted data from the local MIS systems, including data on costs, use, child/family outcomes and process outcomes. This is not anticipated to be a "real time" system; its primary use would be for evaluating the quality and success of both local implementation and the initiative as a whole.

7. **Implement workforce development strategies designed to achieve identified outcomes/performance measures.** This likely will require the re-evaluation and adjustment of state and local workforce strategies to encourage:
   - – State and locally-led professional development programs to increase capacity of existing providers to work in ways that reflect system of care/wraparound principles and practices.
   - – State and locally-led activities to work with post-secondary educational entities to prepare professionals to work in ways that reflect system of care/wraparound principles and practices.

Priority issues

The Steering Committee agreed there are certain priority issues that need to be addressed to implement a well-designed and adequately funded coordinated system of services and supports for children, youth and their families as soon as practicably possible.

These issues are:

- Identification of state and local leaders who will shepherd the Statewide Children's Wraparound Initiative from "vision" to "practice."
- Creation of a blended funding structure that incorporates public and private resources to better meet the individual needs of children and youth.
- Completion of a market assessment to determine population-need service costs and to invest resources strategically to fully fund stages of implementation and core infrastructure for system design.
- Establishment of community readiness criteria for local participation.
- Selection of outcome/performance measures by which to track the initiative's success.
- Development of a new – or enhancement of an existing – management information system that provides quality assurance, accountability and electronic record-keeping.
- Adoption of culturally competent standards throughout every aspect of system of care implementation.
- Support for state and local family and youth support organizations that recruit, train and support youth and families to participate every step along the way.
- Continued efforts to enhance partnership between addictions and mental health, education (including early child care and higher education), juvenile justice, child welfare, developmental disabilities, and workforce development systems at all levels of government.
- Implementation of a social marketing action plan to inform and educate local and state constituents, as well as the general public, about the initiative.

Paths to implementation

The Steering Committee recommends the state take the following steps to address the priority issues identified above and move toward statewide implementation of the initiative.

1. **Establish and fund an implementation team.** Create a project Implementation Team directly accountable to the Governor's Office.

   Responsibilities:
   The Implementation Team will be responsible for the following:

   - Completing the recommended market assessment, which includes:
     - Details regarding target population prevalence served by state and local public agencies.
     - Identification of existing state agency budgets and appropriations for serving the target population.
     - Assessment of the target population not served and the budget needed to do so.
     - Identification of the true costs for outcome and accountability measures.
   - Defining the outcome/performance measures for the initiative.
   - Making recommendations regarding the creation of a Management Information System (MIS) for billing and outcomes tracking.
   - Calculating the size of system contributions and the overall size of a blended funding pool – using data from market assessments – and based on size of population, prevalence of need, and cost to provide services in the benefit package.
   - Developing a protocol and rationale for moving state funds into the state funding pool and identifying opportunities to leverage local resources.
   - Identifying federal and state statutory and administrative barriers to implementation of the initiative and making recommendations for overcoming those barriers including, but not limited to, the need for federal waivers and the need to amend state statutes and/or administrative rules.
   - Identifying criteria for community readiness and strategies to encourage participation and investment at the local level.

   Composition: Ideally, the implementation team would include a mix of experts and family members who collectively possess experience developing systems of care using wraparound or similar approaches; experience setting up and successfully initiating large projects (with 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); experience in working with diverse stakeholder groups; knowledge of evidence-based services and supports and service system development; and first-hand experience as consumers of services.

Funding: Given the scope of work, the Steering Committee recommends funding be obtained to support the work of the Implementation Team. Possible funding sources include a Governor-established, legislatively approved budget and team; state agency contributions (e.g., a percentage of state agency behavioral health budgets assigned to this work); and/ or federal funding through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant.

2. **Develop and implement a social marketing plan to engage the public and stakeholders in support of the initiative.** The goal is to help reduce stigma and ensure community and stakeholder support for values and principles of the system of care.

3. **Consider opportunities to encourage a statewide dialogue regarding the definitions of "evidence based" under SB 267 (2003) and implications for the delivery of culturally competent services and supports.** The Steering Committee had a robust discussion about the implications of SB 267 on the delivery of culturally competent services and supports. The Steering Committee supports the state's efforts to ensure that funding for behavioral health services is being spent on programs that get results, but asks policymakers to consider the following:

- Many aspects of care depend on individual factors such as cultural formation and quality- and value-of-life judgments, which are only partially subject to scientific methods. Application of an "evidence-based" standard must take into account the components of care delivery that are subject to scientific methods, and apply them in combination with individual factors to ensure the best prediction of desired outcomes.
- Opportunities for skills-based training on effective, culturally and linguistically competent approaches to policy development, program management, and service and support provisions are lacking and must be expanded. The state needs to consider ways to encourage or provide technical assistance to organizations and providers on methods for integrating evidence-based practices with culturally appropriate and gender-specific service delivery principles.
- Additional work is needed to create standards for the evaluation of culturally and linguistically competent approaches for organizing, managing and delivering services and supports to determine their efficacy. The state needs to consider ways it could support such work.
- Finally, the state must play a leadership role in compiling information on promising ethnic-specific practices and funding programs to adapt those practice strategies for application in service delivery.

Statewide Children's Wraparound Timeline

October 2007- June 2009

	Oct. - Dec. 2007	Jan. - March 2008	April - June 2008	July - Sept. 2008	Oct. - Dec. 2008	Jan. - March 2009	April - June 2009
	1	2	4	5	6	7	8
FINANCE							
Apply for a statewide SAMHSA grant.	■						
Create project startup implementation team.	■						
Complete market assessment.		■					
Calculate size of system contributions and blended funding pool.			■				
Identify management information system.			■				
Identify and resolve Medicaid issues.					■		
Develop a statewide purchasing collaborative.		■					
Develop a strategic plan establishing an infrastructure.			■				
Create legislation to codify components of the new system of care.						■	
Revise Oregon Administrative Rules (OARs) to align with system of care.		■					■
LOCAL IMPLEMENTATION							
Create or purchase an information management system.			■				
Store service-related information in an electronic record.				■	■	■	■
Manage care through care coordination.				■	■	■	■
Identify a local administrative structure (local service delivery system).				■			
Provide integrated single plan of care.				■	■	■	■
Adopt Oregon's values and principles statewide.	■						
Blend resources for various child-serving systems.				■			
Provide support for families and youth.		■	■	■	■	■	■
Implement a social marketing plan.		■	■	■	■	■	■
Improve access to services.				■	■	■	■
Adopt a lifespan approach to service provision.				■			
Build a local governance structure to implement system of care.		■	■	■	■	■	■
Stage startup in rural/urban communities that are "ready" for implementation.			■	■	■	■	■
Create legislation to codify components of the new system of care.						■	
CULTURAL COMPETENCY							
Develop a statement that describes culturally competent services.	■						
Design standards for culturally appropriate care.	■						
Develop compliance measure for standards.		■					
Adopt statement and standards as "guides" for implementation.		■					
Recommend ways to continuously improve culturally appropriate care.				■	■	■	■
Identify best practice examples.	■	■					
Develop and implement a review process for traditional practices.				■			
Implement a statewide system that reflects culturally competent care.					■		
Develop, implement, evaluate and coordinate provider specialties.					■		
Create legislation to codify components of the new system of care.						■	
DATA AND EVALUATION							
Create one or more committees at the state level to select indicators/measures.	■						
Develop a mechanism to evaluate state/local collaboration with data needs.		■					
Develop standard agreements around shared data.		■					
Identify key service-level child and family indicators.			■				
Identify key service-level process indicators.			■				
Develop outcome data that are objective.			■				
Ensure each local entity has an MIS/Data system that meets requirements.				■			
Ensure each local entity collects data on key indicators.				■	■	■	■
Create legislation to codify components of the new system of care.						■	

Conclusion

The Steering Committee appreciates the opportunity to make these recommendations and participate in this important work. Committee members have learned from one another, from state and local agencies, and particularly from youth and family members.

We have learned that children and youth with emotional, behavioral or substance abuse related health needs often require supports and services from many different child- and family-serving agencies and organizations. Often, these agencies and organizations are serving the same children, youth and families. Committee members are confident that by creating a shared and systemic approach to care delivery (a system of care approach), agencies and organizations will be able to work with youth and families to coordinate services and supports that better meet their ever-changing needs. We know that coordinated services and supports lead to improved outcomes for children, youth and families, and also help prevent the duplication of services for authorized care among government agencies.

We have learned that system of care approaches have helped tens of thousands of children and youth (in Oregon and across the nation) with serious emotional, behavioral or substance abuse related needs make improvements in almost all aspects of their lives. One of the greatest accomplishments systems of care have achieved is making services and supports family-driven and youth-guided. We have learned the importance of having families and youth as empowered and educated decision-makers in the delivery of their own care and in the policies and procedures governing that care delivery in their community, state, tribe, territory and nation.

We are optimistic about what we have learned and our proposed implementation plan for changing the way services and supports are delivered. We know that implementation will require a change in policy, approach, finances and infrastructure. However, we forward these recommendations with a spirit of hope and a sense of confidence about what can be achieved.

We know what to do. The participation in the Steering Committee effort demonstrates that individuals across Oregon have the will do to it. And, when implemented, Oregon will have a system of care for children and youth in which:

- There is a single point of contact for obtaining a comprehensive array of child, youth and family services and supports in homes and communities.
- Families and youth work with service providers to develop, manage, deliver and evaluate policies and programs.
- Services and supports are delivered in the least restrictive, most natural environment appropriate for the needs of children, youth and families.
- Child-, youth- and family-serving agencies establish partnerships to coordinate services and supports.
- Resources are blended at the state and local levels.

- The infrastructure is in place to support the system of care, including financial management and performance/outcome tracking.
- Care management ensures that planned services and supports are delivered and continue to help children, youth and families move through the system as their needs change.
- Evidence-based treatments and interventions are included and appropriately used.
- All services and supports are selected and designed in ways that are responsive to families' beliefs, traditions, values, cultures and languages.
- Agencies and organizations are accountable for evaluating the outcomes of services and supports for children, youth and families.

Appendices

Appendix I: Exectutive order

The following Executive Order was issued by Governor Ted Kulongoski on March 27, 2007:

EXECUTIVE ORDER NO. 07-04
STATEWIDE CHILDREN'S WRAPAROUND PROJECT
Pursuant to my authority as Governor of the State of Oregon, I find that: Oregon children's healthy social and emotional development is critical to their success in school and in life. In the case of young children, services that support their healthy social and emotional development can reduce the prevalence of developmental and behavioral disorders that have high costs and long-term consequences for health, education, child welfare and the juvenile justice systems.

In the case of children who develop emotional, behavioral or substance abuse related needs, they and their families frequently need services from multiple child serving agencies. Integration and coordination of those services can improve outcomes for youth and their families, reduce duplication and gaps in services, and avoid the most expensive, out-of-home placements in foster care or the juvenile justice system.

Oregon state agencies have worked independently for years to improve behavioral health services for children within their own systems. However, children and families who would benefit from specialized services and supports from multiple agencies often experience a lack of coordination and integration in service planning and delivery. Tragically, some Oregon families with children in need of the most intensive services are forced to place their children out of their own homes into residential or other home placements in order to access those services and meet their children's needs.

The time has come for Oregon to develop a statewide, integrated system of care for children at risk of developing, or who have already developed, significant emotional, behavioral or substance abuse related needs and their families. A system of care is a coordinated, comprehensive, culturally competent network of community-based behavioral health services and supports that is organized to:

- Provide services and supports as early as possible so that children can be successful in their homes, schools and communities.
- Reduce the number of children and youth with significant emotional, behavioral or substance abuse related needs who enter foster care or penetrate the juvenile justice system.
- Improve school outcomes for children and youth with significant emotional, behavioral or substance abuse related needs.
- Make services available, to the greatest extent possible, based on the individual needs of the child and family, rather than on system requirements.
- Increase the self-determination of children and families in designing individualized, community-based services and supports.
- Maximize the resources available to serve children and families across systems in order to increase the number of children and youth who have access to appropriate behavioral health services and other needed supports.

Both national and local experience support the effectiveness of systems of care in meeting the emotional, behavioral or substance abuse needs of children, youth and families. Among others, key outcomes include improved and/or stabilized emotional and behavioral health, reduced arrests and placements in juvenile detention and other secure facilities, and improved school attendance and achievement.

THEREFORE, IT IS HEREBY ORDERED AND DIRECTED:

1. The Statewide Children's Wraparound Project Steering Committee is established.
2. The Steering Committee shall develop a strategic plan for statewide implementation of a system of care approach to the delivery of behavioral health services and supports for children, youth and families.
   To that end, the Steering Committee shall:
   - Identify and agree on a common vision and goals for improving services and overcoming barriers to providing coordinated, culturally competent behavioral health services and supports to children, youth and families.
   - Develop and document strategies to better utilize shared system resources, improve cross-agency service coordination at the state and local levels, and improve outcomes for children, youth and families.

- Develop a written, multi-year action plan for implementation of those strategies including, if necessary, recommendations relating to policy and statutory changes and/or requests for federal waivers.

3. The Steering Committee shall prioritize in its planning efforts the development of a comprehensive, strategic financing plan that identifies current spending and utilization patterns across agencies at the state level and makes recommendations about the potential for better coordination of resources across systems, the maximization of federal resources available to the State, and ensuring a locus of accountability for services and the resources that support them.

Appendix II: Project team

One of the first steps taken was to issue of a Request for Proposals through the Department of Human Services for an individual or group to facilitate the process and staff the Steering Committee. A Project Team from Wrap-around Oregon (Multnomah County) was awarded the contract. The Project Team consisted of seven individuals and organizations who have extensive backgrounds in the wraparound process and system of care development, including:

- Janice Gratton, LPC, (team leader), chair of the Multnomah Education Services District (MESD) Board of Directors.
- Larry Marx, MD, Director of Medical Operations for Group Health Cooperative's Behavioral Health Services in Seattle.
- Pam Curtis, MS, Assistant Director of the Center for Evidence-based Policy at Oregon Health and Science University.
- Alice Galloway, MPA, Director of Wraparound Oregon (Multnomah County).
- Janet Walker, PhD, Director of Research and Dissemination at the Research Training Center on Family Support and Children's Mental Health at Portland State University.
- Bruce Kamradt, MSW, Director of Wraparound Milwaukee (Wisconsin).
- Jackie Mercer, CEO, Native American Rehabilitation Association (NARA) Northwest.

The Project Team also provided access to a group of national advisors on issues of system of care development and implementation.

Appendix III: Subcommittee members

SUBCOMMITTEE NAMES AND ORGANIZATIONS

Subcommittee	Last Name	First Name	Organization
FINANCE			
Co-chair	Anderson	Mitch	Benton County Mental Health
	Anderson	Kristen	Family Member
	Anderson	Jesse	DMAP/DHS
	Arenz	Janet	Oregon Alliance of Children's Programs
	Baker	Bruce	Morrison Child and Family Services
	Black	Janell	Gresham/Barlow School Dist.
	Blackburn	Randy	CAF/DHS
	Bolouri	Maryam	
	Branyan	Rod	Dept. Health/Human Services
	Brimner	Karl	Multnomah County Health & Addiction Services
	Bumpus	Sandy	Family Member
	Campbell	Kevin	Greater Oregon Behavioral Health, Inc.
	Campbell	Lorena	East County Schools
	Clark	Marsha	Commission on Children and Families
	Clarke	Richard	Portland Public Schools
	Cox	Phil	Oregon Youth Authority
	Farver	Bill	Multnomah County Chair's Office
	Fay	Marylee	DHS
	Fullerton	Dave	Confederated Tribes of the Grand Ronde
	Jackson	Leroy	Klamath Tribe
	Jarvis	Dale	MCPP Consulting
	Johnson	MaryLou	Centennial School District
	Jorgensen	Barbara	MESD
	Keddy	Donna	CAF/DHS
	Krenk	Chris	Albertina Kerr Centers
	McKechnie	Mark	Juvenile Rights Project
	Mertz	Mary	Portland Public Schools
	Munoz	Gil	Virginia Garcia Clinic
	Newman	Judy	EC Cares
	Olson	Madeline	AMH/DHS
	Ponder	Diane	PHD/DHS
	Read	Lynn	DMAP/DHS
	Richards	Eric	Dept. of Education
Co-Chair	Saxton	Lynne	ChristieCare
	Scherzinger	Jim	DHS
	Shirley	Lillian	Multnomah County Health Dept.

Subcommittee	Last Name	First Name	Organization
	Summers	Ralph	AMH/DHS
	Zeyen-Hall	Janet	AMH/DHS
LOCAL IMPLEMENTATION			
	Abel	Bruce	LaneCare
	Abernethy	Pamela	Marion County Court
	Abrams	Rob	Wraparound Oregon - EarlyChildhood
	Andall	Karen	Oregon Youth Authority
	Bouska	Bill	AMH/DHS
	Coulter	Laney	NW Regional ESD
	DePew	Debra	Family Member
Co-chair	Farish	Jammie	Family Member
	Gates	Georgia	Clatsop Co. Juvenile Dept.
	Gelbrich	Ruth	Salem-Keizer School District
Co-chair	Guidera	Sharon	Mid-Columbia Center for Living
	Hartman	Clifford	Linn County Mental Health
	Hudson	Shelbee	Oregon Foster Parents Association
	Jackson	Leroy	Klamath Tribes
	Johnson	MaryLou	Centennial School District
	Joyce	Shelly	Family Member
	Kuhn	Steve	Marion County Health Dept.
	Linfoot	Ally	Family Member
	Livingstone	Yvonne	Coquille Social Services
	Maier	Belinda	Serendipity
	McKechnie	Mark	Juvenile Rights Project
	Nystrom	Robert	PHD/DHS
	Pearl	Matthew	DHS/AMH
	Perry	Scott	COSA Linn/Benton
	Phillips	Jeanny	DMAP/DHS
	Pickett	Diannna	DHS
	Rea	Cody	Youth
	Reinhart	Marge	CAF/DHS
	Rice	Theresa	Family Member
	Rogers	Molly	Wasco Co. Juvenile Services
	Russell	Jim	Mid-Valley Behavioral Care Network
	Rux	Valerie	DMAP/DHS
	Schubert	Derenda	Trillium Family Services
	Soto	Annie	Head Start Lane County
	Sullivan	Larry	Eugene School District

Subcommittee	Last Name	First Name	Organization
	Wellard	Bob	The Child Center
	Waller	Nan	Multnomah County Court
	Wallick	Elaine	CAF/DHS
	Westfall	Michelle	Family Member
	Wheeler	Karen	AMH/DHS
	Williams	Janette	DHS
	Zeyen-Hall	Janet	AMH/DHS
CULTURAL COMPETENCY			
	Anderson	Gloria	CAF/DHS
	Baragli	Marita	CAF/DHS
	Carley	Connie	Commission on Children and Families
	Coleman-Voulgaris	Lisa	Early Childhood
	Cook	Rod	Clackamas County CCF
	DiPrete	Bob	DMAP/DHS
	Dodson	Donalda	Oregon Child Development Coalition
	Garcia	Marvin	Klamath Tribe
	Jackson	Lonnie	Oregon Youth Authority
	Jensen	Sheryl	Family Member
	Kraus-Dorn	Debbi	DHS
	Leung	Holden	Asian Family & Health Center
	Linfoot	Ally	Family Member
Co-chair	Mack	Robin	Consultant
	Mason	James	PHD/DHS
	Palmanteer	Mattie	Youth
	Pelkey	Jon	DMAP/DHS
	Poe	Lolenzo	Multnomah County Chair's Office
	Portillo	Frances	Seletz Tribal Head Start
	Riley	Cris	OHSU
	Sekino	Anya	Commission on Children and Families
	Seubert	Kathy	AMH/DHS
	Sewell	Erin	Lifeworks Northwest
	Swigart	Ted	CAF/DHS
	Tarich	Sokham	IRCO
	Urbana	Carmen	OSU
Co-chair	Wells	Diane	Family Member
	Zeyen-Hall	Janet	AMH/DHS

Subcommittee	Last Name	First Name	Organization
DATA & EVALUATION			
	Andersen	Mindy	CLUSI Tribal Council
	Anderson	Kris	Family Member
	Arbor	Susan	DMAP/DHS
	Biglan	Tony	Oregon Research Institute
	Bouska	Bill	AMH/DHS
	Boyer	Stephanie	Family Member
	Collins	Jon	AMH/DHS
	Conrad	Rita	Oregon Progress Board
	David	Marion	AMH/DHS
	Duryea	Maria	CAF/DHS
	Fleming	Vickie	Remond School District
	Gallia	Charles	DMAP/DHS
	Gibbs	Barbara	Meyer Memorial Trust
Co-chair	Gilbert	Stanley	Klamath Youth Development Center
	Hille	Marcia	Portland Hope Meadows
	Jaeger	Cynthia	NW Regional ESD
	Koroloff	Nancy	PSU Regional Research
	Kraynick	Vera	DHS
Co-chair	Latini	Nancy	Dept. of Education
	Long	Angela	CAF/DHS
	Mohr-Peterson	Judy	DHS
	Negley	Jeanne	CHARRP
	Nelson	Kelly	Grand Ronde
	Nishioka	Vicki	NW Regional Education Lab
	Petersen	Jill	Oregon Youth Authority
	Rice	Theresa	Family Member
	Robinson	Jim	Indian Health Services
	Rowland	Margaret	CareOregon
	Sanders	Becca	Columbia River Wrap
	Savicki	Kathy	Mid-Valley Behavioral Care Network
	Woodcock	Steve	Dept. of Education
	Zeyen-Hall	Janet	AMH/DHS

Appendix IV: Subcommittee charges

Four subcommittees were formed to study and make recommendations around key subject areas of finance, local implementation, cultural competency and data and evaluation. More than 130 Oregonians from all sectors and regions of the state participated. Family members were actively recruited so each subcommittee would have as many family voices as possible. Subcommittee membership included representatives from government, nonprofit organizations, the court, business, advocates, education, and others. Subcommittees had two chairs, with at least one chair coming from the Steering Committee. Subcommittees met at least four times between April and September 2007. Subcommittee "charges" were:

FINANCE – recommend approaches for sharing resources across child-serving systems to promote system of care principles and values. Include:

- Current spending and utilization patterns across agencies at the state level; point out the types of resources expended by other payers.
- Recommendations to better coordinate resources across all systems.
- Mechanisms to maximize federal resources available to the state and local communities.
- Best means to ensure local accountability for services and resources to support those services.
- Suggestions around match, cost sharing and coordination of resources at local level necessary to maximize all available resources.

LOCAL IMPLEMENTATION – develop recommendations to implement system of care approach statewide, across diversity of Oregon communities. Address:

- Local mechanisms for coordinating services and resources across systems.
- Local accountability for outcomes for children and families.
- Ways to roll-out system of care approach to Oregon communities.
- Integration of system of care approach into the work of local child serving systems.

CULTURAL COMPETENCY – recommend approaches for embedding cultural competent care into the statewide system of services and supports for children and their families. Include:

- A statement that describes culturally appropriate services in system of care context.
- Design standards for culturally appropriate care and means to measure compliance.
- Best practice examples of culturally competent services in system of care models.
- Ways to continually improve culturally appropriate care.

DATA AND EVALUATION – recommend approaches to evaluating programmatic and financial outcomes of statewide system of care. Include:

- Core outcomes for children and families.
- Core outcomes for financial utilization and coordination.
- Ways to track data across agencies at state and local levels.
- Implementation of system of care principles.
- Evaluation of state and local resource coordination and resource allocation.
- Implications for Oregon Benchmarks and state and local outcome systems.

Appendix V: Glossary of terms

Acute Care: means short term psychiatric treatment in a hospital or other equivalent level of care.

Acute Inpatient Hospital Psychiatric Care: Acute Care provided in a psychiatric hospital with 24-hour medical supervision.

Capitation: A payment model which is based on prospective payment for services, irrespective of the actual amount of services provided, generally calculated on a per OHP Member per month basis.

Care Coordination: A process-oriented activity that provides ongoing communication and collaboration with children and families multiple needs. The activity can include: facilitating communication between the family, natural supports, community resources, and involved child-serving providers and agencies; organizing, facilitating and participating in team meetings at which strengths and needs are identified and safety planning occurs. The activity provides for continuity of care by creating linkages to and managing transitions between levels of care and transitions for older youth to the adult service system.

Case Management: The service provided to children and families to link and coordinate segments of the service delivery system of a single provider or of several providers to ensure that the most effective means of meeting the child's needs for care are used. Case management functions for children with intensive treatment needs include planning specific treatment goals and services needed to achieve goals; linking the child to appropriate services delineated in the care plan; monitoring and ongoing contact with the child to ensure that services are being delivered appropriately; and advocating for the child's clinical needs.

CASII (Child and Adolescent Service Intensity Instrument): An assessment tool to determine need of service for a child or adolescent (6 – 18 years of age), developed by the American Academy of Child and Adolescent Psychiatry.

Child and family team: A group of people, chosen by the family and connected to them through natural, community, and formal support relationships who will work together to develop and implement the family's plan; address unmet needs; and work toward the family's vision.

CMHP (Community Mental Health Program): An organization that provides all services for persons with mental or emotional disorders and developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority (LMHA) and operated in a specific geographic area of the state under an omnibus contract with the Department of Human Services.

Crisis safety/response plan: A dynamic document that details the actions that the members of the child and family team develop and are prepared to implement if a particular risk is realized. The crisis response plan describes how Community/ Public Safety is provided or needs are met, addressing placement, school, working with law enforcement and community.

Culture competence is accepting and respecting diversity and difference in a continuous process of self assessment and reflection on one's personal (and organizational) perceptions of the dynamics of culture.

Linguistic competence is the capacity of an organization and its personnel to communicate effectively and convey information in a way that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities.

Culture can be defined as a broad concept that reflects an integrated pattern of a wide range of beliefs, practices, and attitudes that make up an individual.

Discharge criteria means the standards to be met to complete service provision.

Discharge summary: The written documentation of the last service contract with the child. Documentation must include the diagnosis at enrollment, and a summary statement that describes the effectiveness of treatment modalities and progress, or lack of progress, toward treatment objectives as documented in the mental health treatment plan. The discharge summary also includes the reason for discharge, changes in diagnosis during treatment, current level of functioning, prognosis, and recommendations for further treatment. Discharge summaries are completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge.

DSM Code means the fourth edition of the "Diagnostic and Statistical Manual of Mental Disorders," published by the American Psychiatric Association. Diagnosis means the principal mental disorder listed in the DSM, that is the medically necessary reason for clinical care and the main focus of treatment. The principal diagnosis is determined through the mental health assessment and any examinations, tests, procedures, or consultations suggested by the assessment. A DSM "V" code condition, substance use disorder or mental retardation is not considered the principal diagnosis although these conditions or disorders may co-occur with the diagnosable mental disorder.

EBP (Evidence-based practice): programs or practices that effectively integrate the best research evidence with clinical expertise, cultural competence and the values of the persons receiving the services. These programs or practices will have consistent scientific evidence showing improved outcomes for clients, participants or communities. Evidence-based practices may include individual clinical interventions, population based interventions, or administrative and system-level practices or programs.

Early Intervention: Provision of Covered Services directed at preventing or ameliorating a mental disorder or potential disorder during the earliest stages of onset or prior to onset for individuals at high risk of a mental disorder.

Emergency Service: Inpatient or outpatient Covered Services by a Provider that is qualified to provide these Services and that are needed to evaluate or stabilize an Emergency Situation. See definition for Twenty-four (24) Hour Urgent and Emergency Services.

Evaluation: A psychiatric or psychological Assessment used to determine the need for mental health services. The Evaluation includes the collection and analysis of pertinent bio-psychosocial information through interview, observation, and psychological and neuropsychological testing. The Evaluation concludes with a five axes Diagnosis of a DSM multi-axial Diagnosis, prognosis for rehabilitation, and treatment recommendations.

Facilitator: A person who is trained to coordinate the wraparound process for an individual family. This person could be a professional, family member or other team member.

Family: Parent or parents, legal guardian, siblings, grandparents, spouse and other primary relations whether by blood, adoption, legal or social relationship. Guardian means a parent, other person or agency legally in charge of the affairs of a minor child and having the authority to make decisions of substantial legal significance concerning the child.

Family-Driven: Means families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for

all children in their community, state, tribe, territory and nation. This includes:

- choosing supports and services
- setting goals
- designing and implementing programs
- partnering in funding decisions
- monitoring outcomes and determining the effectiveness of all efforts to promote the mental health and well being of children and youth.

FFS (Fee-For-Service): The payment for reimbursable services retrospectively based upon agreed rates and the amount of service provided.

Flexible Service: A service that is an alternative or addition to a Traditional Service that is as likely or more likely to effectively treat the mental disorder as documented in the OHP Member's Clinical Record. Flexible Services may include, but are not limited to: Respite Care, Partial Hospitalization, Subacute Psychiatric Care, Family Support Services, Parent Psychosocial Skills Development, Peer Counseling, and other non-Traditional Services identified.

FCHP (Fully Capitated Health Plans): Prepaid Health Plans that contract with DHS to provide physical health care services under the OHP Medicaid Demonstration Project and State Children's Health Insurance Program.

Intake: The process of gathering preliminary information about a potential Consumer to determine whether the person is eligible for services, the urgency of the situation or need for services, and the initial provisional Diagnosis. This information is used to schedule the first appointment, if applicable.

Psychiatric Residential Treatment Services: The behavioral health care programs certified under rule 309-032-1110 to provide 24-hour, seven days per week active mental health treatment under the direction of a psychiatrist for children under age 21.

Juvenile Psychiatric Security Review Board: The Board is authorized to have jurisdiction over youth who are charged with a crime and found guilty except for insanity.

Legal party: A person or entity who has legal standing on the child's dependency or delinquency case. Legal parties typically include the child, the parents and the state in dependency cases. By statute certain agencies are also parties to juvenile cases based on the care and commitment of the child. Agencies that might be included are child welfare, Oregon Youth Authority, juvenile justice, and mental health. An agency can contract with another agency to provide a particular service to the child and/or family, but the duties and obligations of a party cannot be transferred. A party may proceed without an attorney (known as appearing 'pro se'), but an attorney will always represent a party to the case.

LMP (Licensed Medical Practitioner): means any person who meets the following minimum qualifications as documented by the Local Mental Health Authority or designee:

(a) Holds at least one of the following educational degrees and valid licensures:

(A) Physician licensed to practice in the State of Oregon;

(B) Nurse Practitioner licensed to practice in the State of Oregon;

(C) Physician's Assistant licensed to practice in the State of Oregon; and

(b) Whose training, experience and competence demonstrates the ability to conduct a Comprehensive Mental Health Assessment and provide medication management.

(c) When the LMP is not a psychiatrist, the LMP shall have access to consultation services provided by a psychiatrist, preferably a child psychiatrist, either through direct employment by the provider or through written contract between the provider and the consulting psychiatrist.

LMHA (Local Mental Health Authority): As defined in ORS 430.620, the county court or board of commissioners of one or more counties who choose to operate a CMHP; or, if the county declines to operate or contract for all or part of a CMHP, the board of directors of a public or private corporation which contracts with DHS to operate a CMHP for that county.

Medicaid: A federal and state funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by DHS. The program provides medical assistance to poor and indigent persons.

Medical Assistance Program: now called Division of Medical Assistance Program

Mission statement: Family mission statement – a statement crafted by the wraparound team that provides a one or two sentence summary of goals the team is working toward with the child and family.

MHO (Mental Health Organization): A Prepaid Health Plan under contract with DHS to provide Covered Services under the OHP Medicaid Demonstration Project and State Children's Health Insurance Program. MHOs can be FCHPs, CMHPs or private MHOs or combinations thereof.

OHP (Oregon Health Plan): Oregon's health care reform effort consisting of a Medicaid Demonstration Project, State Children's Health Insurance Program, an individual insurance program for persons excluded from health insurance coverage due to pre-existing health conditions, and a group insurance program for small businesses. One objective of this reform effort includes universal coverage for Oregonians. In the context of this Agreement, Oregon Health Plan refers to the OHP Medicaid Demonstration Project and State Children's Health Insurance Program.

OHP Member: An individual found eligible by a program of DHS to receive health care services under the OHP Medicaid Demonstration Project or State Children's Health Insurance Program and who is enrolled with a Prepaid Health Plan t.

OHP Member Representative: A person who can make Oregon Health Plan related decisions for OHP Members who are not able to make such decisions themselves. An OHP Member Representative may be, in the following order of priority, a person who is designated as the OHP Member's health care representative, a court-appointed guardian, a spouse, or other family member as designated by the OHP Member, the Individual Service Plan Team (for OHP Members with developmental disabilities), a DHS case manager or other DHS designee. For OHP Members in the care or custody of DHS's Children, Adults and Families Services or Oregon Youth Authority (OYA), the OHP Member Representative is DHS or OYA. For OHP Members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the OHP Member shall be represented by his or her parent or legal guardian.

OHP Client: An individual found eligible by a program of DHS to receive health care services under the OHP Medicaid Demonstration Project or State Children's Health Insurance Program.

OHP Plus Benefit Package: A benefit package with a comprehensive range of Services, as described in OAR 410-120-1200, Medical Assistance Benefits, available to OHP Members who are over the age of 65, the disabled, the TANF population, General Assistance recipients, and pregnant women and children (under the age of 19) up to 185 percent of Federal Poverty Level (FPL).

OHP Standard Benefit Package: A benefit package that provides basic health care Services as described in OAR 410-141-0500 and OAR 410-120-1200, Medical Assistance Benefits, for adults who are not otherwise eligible for Medicaid (Parents, Adults/Couples)

Oregon Youth Authority (OYA): The Department created by the 1995 Legislative Assembly that has responsibility for care and housing of child and adolescent offenders adjudicated and sentenced by juvenile justice to the juvenile correction system.

Other Inpatient Services: Services which are equivalent to Acute Inpatient Hospital Psychiatric Care but which are provided in a non-hospital setting.

Outpatient Hospital Services: Covered services received in an outpatient hospital setting where the OHP member has not been admitted to the facility as an inpatient, as defined in the DHS Hospital Services Guide.

Paraprofessional: A worker who does not meet the definition of QMHA or QMHP but who assists such associates and professionals.

Plan of Care: A dynamic document describing the family, the team and the work to be undertaken to meet the family and child's needs to achieve the family's long-term vision. This is an evolving and changing document. Progress and updates are included as components of the Plan of Care.

Psychiatric Day Treatment Services: the comprehensive, interdisciplinary, non-residential community based program certified under rule 309-032-1110 consisting of psychiatric treatment, family treatment and

therapeutic activities integrated with an accredited education program.

PSRB (Psychiatric Security Review Board): The Board is authorized to have jurisdiction over persons who are charged with a crime and found guilty except for insanity.

QMHA (Qualified Mental Health Associate): A person delivering services under the direct supervision of a QMHP and meeting the following minimum qualifications as documented by the provider : a bachelor's degree in a behavioral sciences field; or a combination of at least three years' relevant work, education, training or experience; and has the competencies necessary to communicate effectively; understand mental health Assessment, treatment and service terminology and to apply the concepts; and provide psychosocial Skills Development and to implement interventions prescribed on a Treatment Plan within their scope of practice.

QMHP (Qualified Mental Health Professional): A LMP or any other person meeting the following minimum qualifications as documented by a provider : graduate degree in psychology; bachelor's degree in nursing and licensed by the State of Oregon; graduate degree in social work; graduate degree in behavioral science field; graduate degree in recreational, art, or music therapy; or bachelor's degree in occupational therapy and licensed by the State of Oregon; and whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess Family, social and work relationships; conduct a mental status examination; document a multiaxial DSM Diagnosis; write and supervise a Treatment Plan; conduct a Comprehensive Mental Health Assessment; and provide Individual Therapy, Family Therapy, and/or Group Therapy within the scope of their training.

Strengths needs assessment: A document that describes the strengths and needs of a child based on a strengths inventory including positive skills, attributes and features of the family. This would include a list to capture the needs of the family that are either verbally or behaviorally shared. This document will include background, summary and progress information on the family; a place to live; social/fun; emotional/behavioral; education/vocational; legal; medical; safety/crisis; spiritual; cultural; financial, including additional comments or information.

System of Care: A system of care incorporates a broad, flexible array of services and supports for a defined population that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, and has supportive policy and management infrastructure.

Treatment: A planned, Medically Appropriate, individualized program of interactive medical, psychological, or rehabilitative procedures, experiences, and/or activities designed to rehabilitate, relieve or minimize mental or emotional disorders identified through a mental health Assessment.

Treatment Foster Care: A program of rehabilitation as prescribed in the Treatment Plan and provided in the child's foster home. Skill development activities are delivered on an individualized basis and are designed to promote skill development in areas identified in the Treatment Plan. The service requires the use of Treatment Foster Care in coordination with other mental health interventions to reduce symptoms associated with the child's mental or emotional disorder and to provide a structured, therapeutic environment. The service is intended to reduce the need for future services, increase the child's potential to remain in the community, restore the child's best possible functional level, and to allow the child to be maintained in a least restrictive setting.

Treatment Plan: A written individualized comprehensive plan based on a completed mental health assessment documenting the OHP Member's treatment goals, Measurable Objectives, the array of services planned, and the criteria for goal achievement.

Utilization: The amount and/or pattern of Covered Services used by an OHP Member, measured, for example, in dollars, units of service, or staff time.

Utilization Guidelines: Guidelines for the amount of Covered Services expected to be used by an OHP Member with a specific mental disorder over time.

Utilization Management: The process used to regulate the provision of services in relation to the overall Capacity of the organization and the needs of Consumers.

Wraparound Process: Wraparound is a philosophy of care that includes a definable planning process involving the child, and the family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes.

Wraparound Principles: A set of 10 statements that defines the wraparound philosophy and guides the activities of the wraparound process (see below).
Wrap meeting: A family-driven meeting of the child and family team called and facilitated by the facilitator during the Plan

Appendix VI: Acronyms

A&D	Alcohol and Drug
AFDC	Aid to Families with Dependant Children
AMH	Addictions & Mental Health Division
CAF	Children Adults and Families (Division of Department of Human Services)
CASA	Court appointed special advocate
CASII	Child and Adolescent Service Intensity Instrument
CASSP	Child & Adolescent Service System Program – A program that was funded by the National Institute of Mental Health to develop with local communities to plan, develop and implement services for children and adolescents with serious emotional disorders.
SCHIP	State Children's Health Insurance Program (provides medical assistance to children up to age 19 who qualify for Medicaid but have family income under 170% of the federal poverty level)
CMHP	Community Mental Health Program
CMHS	Center for Mental Health Services, located in the Substance Abuse and Mental Health Services Administration (federal agency) established under PL 102-321
CMS	Centers for Medicare and Medicaid Services
DD	Developmental Disabilities
DHS	Department of Human Services
ODE	Oregon Department of Education
DMAP	Division of Medical Assistance Programs
DSM IV	Diagnostic and Statistical Manual of Mental Disorders (4th Edition) classification system for mental illnesses developed by the American Psychiatric Association
EBP	Evidence-Based Practice
EI	Early Intervention or Early Identification
EPSDT	Early and Periodic Screening, Diagnosis and Treatment – part of Title XIX Medicaid

ESD	Education Service District
FCHP	Fully Capitated Health Plan (health plans that contract with DMAP to provide capitated services, including inpatient hospital, to Medicaid clients)
FERPA	Family Education Rights and Privacy Act (student school records act) Federal regulation governing confidentiality of student re cords and parental rights of access and consent to release.
FFCMH	Federation of Families for Children's Mental Health – a national organization of families and professionals dedicated to advocacy and systems change for children's mental health
FFS	Fee-for-service (payment to medical providers based on each service or group of services provided)
HHO	Household of one
HHS	United States Department of Health and Human Services
HMO	Health Maintenance Organization
ICTS	Intensive Community-Based Treatment Services
IDEA	Individuals with Disabilities Education Act
IEP	Individual Education Plan – a written plan for education services for a child with a disability developed jointly by parents and school personnel as required under federal law
IFSP	Individualized Family Service Plan – written objectives for each child under 5 years of age, addressing both the child's and family's needs in the Early Intervention or Early Childhood Special Education education program
ISA	Integrated Services Array
ITS	Intensive Treatment Services
LCSW	Licensed Clinical Social Worker – licensed by the State Board of Clinical Social Workers following successful completion of educational, supervised practice and testing requirements.
LEA	Local Educational Agency
LMHA	Local Mental Health Authority
MHO	Mental Health Organization

NAMI	National Alliance for the Mentally Ill – is the nation's largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families.
NICWA	National Indian Child Welfare Association is a national voice for American Indian children and families. We are the most com prehensive source of information on American Indian child welfare and the only national American Indian organization focused specifically on the tribal capacity to prevent child abuse and neglect.
NMHA	National Mental Health Association
OHP	Oregon Health Plan -- Medicaid
OJJDP	Office of Juvenile Justice and Delinquency Prevention
OYA	Oregon Youth Authority
PPO	Preferred-provider organization
QMHP	Qualified Mental Health Professional
QMHA	Qualified Mental Health Associate
SAMHSA	Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
SED	Serious Emotional Disorder – also commonly EH for 'emotional handicap' or EBD for 'emotional or behavioral disorder.'
SIG	State Incentive Grant
SMHA	State Mental Health Authority
SOC	System of Care
SPD	Seniors and People with Disabilities Division
SSA	Social Security Administration – a federal agency that administers social security and disability benefits
SSBG	Social Security Block Grant, Title XX of Social Security Act
SSDI	Social Security Disability Insurance – a federal program administered by SSA
SSI	Supplemental Security Income – a federal program administered by SSA

TANF	Temporary Assistance for Needy Families Program
Title IV	Child Welfare Act Section of Social Security Act
Title IV-A	Aid to Families with Dependant Children (Section of Social Security Act)
Title IV-B	Child Welfare Services Program (Section of Social Security Act)
Title IV-E	Foster Care and Adoption Assistance Programs (Section of Social Security Act)
Title V	Maternal and Child Health (Section of Social Security Act)
Title X	Federal Family Planning Program (Section of the Public Health Services Act)
Title XVIII	Medicare (Section of the Social Security Act)
Title XIX	Medicaid (Section of the Social Security Act)
Title XX	See SSBG
WIC	Special Supplemental Food Program for Women, Infants and Children

Appendix VII: Ten priciples of wraparound

(from the National Wraparound Initiative, www.rtc.pdx.edu/nwi)

1. ***FAMILY VOICE AND CHOICE.*** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspective, and the team strives to provide options and choices such that the plan reflects family values and preferences.
2. ***TEAM BASED.*** The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.
3. ***NATURAL SUPPORTS.*** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.
4. ***COLLABORATION.*** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspective, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
5. ***COMMUNITY-BASED.*** The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.
6. ***CULTURALLY COMPETENT.*** The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.
7. ***INDIVIDUALIZED.*** To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.
8. ***STRENGTHS BASED.*** The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
9. ***PERSISTENCE.*** Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no loner required.
10. ***OUTCOME BASED.*** The team ties the goals and strategies of the wraparound plan to observable of measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

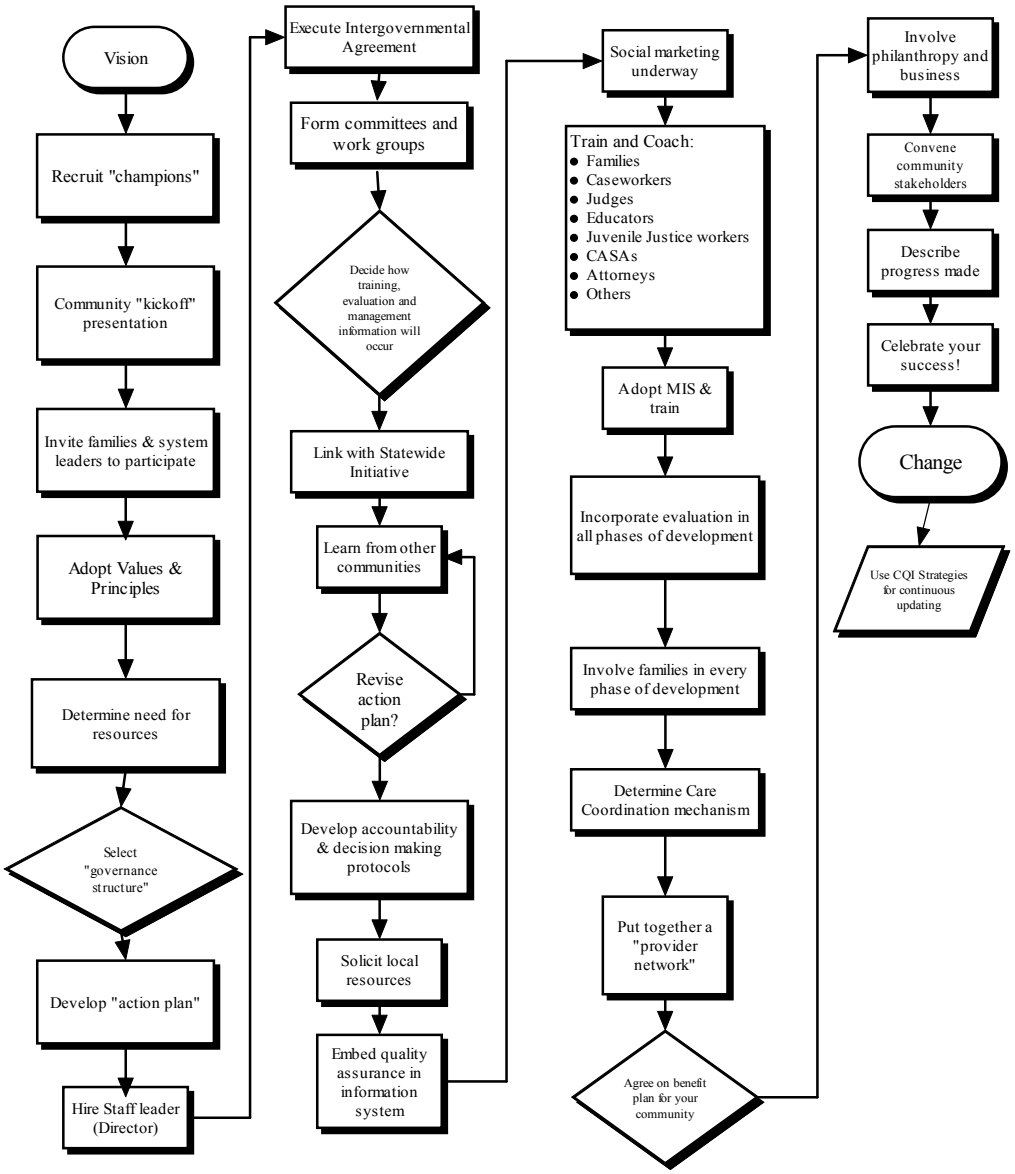
Appendix VIII: Local "readiness" checklist

Local "readiness" checklist to help with identifying communities who are organized, prepared and committed to implementing a "system of care" approach. Elements to be assessed should include:

- 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).
- Ability to complete the steps on the implementation map (next page).
- Demonstration of nimble decision-making.
- Capacity for financial/policy/data management.
- Ability to make budgetary decisions under the purview of agents contributing to the blended pool.
- Technical assistance from the state to ensure success for local communities.

In addition, technical assistance should be provided to communities in completing the implementation steps outlined on the map on the next page.

Appendix IX: Tips on local SOC implementation



Proposed Basic Benefit package

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.

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.

AUTHORIZATIONS

Individualized services from the benefit package will be authorized based upon the coordinated services and support plan developed by a child and family team.

Benefits by categories

BEHAVIORAL HEALTH

- Crisis intervention
- Day treatment
- Family Assessment
- Family preservation
- Family therapy
- Group therapy
- Individual therapy
- Parenting/family skills training
- Substance abuse assessment
- Substance abuse therapy, individual and group
- Special therapy, i.e. sex offender treatment

PSYCHIATRIC

- Assessment
- Medication follow-up/psychiatric review
- Nursing services

MENTOR

- Case aide
- Clinical mentor
- Education mentor
- Life coach/independent living skills mentor
- Parent and family mentor
- Recreational/social mentor
- Tutor
- Community supervision

RESPITE

- 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

- Universal developmental assessment
- 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

Benton County Mental Health
serving children and families of Benton County

Benton County began building a wraparound system of care for children and families as early as 1997 with the establishment of ACIST a community integrated service team. This team was funded through a local option levy and was designed to provide proactive services and supports for children identified as having difficulties at school and their families. In 2001 the capacity of children's mental health services was expanded with the encouragement and subsequent certification of two local non-profits – Old Mill Center for Children and Families and Trillium Family Services, the Children's Farm Home Campus – as outpatient children's mental health providers. The belief was and still is that a strong public/private partnership is a necessary component of a successful system of care. This was followed by the development of a local partnership of child and family stakeholders who developed a response to the SAMHSA System of Care grant in the fall of 2003. While the grant was not received, the partnership continued and utilized the model it had developed in establishing a system of care in response to the State Addictions and Mental Health Division's children's system change initiative that started in the fall of 2005.

The County employs three care coordinators and has primary responsibility for Care Coordination. Patricia Miles, a national expert, provided training.

A family coordinator was employed at the beginning of the project (first as an intern and then through a partnership with Oregon Family Support Network). A parent handbook was developed along with a family friendly complaint/comment form, parent support groups, youth life skills groups, and an advisory committee on children's mental health for the County.

Community Partners include: Benton County Parent Advisory Council; Linn/Benton/Lincoln Educational Services District; Old Mill Center for Children and Families; Juvenile Department; DHS; Children's Farm Home; Jackson Street Youth Shelter; Philomath, Alsea, Monroe and Corvallis School Districts; The Oregon Family Support Network; The Commission on Children and Families; Accountable Behavioral Health Alliance; Children and Families

The partners are organized in to two committees to oversee the development and delivery of a wraparound system of care:

The Family and Child Coordination Committee (CFCC) is the decision making body for coordination of care and blending of services, authorization of day treatment, residential placements, individualized supports and administration of flex funds. It serves as the committee to staff and plan for delinquent/dependent cases for Child Welfare and the Juvenile Department. The CFCC is composed of provider/school representatives, parents and youth. It is a resource group for ACIST and families.

Benton County Child and Family Policy and Advisory Council (CFPAC) brings together child and family stakeholders to:

- Oversee the development of a system of care firmly grounded in a philosophy of services which is child-centered, family focused and community-based.
- Maintain stakeholders buy-in regarding blending and seeking resources in support of a children and family continuum of care.
- Set policy that promotes family friendly, community-based, and easily accessed services and supports.
- Discuss and problem solve issues of mutual interest.
- Advocate for and promote cooperation, collaboration and the integration of services for family and youth stakeholders throughout the county.
- Encourage efficient use of resources among local funding sources.
- Educate and clarify regarding resources, roles and responsibilities.
- Create and maintain a local flexible fund pool for funding non-traditional service/support needs.

This council created the bylaws and memorandum of understanding that defines the organizational structure and established a business partnership that allows for cross-system information sharing to assure continuity of planning and care for children and families in Benton County.

Columbia River WrapAround
serving children and families of Wasco, Sherman, Gilliam and Hood River Counties

Columbia River WrapAround is in the fourth year of implementation. Community partners, families, youth and advocates recognized the need to develop a System of Care approach to serving youth and families that were struggling with behavioral and emotional challenges. Through funding from Substance Abuse and Mental Health Services Administration (SAMSHA) Children's Mental Health Initiative Grants, four counties including Wasco, Sherman, Gilliam and Hood River worked to embrace and implement the values and principles of a Systems of Care and develop wraparound services for the families and youth ages 0-21. Currently 41 youth and families are enrolled with a total of 136 receiving services over the four years. An extensive evaluation of the outcomes is in progress.

The most notable for year three of the project are summarized below:

In school:
- School suspensions decreased from 42 percent (intake) to 26 percent (at 12 months).
- Nearly 50 percent of the children and youth improved in school attendance.
- A third of the youth involved had improved grades.

Out of trouble:
- For both males and females there was a sharp decline in occurrences of physical fighting over time: -77 percent decrease for males and -66 percent decrease for females.
- Marked decline in the incidences of 'bulling or threatening' over time particular for males (31 percent reported bulling at intake, 0 percent at 12 months).

At home:
- 71 percent of the youth experienced living stability.
- Youth who experienced changes in living situation moved to less restrictive settings with lengths of stay in residential treatment reduced from years to a few months.

Columbia River WrapAround has established:
- A Governance Council to ensure community is on track with Systems of Care development and sustainability. Families and Youth are 51 percent of the board and hold the Chair and Co-Chair positions. Public health, juvenile justice, the local Commission on Children and Families, local school districts, child welfare and other community partners and advocates are active participants. Evaluation and Service Delivery committees are also active and include families and youth.
- Youth and family support groups and leadership teams are an integral part of the system.
- A Cultural Competency Plan has been developed and trainings held. Satisfaction surveys report high scores on cultural sensitivity for system of care staff.

Sustainability after the federal funds will be the biggest challenge. Some projects have occurred with a local school district, juvenile justice and mental health using the SOC framework.

Wraparound Oregon serving children and families of Multnomah County

Work on Wraparound Oregon, located in Multnomah County, began in July 2005 under the leadership of Multnomah County Chief Family Law Judge. After one year of monthly meetings (all volunteer time), funds were acquired to hire an Executive Director to guide the initiative. Northwest Health Foundation nominated Wraparound Oregon for a Robert Wood Johnson Local Initiative Funding Partners grant in early 2005. Wraparound Oregon was one of 16 projects nationwide to receive this grant. Private funding launched the initiative and a cadre of system leaders moved it forward.

Community partners include: families and youth, philanthropy, advocates, child welfare, juvenile Justice, Oregon Youth Authority, mental health, schools, health, addictions, developmental disabilities, early childhood and family organizations.

Today, Wraparound Oregon has two projects – the School-age Project funded by philanthropic and some federal funds and the Early Childhood Project funded by a Substance Abuse and Mental Health Services Administration (SAMHSA) grant. These two projects "inform" the building of a comprehensive, coordinated system of services and supports for children and youth with complex mental health needs and their families.

Wraparound Oregon has developed a shared information management system to track progress of participants. This system is web-based and can be accessed by each of the participating systems – child welfare, juvenile justice, mental health, education and Oregon Youth Authority. A two-tiered evaluation monitors system and service outcomes. And, a cross-system training academy provides training and workforce development to system workers, managers, and top-level leaders.

Wraparound Oregon is implementing high fidelity wraparound through single plans of care, care coordination, family driven and youth guided decision making, crisis planning and shared resources. System of Care values and principles are the foundation for this work.

Accomplishments from other states

The Project Team identified a number of innovative children's mental health initiatives currently underway in other states. Some of these models are organized on a more local basis and others are operated on a statewide basis. All of them share some similar features in being able to provide comprehensive yet very individualized services, being more community-based than providing institutional care, very youth guided and family-driven and all with a primary emphasis on achieving positive, measurable outcomes for the youth and family they serve.

Some of the nationally recognized projects that the Project Team and Sub-Committee Workgroups reviewed include: New Jersey, Wisconsin, Pennsylvania and Arizona.

NEW JERSEY

Target group – The six year-old New Jersey children's initiative serves both Medicaid and non-Medicaid children with serious mental health and emotional needs. Focus is on children served crossing two or more systems.

Multifaceted funding approach – New Jersey's program took existing funds from mental health, child welfare, Medicaid, new general purpose funds approved by the legislature and pooled them at the state level. There was an expanded use of Medicaid using the federal Rehabilitation Option. The leveraging of general funds was used to capture more federal reimbursement for the costs of the expanded service array. New Jersey pooled $85 million in Medicaid, Child Welfare and other monies to leverage more Medicaid money. New Jersey also went to a single payer system and now gives the blended funding to the State Medicaid agency to administer and pay for services.

Screening and Assessment – Uniform screening and assessment protocols and tools were developed by the state to better identify mental heath needs. A new Assessment tool called Information and Decision Support

Tools (IMDS) was developed for use by state agencies.
Administration – New Jersey utilizes a statewide Administrative Services Organization called an ASO– (Value Options Inc.) to coordinate, authorize and track youth needing services. A non-risk bearing ASO, Value Option manages a single payment system and single Information Technology (IT) system for all children

Care Management – Integral to the system are care management organizations (not-for-profit) located in each county or region of counties called CMOs. They receive a case rate to provide care coordination and care planning services and use wraparound approaches with child and family teams developing individualized service plans. They must address safety and permanency plans for those CMO youth involved in child welfare. CMOs employ care managers assigned small caseloads of 1:10 families.

Family Support Organizations (FSOs) – Every CMO has an attached family support organization and families have an assigned parent advocate to help them. This ensures family voice is incorporated in the planning and delivery of services.

Benefit Plan – The array of mental health services and supports offered to families are broad and flexible and include traditional mental health and non-traditional services. They use the Rehab Option under Medicaid to expand the state benefit plan to include: assessment, mobile crisis, residential treatment, group home, treatment foster homes, care management, intensive in-home therapy, behavioral aides and "wraparound services".

Presumptive eligibility – Children who are Medicaid eligible or meet SED definition are presumed eligible and given a system of care identifier number

Provider Network – All providers contract with State of New Jersey Department of Human Services and are paid fee-for-service. Local care management organizations receive separate allocations for "wraparound" type services for families.

WISCONSIN

Target Group – Wraparound Milwaukee, a locally operated system of care serving over 1,000 children with serious emotional and mental health needs was named by the President's New Freedom Commission on Mental Health as a national model in children's mental healthcare. It has been replicated elsewhere in Wisconsin and in the United States.

Pooled Funding – Wraparound Milwaukee has the most extensive pooled funding plan anywhere in the U.S., blending over $40 million per year from Medicaid, child welfare, juvenile justice, state bloc grant funds and third-party insurance. Funding is flexible and easily available to the child and family planning teams.

Administrative Structure – This program functions as it's own type of health maintenance organization with internet based information system that allows for an electronic case records, authorization and claims processing system that can easily interface with other county or state information systems.

Care Management – Wraparound Milwaukee utilizes a single care coordinator and single care plan across child serving systems. It also utilizes a strength-based, individualized care planning approach called the wraparound approach.

Medical Necessity – "Medical Necessity" for approving needed services for families is determined met for Medicaid purposes by decisions made by the child and family team.

Provider Network – An extensive network of over 230 provider agencies offer over 80 different mental health and support services to children and their families on a fee-for-service basis.

Outcome Indicators – Extensive clinical and programmatic outcomes are in place to measure the impact of program services on improved school attendance, reduced delinquency recidivism and the attainment of permanent placements for youth.

PENNSYLVANIA

Target Group – Pennsylvania includes a broad target group of TANF eligible families, pregnant and low income, SSI.

Financing model – It blends Medicaid, mental health and substance abuse dollars and employs a mandatory reimbursement strategy

Administrative features - Counties have the first option to act as their own Management Care Organizations (MCO). Counties, may in turn, subcontract MCO functions to commercial or non-profit organizations. Counties receive risk based contracts for the State and may, in turn, sign risk based agreements with the commercial or non-profit MCOs.

Care Management Model – The Managed Care Organization must employ a wraparound philosophy and approach and must serve on the interagency service planning teams for children with serious emotional and mental health needs. They must also have memorandum of agreements in place with all child-servicing agencies that address coordination, service planning and service delivery.

Benefit Plan – The benefit plan is broad.

Medical necessity criteria – State developed decision making criteria for medical necessity was developed with input of stakeholders, including families. They broadened eligibility criteria for services and also extensive use of the federal Early Periodic Screening and Assessment Program (EPSDT) to screen to children to determine the need for such services as in-home therapy.

Provider Network – They have an extensive network of providers under contracts and fee-for service arrangements. Allows for use of non-traditional providers under special designation with state to provide certain rehab and support services. The MCO contracts with providers requires that providers participate on interagency teams and coordinate the provision of services with child servicing agencies including child welfare, juvenile justice and mental health.

Outcome indicators – This State system has a Performance/Outcome Management System in placed called (POMS). It tracks such outcomes as reduction in restrictiveness of placement, improved vocational/education status, reduced criminal activity, improved health care, family satisfaction and improved service utilization.

ARIZONA

Target group – Arizona began its system with a pilot for 200 children with serious emotional challenges focusing on children in out-of-home placements, multi-system involved families or children whose service plans have been unsuccessful. The intent is to extend the availability of the Child and Family Team process to every child enrolled in the mental health system.

Funding approach – Arizona has an 1115 waiver that allows for the enrollment of Medicaid eligible persons in a statewide system of health plans. The State Medicaid Agency, Arizona Health Care Cost Containment System, contracts with the Arizona Dept. of Health Services Division of Behavioral Health to operate a behavioral health carve-out for mental health and substance abuse services. The Arizona Department also receives federal block grants and state appropriations. Regional Behavioral Health Authorities (RHBAs) operate as capitated managed care entities.

Care management – Care Managers who work for Value Options are assigned to families. The Child and Family Team, wraparound process, is utilized for care planning. One member of the team is selected as the single point of contact. A parent partner acts as a co-partner with the team facilitator. There is also a clinical liaison, a behavioral health technician or other mental health professional to support the family, facilitate the assessment process, to coordinate with the child's health care provider. Caseload size for case managers is between 1:12 and 1:15 and does not exceed 20 children per manager.

Benefit plan – Includes a broad array of services available through State Plan but also expands available services such as team planning process, flex funds and other covered services and supports designated in the child's plan.