Cuyahoga County Family and Children First Council
Service Coordination Mechanism

Intent of this Document:
This Service Coordination Mechanism shall serve as a guiding document that will drive the development of protocols and procedures for serving multi-system children and their families in Cuyahoga County. The Mechanism was reviewed and revised by Family and Children First Council staff, the Service Coordination Team, the System Coordination Committee, the FCFC Executive Committee, and the FCFC Full Council, which includes parent representation.

For children who also receive services under the Help Me Grow program (HMG), the service coordination mechanism shall be consistent with rules adopted by the Department of Health under section 3701.61 of the Revised Code. This mechanism was developed and approved with the participation of the agencies, partners, and parents involved in the Cuyahoga County Family & Children First Council, which has the required membership to meet the specifications within Ohio Revised Code 121.37 (C).

Distribution of the County Service Coordination Mechanism
Families and agency personnel will become aware of and trained in the Service Coordination Mechanism process in Cuyahoga County through the following venues:

1. Local Service Coordination Team Liaison Monthly Meetings
2. Quarterly Meetings with Community Partners
3. Family and Children First Council Website
4. Service Coordination "Tough Case Campaign"
5. Parent Advocacy and Leadership Coalition and Youth Advocacy and Leadership Coalition
6. Service Coordination Team Liaisons will disseminate the mechanism within their own agency/organization
7. Training on Service Coordination and Wraparound Processes

Overview and Purpose of Service Coordination:
Since its inception in the early nineties, the Ohio Family & Children First Initiative has been a catalyst for bringing communities together to coordinate and streamline services for those families and children needing or seeking assistance. Collaboration has proven to be in the best interest of families as well as each state and local child-serving system.

As the policy and planning entity for Cuyahoga County, the Family & Children First Council convenes partners to prepare children and youth for healthy, stable adulthood, by supporting programming and planning that increases the self-sufficiency and decision-making abilities of families, prevents children from becoming deeply involved in public systems, and better connects the services a child really needs.

The state mandated that each county develop a service coordination plan that will drive the development of protocols and procedures for serving multi-system children. The current standard is to coordinate services influenced by the Wraparound Philosophy. This approach assists families in identifying their needs and strengths in effort to obtain goals with an individualized strategy within a team. This may be achieved by intervening with intensity and frequency to avoid a potential placement, to avoid involvement in a mandated system, or to reduce the length of stay if a placement is sought.

Service Coordination is a ***family driven process*** for systems and community providers to assist families with planning, organizing, and linking to services or resources. It is designed to meet the needs of multi-systemic children and youth ages 0 through 21. Families are served utilizing a wraparound approach that allows children and families to become more familiar with a multitude of services including financial assistance programs, child support, employment, schools, Help Me Grow services, mental health and alcohol and drug services, childcare, and kinship services.

Service Coordination in Cuyahoga County ensures that families receive the services they need, when they need them, to resolve a chronic problem or address a crisis. It streamlines services to families, promotes shared responsibilities, reinforces collaborative values, and encourages accountability in achieving goals within a parent driven-process. The main objective of Service Coordination is to prevent multi-system involved children and their families, in need of services, from "falling through the cracks" due to gaps or barriers. It is a formal process led by written procedures, which embodies the mission and philosophy of FCFC. It is also an arena where issues and concerns can be identified and addressed.

The Service Coordination Model focuses on developing a coordinated and cooperative public system infrastructure that promotes cross system collaboration—at the policy, programmatic, and case levels. Three guiding principles have been adopted by the public systems—No Wrong Door, Lead System and Cross System Planning. All the child/family serving public systems have agreed on expectations of effective service coordination at the case, or program planning level.

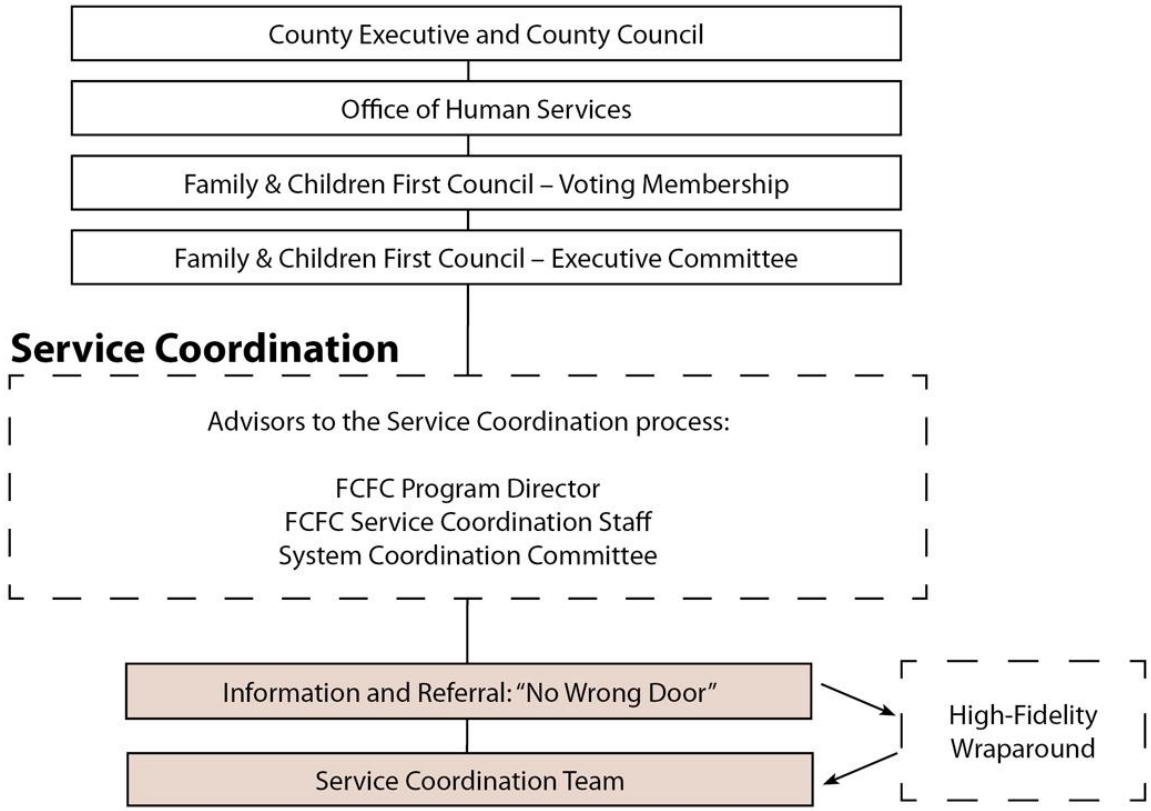
- **No Wrong Door**- Families are linked to the appropriate system and/or service no matter what system or agency they contact initially.
    - The objective of the "no wrong door" philosophy is to ensure that a family does not fall between the cracks. A system is to assume responsibility for a family (child) until that family is connected with the appropriate system.
    - If a family contacts the wrong county system, the family can be given the correct system and # to contact. If the appropriate contact person is known, this information is to be provided to the family
    - If the family is already system involved but needs additional services, systems are to assist a family with connecting to another system or community based agency/ organization, not just make a referral

- **Lead System**-A community provider within one of the child-serving system is designated as the "lead" to guide families through the SCT process in effort to provide a seamless coordination of services.
    - The objective of the coordinating system piece is to ensure that systems are comprehensively addressing the service needs of families; services are to be coordinated across all systems that are involved with a family.
    - The family, or team can designate the lead.
    - The lead does not always have to be the system with the most involvement.
    - Consideration is made on behalf of the families, when assigning a "lead" system due to negative experiences and negative stigmas those systems may carry. Ideally the system "lead" should be the identified system provider that has a rapport with the family.
    - The lead assumes the responsibility of coordinating placements and services as identified by the team. However, all team members participate in the planning around the child and family's need.

- **Coordinated Plan-** Because Service Coordination is multi-system involvement it is possible that each system will have a plan. As a result, the various plans will be inclusive of each other.
    - The responsibility of the coordinating system is to facilitate team meetings, ensuring communication across systems and agencies/ organizations, obtaining a release of information from the family that allows other involved systems and agencies/organizations to share case specific information to formulate a coordinated plan.
    - A coordinated plan helps systems involved understand their role and objectives with the youth and family.
    - A coordinated plan eliminates some of the confusion for youth and their families.
    - The plan should be reviewed and updated as needed.

Cuyahoga County FCFC Infrastructure

The Family and Children First Council is comprised of several levels to manage and implement the Service Coordination Mechanism.



- **Family and Children First Council Voting Membership** consists of the top executives of all the systems who participate in the Family and Children First Council, along with parent representation. The Ohio statute 121.37 sets the membership. In addition to its mandated membership, the council also has representation from partner agencies. The purpose of the council is to help families seeking government services. The council identifies and approves policies, programmatic decisions, and activities.

- **Family and Children First Council Executive Committee** is a subcommittee of the Voting Membership. The Executive Committee establishes service priorities and assures the coordination of activities designed to address those priorities. The FCFC Executive Committee generates and approves policy and action, which will drive system change. The members make recommendations that are later ratified by the full FCFC Voting Membership. The FCFC Executive Committee also provides oversight and direction to all Family and Children First Council subcommittees.

- **System Coordination Committee**. The System Coordination Committee (SCC) is the policy implementation group that reports to the FCFC Executive Committee. The SCT makes recommendations to the SCC, which translates those recommendations into policy. The members of the SCC are empowered by the agency executives to implement policy changes within each system. The SCC monitors the service coordination process, service trends, length of stay for out-of-home placements, shared indicators, and cross system collaboration.

- **Service Coordination Team.** The Service Coordination Team (SCT) exists to help multi-need/multi-system children and their families access appropriate community services and to assure the effective coordination and delivery of services among systems for their best possible health and safety. This team works within the public systems to ensure families are not experiencing system barriers. The Service Coordination Team works with wrap teams to assist when children are in crisis and in need of a short term placement. These system liaisons are able to commit dollars on behalf of the systems they represent, and help monitor the child's length of stay. The systems represented on the Service Coordination Team are: Alcohol, Drug Addiction & Mental Health Services Board of Cuyahoga County (SCT child system consultants are PEP Connections (Mental Health) and Catholic Charities (Alcohol and Drug Addiction Services), Cleveland Metropolitan School District, Cuyahoga County Board of Developmental Disabilities, Cuyahoga County Job and Family Services, Department of Children and Family Services, Help Me Grow, Juvenile Court, Adult Probation, ODYS, Starting Point,. Each system identified has designated one or more individuals to serve as their System Liaison. They are the planners, coordinators, and navigators for a family-driven service coordination team process, which is guided by the service coordination mechanism. The system liaison is considered the expert in their system and has the authority to make decisions on behalf of their system. They help the family's team identify strengths, needs, and resources in systems and communities.

    - The liaison's position is a unique position within each of the systems. There are some liaisons who wear multiple hats in their agency. When in the role of a Liaison, they do not provide direct services to children or families. They float in and out of existing family teams to assist staff from their own system to overcome barriers or resolve problems that are preventing the team from moving forward.
    - The System Liaisons depending on their agency have different levels of intervention. The interventions are:

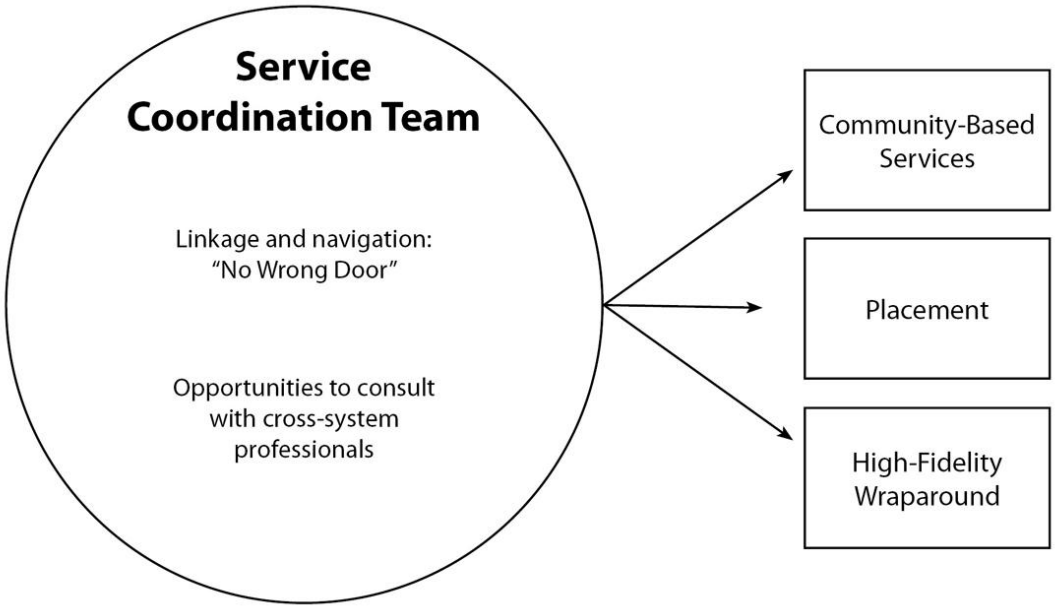
        1. **Linkage, or Navigation**, which incorporates the "no wrong door" principle in working with children and families to link them to necessary services. This may occur through a phone call, or conversation with a family about what services are available and how to connect with that system, or organization.

        2. **Consultation** with professionals, both internally and externally, may occur through phone conversation, face to face, or team meeting to provide assistance and direction to

families or professionals who are trying to determine what services, resources, and supports are appropriate or available.

The system liaison is the expert in their system and has knowledge of other resources or services available through other systems, and can seek guidance from another liaison or representative to navigate the presenting issues or crisis. System liaisons may be asked to consult on closed cases based on the systems history with the family. In those instances, system liaisons should be invited to attend a face-to-face meeting. When system liaisons are asked to consult on cases that have no previous history with their system, the consultation may occur by phone or at a Service Coordination Team meeting.

3. **Service Coordination Team (SCT) Meeting** occurs when there are gaps in services or questions about funding that is available. The SCT Meeting is to explore services including community based, high-fidelity wraparound, or short-term residential placements, as well as to explore funding options. The SCT meetings are typically coordinated by the system liaison or lead system. The lead system, as described on page 2, is designated and approved by the family, to track the progress of the family service coordination plan, schedule reviews as necessary, and facilitate the family service plan meeting process. A family could initiate a SCT meeting by contacting the Service Coordination Specialist at FCFC or the lead system working with the family. The system liaisons or the Service Coordination Specialist at FCFC work with the family to determine who should be invited to a Service Coordination Team Meeting, as well as the goal of the meeting. On a quarterly basis, the SCT Liaisons meet with the local Residential Intake Directors and the local Hospital Social Work Supervisors. The purpose of the quarterly meetings is to enhance collaboration and communication, assist in understanding the service coordination process, and discuss gaps or barriers related to placements or services



Along with the different levels of intervention, the system liaisons also have the following Roles and Functions:

1. Assist in the development of internal procedures needed to implement the Service Coordination Plan (SCP) and in training staff to participate in cross-system activities.
    - Liaisons provide an internal interpretation to agency staff regarding the SCP and the collaborative process.
    - Work with the System Executive, the System Coordination Committee member, and other staff, as appropriate, to keep them informed about the progress, problems, and issues arising from SCP implementation.
    - Assist supervisors/staff who are having problems accessing services from another system; initiate contact with liaison(s) in other systems.

2. The contact point in one's own system to resolve any cross-system issues related to individual cases.
    - Work with other liaisons to resolve multi-system issues that have not been resolved at the work and/or supervisory level**s**.
    - Serve as consultant to the case planning process in an emergency, or to offer advice on a service continuum for short and/or long-term care.

3. Assist liaisons and staff from other systems who are trying to access services
    - Liaisons will work to facilitate access to resources within their own systems.

4. Attend Service Coordination Team meetings and participate in the functions of the Service Coordination Team.

- On a quarterly basis, the subcommittee meets with the local Residential Intake Directors and also the local Hospital Social Work Supervisors. The purpose of the quarterly meetings is to enhance collaboration and communication, assist in understanding the service coordination process, and discuss gaps or barriers related to placements or services.

When should staff contact the system liaison?

All Liaisons

- Prevent deeper system involvement
- To make a connection with another system
- System needs to call 696-KIDS
- Parents are overwhelmed/stressed and refusing to participate in planning
- Multiple disruptions in school (suspensions and expulsions)
- Aggression at home
- Multiple hospitalizations
- Caseworker received a letter from a doctor requesting residential placement

Placement system liaisons (*these circumstance exist in addition to those listed above)*

- Multi-system involvement

- Placement needed - no child abuse/neglect
- Intent to grant custody - no child abuse/neglect

Liaison Consultation

- Multi-system involvement (Worker/Supervisor are not sure what to do to assist the family
- Issues related to health care eligibility
- Get information about other systems and possible resources

- **Youth Advocacy and Leadership Coalition** and **Parent Advocacy and Leadership Coalition**. The Youth and Parent Advocacy and Leadership Coalitions are subcommittees of the Executive Committee that cut across all areas of Family and Children First Council work. Parents and Youth are invited to participate in our planning processes to ensure committee input and feedback at the planning and implementation levels.

  The objectives of the **Youth Advocacy and Leadership Coalition** are to provide youth with opportunities to discuss issues important to them, solicit opinions of peers, serve as youth representatives, and promote youth development. Through participation on Youth Advocacy and Leadership Coalition, young people work in partnership with adults to become leaders on issues that matter to them and develop skills that will be useful for the rest of their lives.

  The **Parent Advocacy and Leadership Coalition** members have the opportunity to model for other parents how to work in partnership with public and private agencies, to disseminate information and serve as an advocate to help children and families reach their full potential. There are parent representatives who participate throughout committees associated with the Family and Children First mission.

  Target Population
  The Service Coordination Team of Cuyahoga County provides service coordination to Cuyahoga County residents from birth through 21 years of age who meet at least one of the following criteria:

  1. Are not system involved, but have a need.*
  2. Need assistance with navigation to get their needs met across systems.
  3. Experiencing difficulties moving smoothly through the system processes.
  4. Families whose wishes differ from what the system is offering.
  5. The needs outweigh the resources of one or more system.
  6. Families who have encountered barriers within or between a system which may impede or disrupt the process.
  7. Families who are having difficulty accessing needed services or supports.
  8. Families who are involved with multiple systems and whose children are at risk of placement outside their home.

  *There are eligibility criteria for some systems/programs.

  Referral Process
  Cuyahoga County has three referral options for Service Coordination. The council will accept requests for assistance from any agency, including juvenile court, and/or any family voluntarily seeking services for their

child(ren). Service Coordination is considered a fundamental way of doing business. Service Coordination referrals are accepted at four levels. Level 1-Families who need support navigating through systems and assistance in understanding services that are available. Level 2 – Families who are diverted from the system with a onetime financial assistance. Level 3 – Families who receive high fidelity wrap from PEP or DCFS/Tapestry System of Care. Level 4 – Youth who are placed in residential treatment with the assistance of the Service Coordination Team. Families are enrolled in the Service Coordination process through the Service Coordination process through a system liaison.

1. Family and Children First Council

A request for assistance is sometimes received by FCFC from the family or from a community agency on behalf of the family. The Service Coordination Specialist will assess the level of intervention needed, and then make a referral to the least restrictive service or system. Most families are referred to one of the fourteen neighborhood collaboratives or the public system that can best service their need. If the family does not live in one of the fourteen neighborhoods, and is not familiar with the closest site, FCFC will contact the collaborative to help the family make a request for services. If the family is not comfortable with that approach, FCFC also works with United Way's First Call for Call Help (211) to assist families.

If a family is deemed not appropriate for the Service Coordination Mechanism but is in need of a referral, or information in order to meet the needs of their child, this information will be given to them and as much assistance as possible offered to help them negotiate systems and/or community resources.

2. Community

Neighborhood Collaboratives, a partnership of community social service agencies, are vehicles to access neighborhood support, services, and resources to resolve the issues of child safety, family stability, and permanency. FCFC refers families to the Neighborhood Collaborative closest to their residency for information about Community based services and supports. Each of the fourteen Collaboratives has staff that consists of 2 to 3 wrap specialists and supervisors who are all trained to facilitate high fidelity wraparound and work with a team to develop individual plans for the youth and their families. The role of the wrap specialist is to work with families who have needs that are not at the level of system involvement. The Neighborhood Collaboratives offer a range of programming/services for children and families. Families who engage with the Neighborhood Wrap Specialists are usually families who:

- Are not system involved
- Have a need that does not warrant system involvement.
- Have a one-time-only emergency or basic living need, such as an appliance or a rental payment.

The Neighborhood Collaboratives also provide a resource specialist for families who have a one-time need and do not met the criteria for wraparound.

3. Community Based High Fidelity Wrap Around

Additionally, the Family and Children First Council (FCFC) partners with two agencies to provide an additional gateway to services for families. The two agencies are PEP Connections through the Alcohol and Drug and Mental Health Services Board and The Division of Children and Family Services /Cuyahoga County Tapestry System of Care (CTSOC).

Community based High Fidelity Wrap Around is offered to families who are in need of services and supports but at the time of the referral are involved minimally with a system or services. Along with the

High Fidelity Wrap Around, youth and families are monitored to determine whether the case is appropriate for the Service Coordination process.

*See page 20-30 for more information about both programs including the referral process.

Role of the School Districts
Cuyahoga County has 31 school districts. School involvement can occur at several points in the process: the parent requests the school's attendance, the school requests the meeting, or a public system invites the district. School districts work with teams to identify appropriate school placements, discuss supportive services, and share academic and attendance history. The family and the school district will make final decisions regarding school placements and supportive services. School districts will be invited by phone or e-mail correspondence. Any team member, including the family, can extend the invitation.

The Division of Children and Family Services/Cuyahoga County Tapestry System of Care
Using a community wraparound process, CTSOC serves more than 600 families each year through both care coordination and family advocacy. Children with serious social and emotional needs and their families are connected to a Care Coordinator who works for a Care Coordination Agency (also frequently referred to as a community mental health agency). The Care Coordinator teams with a Parent Advocate from the Neighborhood Collaborative agency to support the family in the development of a Plan of Care, which addresses the family's strengths, needs, and unique culture. Together, the Care Coordinator and Parent Advocate work to identify and coordinate community based services for the family. One of three referral options identifies the families who are enrolled in CTSOC and subsequently are assigned to a Care Coordinator and Parent Advocate:

- Children & Family Services
- Juvenile Court
- Neighborhood Collaboratives

Neighborhood Collaborative/Community: Families with the potential for system involvement as identified by FCFC or DCFS and who require a higher level of service/intervention; and families known to the Neighborhood Collaboratives without any system involvement, and who require a higher level of service/intervention and 0 – 21 years of age.

The third referral option (Neighborhood Collaborative/Community) noted above is the one most applicable to serving children prior to system involvement. The identification and enrollment process for the Community referral option begins with an initial screening, which is completed by the System of Care supervisor at the Neighborhood Collaborative agency. Families who need assistance beyond what the Neighborhood Collaborative can manage (see above criteria for Neighborhood Collaborative/Community referrals) are then referred to CTSOC so the family can be enrolled with CTSOC and assigned a Care Coordinator and Parent Advocate. The child does not need to have current system involvement or a mental health diagnosis in order to be eligible for the Community referral option. Enrollment in CTSOC can be processed in 24 to 72 hours.

Through Child and Family Serving Public Systems of the County
Each public child serving system has designated one or more individuals to serve as their System Liaison. This Liaison has the primary responsibility to represent their individual system, and has the authority to make decisions on behalf of their system.

The liaison's position is a unique position within each of the systems. Some liaisons wear multiple hats in their agency. When in the role of a Liaison, they do not provide direct services to children or families. They float in and out of existing family teams assisting staff from their own system to overcome barriers or resolve problems that are preventing the team from moving forward. There are times outside of placements, where a liaison may provide suggestions or direction of treatment for the family but it might not be appropriate for that liaison to stay involved.

When the liaisons are contacted to sit on a team meeting typically there are issues that have not been able to be addressed at the worker-to-worker level, or the supervisor or supervisor level. The Liaisons are the persons to resolve cross system issues related to individual issues within each system. They advise family teams about their system's service continuum for short or long-term care. Therefore, a liaison may be asked to consult on a case that the family is not involved in that system but there are concerns that the team may have about the child's presenting issues and whether or not they are eligible for that system.

The liaison also assists with navigation and linkage between the liaison and staff from other systems. Liaisons facilitate access to resources through their own system as appropriate. Liaisons may have knowledge of another system but they are not the experts of that particular system. The liaisons are experts in their own system and often times the team is able to begin to discuss resources that direct service workers are not aware what is available for them to access in that situation. As well as understanding that there are supportive services outside their scope.

All direct service workers or their supervisors or managers are aware of the liaison, and can contact the liaison to assist with the resolution of the system gap/barrier. If there is a problem, typically the chain of command is worker to worker within the systems and if they cannot work it out then it goes to the supervisor, if the supervisor or managers cannot work it out then it goes to the liaisons. That is the beginning of the dispute resolution process. See the complete dispute resolution process on page 28.

Service Coordination Procedures:

The Wraparound Philosophy
The driving force behind the wraparound planning philosophy, also referred to as Individualized Service Planning, is that a child and his/her family's life can be improved if their needs are met. This process is nationally recognized for its success in treating children, adolescents, and families who have significant system involvement. The process requires family teams to think outside of the traditional service packages that are offered by the agencies involved with the family to create a package of services that are tailored to the child and family.

The plan development requires a complete assessment of the child and family's strengths, needs and goals as they relate to each of the life domains. The plan should include traditional and non-traditional services. Traditional services are therapeutic services that an agency will offer to a family via contract with a service provider or by using employees of that agency. Some examples of traditional services are individual and

family therapy, family preservation, parenting or a parent aide. Non-traditional services are unique services that are designed to meet the specific needs of the child and family. Some examples could include a membership to the YMCA, expressive therapy (art or music), tutoring, transportation and a sports activity along with the equipment, just to name a few.

Procedure for a family to initiate a meeting and invite support persons

The family media for service coordination will include information for families to explain that they are welcomed and encouraged to bring any community or family support that they feel would be helpful at their team meeting. Liaison will also develop a checks and balance process to ensure that case managers from each are asking families about the support systems prior to a team to ensure that the presence of those family support persons.

Service Coordination Team Procedures

A. Families Who Present, but Do Not Meet Services Criteria of Any County System

The purpose of the following procedure is to assist county agencies in providing maximum assistance to persons calling with requests for service when that service does not fall within the responsibility of any county agency.

Any emergency should be addressed immediately

Step 1

When a system receives a call, usually at intake, the worker fills out his/her agency's basic screening information form and determines that there is no county system currently involved with the family and the family is not eligible for their own system or any other county system.

Step 2

The worker consults First Call for help, its own resource file, and to the best of the worker's ability, recommends an appropriate community resource for the family to contact. The worker should volunteer to call the agency on behalf of the family. If the family rejects the offer, the worker will provide the family with the resource specialists' name, address and phone number. The worker may also mail the information to the family if the family wishes. If the call is made at the end of the day or over the weekend, information can be given for the family to follow up on the next working day or the worker can volunteer to make the call for the family on the next working day.

The worker always should explain to the family the Service Coordination Grievance Process as well as give the family the Service Coordination Specialist contact information if further assistance is needed.

B. Families Who Present to the Inappropriate System

The purpose of the following procedure is to assist families in connecting with the appropriate County agency in a timely manner when the agency receiving the call determines that it is not the appropriate system to address the family's needs.

Step 1
A worker in the system 1 receives a call in which a problem is presented. The worker gathers the basic information, determines if any current system is involved, and through a brief interview determines that their own services are not an appropriate match, but another county system may be. Using this guide, the worker recommends a referral to the appropriate system. The worker offers to make the call for the family. If the family agrees, the name and phone number is obtained (this constitutes an agreement to waive the confidentiality).

Step 2a: The Family Does Not Give its Name and Phone Number to System 1 Worker
If the family does not agree to give its name and phone number, the worker gives the family the name and phone number of the agency to which the referral is being made and the Service Coordination Specialist's number.

Step 2b: System 2 Accepts Case
The receiving agency processes the case as it would any other referral. The system 1 worker calls the other system and gives a brief introduction of the family and its needs.

If, after evaluation, the system 2 agency determines that the case is not eligible for its service, it makes a referral to another county agency using the procedures contained in step 1 above or refers the family to a community agency.

Step 2c: System 2 Does Not Accept Case
If the system 2 agency refuses to accept the referral prior to an actual assessment and the system 1 worker believes that this is an eligible referral, the following procedures are adopted.

1. Should a disagreement occur between the system 1 worker and the worker in the system from which assistance is being requested, the case will be referred to the next level (supervisory) in both systems. System 1 will maintain responsibility until resolution.

2. If resolution is still not accomplished at the supervisory level, the case and all available information will be referred to the liaisons in each of the systems involved. Time allowed up to this point is next business day. Liaisons are authorized to resolve issues.

3. Because the family is not presently receiving services from other county systems, the system 1 agency maintains contact, by phone or otherwise, with the family until a resolution has been reached and arranges for any needed emergency services.

If the case issues are resolved at this point, the case resolution form will be sent to the Service Coordination Specialist at FCFC.

When a resolution, which is agreeable to the family and the system 1 worker, is not forthcoming, system worker 1 should follow the Case Resolution Process.

C. Families Needing Multiple System Case Involvement

The purpose of the following procedures is to:

1. Describe the process used in serving families who are determined to need the services of additional systems. In this case, families are already being served by at least one system herein identified as the lead.

2. Resolve case planning differences between and among systems at the lowest professional level, and;

3. Document for the Family and Children First Council service gaps, systems' problems, and needs in context, quality, quantity, and financial resources.

Step 1
When the coordinating system staff determines that an open case should be transferred or another public system should share in the provision of services, the staff person will refer the case to another system through the usual intake procedures as identified in this guide. (See the Referral section for more information) The coordinating system will provide services to the child and family until the case has been transferred, a new lead has been identified or the case is closed. This will allow for continuity for the family and ensure that the case is not lost in the transfer.

Step 2
Should a disagreement occur between the coordinating system worker and the worker in the system from which assistance is being requested, the case will be referred to the next level (supervisory) in both systems. The coordinating system will maintain responsibility until resolution.

Step 3
If resolution is still not accomplished at the supervisory level, the case and all available information will be referred to the liaisons in each of the systems involved. Time allowed is the next business day.

Liaisons will be authorized to resolve issues and identify financial solutions and case service plans on behalf of their systems. Liaisons will have the ability to access existing resources within their system. They are expected to work creatively and consider each case a unique problem to be solved utilizing the Wrap around philosophy to identify resources from the public systems and in the community at large.

If the case issues are resolved at this point, the case resolution form will be sent to the Service Coordination Specialist at FCFC. If there is not a service appropriate to meet the family's needs, alternative solutions should be sought and an attempt made to find services to meet the family's needs. When no workable service can be developed, the case should be taken to the full Service Coordination Team (SCT), in addition to following the case resolution process.

When a resolution, which is agreeable to the family and the system 1 worker, is not forthcoming, system worker 1 should follow the Case Resolution Process.

The Service Coordination Plan Procedures ensure that each case has a "lead system". The Lead system is identified by the collaborating system liaisons. This individual will ensure that all necessary case

management-type functions and appropriate communication with a family occur. The coordinating system/agency will clarify the role and responsibilities among collaborating systems such as communication with families, systems, and providers. The primary service needs of the family determine which system will be the lead system. There will be times when the lead system may shift during the life of the case. The Lead System may also be chosen with input from the family. The family may prefer one system as the coordinator as opposed to another, as long as responsibilities and roles are clear and the "wanted Lead System" would produce positive results, the family's request should be considered.

The system that receives the initial call from a family should extend themselves as well as the Service Coordination Specialist at FCFC as a contact for further assistance. This would provide reassurance to the caller that their concerns and requests for help are not being ignored. When there is a dispute regarding which system is the appropriate system to service a family, the system that was initially contacted should maintain contact with the family until the dispute is resolved. In multiple system cases, the Lead System is responsible for the overall case management of the case and will take the lead in communicating, case planning, conflict resolution, and service provision with the family.

The Lead System should never be chosen based upon a perception of one system having more financial or placement resources that another.

Requirements

The first agency contacted or lead system will assume lead responsibility and maintain contact, by phone or otherwise, with the family until the issues have been addressed and the case is transferred.

Documentation is required for each step of the process. It must be accurate and reflect all perspectives, including those that dissent and the reasons for dissension.

Liaisons must submit "uniform reporting forms" for each case in which they are involved to the FCFC. This includes cases, which they resolve. All reports should note service gaps, lack of availability of existing services and information on programs which purport to meet a specific need but do not (e.g. Treatment foster care seems to be limited to very mild types of behaviors.) This is particularly important to the Council in order to continue to improve service delivery. SCC will monitor and evaluate the service coordination mechanism and services provided. They will recommend any changes/update to the service coordination mechanism.

The FCFC Program Director will issue reports, as appropriate but at least minimally once a year on the utilization of the system flow, the types of issues involved and the resolution of each. The Program Director will also bring to the attention of the Council gaps and problems with specific services as they are identified in the liaisons' reports.

The family will be kept informed and involved throughout the process and encouraged to have input at every step.

Each system has a placement policy that youth and families that they follow prior to the placement of a child/youth. The cost of multi-system placements are shared and monitored by the service coordination team. When DFCS is involved, the team meeting or staffing is held with the other participating systems at

the table. When DCFS is not involved, the participating systems have a team meeting with the family and child to determine the appropriateness of the placement and to form or enhance the family team.

The SCT liaisons do not stay on family teams for their duration. There are too many family meetings to have a SCT liaison at each meeting. The role of the liaison complements the family team process. They float in and out of teams based on the needs of the family and their team. When a family team experiences at system gap and/or barrier, system liaisons are called on the assist so the team can move past those issues to continue addressing the needs of the family. The liaison can do this in several ways. Some examples are blended funding to cover the cost of a service, clarifying a system policy, meeting with administration staff or judges to advocate on behalf of the family, and assisting with the referral process to another system or the community.

Who is on the child and family teams?

The system liaison works with your family to identify who should be on your child and family team. Members of the child and family team usually include people who are providing services to your family as well as persons who are supportive to your child and family. A typical team might include:

- The Child for whom services were requested
- Parents and/or Caregivers
- Legal Guardian if the child is in the custody of the county
- Care Partner (who are sometimes called Care Managers, Care Coordinators, Tapestry Care Coordinators, PEP Connections, Community Wrap Specialists or Wraparound Facilitators)
- Parent Advocate, someone who has been through the process and is willing to support you as you participate in the process
- Family, members of the faith community, friends and neighbors who you would like to participate in the process
- Formal supports, those professionals like teachers, guidance counselors, therapists, child protective service workers, probation officers, support administrators, etc., who work with your child and family

Meeting times and locations are coordinated by the lead system. Families and team members are notified by phone within 48 hours of the initial request. Families are encouraged to invite other family members, school staff, mentors, and any person/people they deem as a support.

What are the steps in the team process?

- The worker of record will contact the system liaison to discuss the family's story, including their needs, hopes, strengths, and vision for the future
- The liaison will determine whether the family meets the criteria for service coordination. If the family does not meet the criteria, the liaison will work with the social worker to identify alternative options.
- If the family is appropriate, the liaison will determine if other system liaisons should be involved. The liaison will work with team and other liaison partners to coordinate a meeting.
- At the meeting the team will:
- Determine what interventions have already been accessed
- Assess needs and determine treatment direction

- Brainstorm new options/approaches
- Assign tasks
- Coordinate additional meetings

Plan for the time when your family is ready to move on and no longer needs to meet regularly with the team

Residential placement

The wraparound plans should be strength and community-based, unrestricted, and totally centered on the child and family. Each plan should follow the life domains and meet the goals of at least three of those domains. Residential treatment can be a part of the plan if the child and family have exhausted all family and community based options. The team must agree that the placement is for last resort and is for short-term stabilization only. Reunification should be the primary goal of the plan. Placements will be reviewed weekly for step down or continuation to:

- Ensure children are getting the appropriate treatment
- Monitor the effectiveness of the treatment
- Ensure the step-down process began at the point of placement

Youth may step-down at any time between the review points. If the team determines the placement will exceed 90-days, the liaisons must notify the System Coordination Committee members, System Executives, and the Family and Children First Council office. The System Coordination Committee members and System Executives need to discuss continued funding. The Family and Children First Council office needs document potential gaps and barriers to service.

Youth that are eligible for residential treatment must meet at least one the following criteria:

- Continued use of alcohol or drugs or relapse, which causes a continued need for placement with Intensive Outpatient services for step down.
- Poses a safety risk to self and others, with or without a plan.
- Poses community safety threats to others with continuous charges and/or criminal activity.
- Needs a significant medication change in a safe environment
- Extreme violent and combative behaviors with plans of suicide or homicide

If residential placement is agreed upon as a next step at a SCT meeting, the lead liaison would begin working with the intake department at an identified residential placement facility to determine the youth's eligibility for placement at that facility.

The Service Coordination Team utilizes a continuum of care model to assess the individual treatment needs of the behavioral health youth to assist in determining what services and supports are appropriate for the youth. The continuum of care may include the following services:

(1) Wellness programs
(2) Engagement Services.
(3) Outpatient and Inpatient services.
(4) Rehabilitative and habilitative services
(5) Residential care and supported housing
(6) Acute intensive services.

Unruly Children and Service Coordination

If an alleged "unruly child" is brought to the attention of a Service Coordination Team, it is important that the team assess and address the individual needs of the youth and their family. After identifying the needs, the team with family input will develop a Service Plan. The ultimate goal of this plan should be to involve the child and family in pro-social community resources in their community. Examples of this may be clubs, organizations in school and churches. The Service Coordination Team must realize the importance of not over servicing these youth or placing them in deep-end services where they would interact with high-risk youth. This may further involve them into the system. The plan for the "unruly youth" should be short-term and it should promote competency and developing skill sets as well as sustainability. Recommendations and/or referrals to the Court Unruly Program should not take the place of other county and/or other service providers involved with families. This in turn will help avoid duplicating services.

Cuyahoga County Juvenile Court utilizes **The Court Unruly Program (CUP)**. The Court Unruly Program involves use of service providers to provide an assessment, in-home individualized service plan, and case management services for all youth whose unruly cases have been diverted from formal (Official) Court action by the Court Intake and Diversion Officers. Medicaid eligible CUP youth may also be referred for more intense services such as psychiatric assessments, in-home or outpatient counseling, drug and alcohol assessments, dual diagnosis, and development disability services.

The Objectives of the Court Unruly Program:

- Be family-centered; driven by the needs of the youth and their families, and built on strengths of the family.
- Empower parents to take responsibility for the needs of the youth and their families and support and enhance the parent-youth relationship, while recognizing that youth in the program are best served through diversion rather than formal court processing.
- Be comprehensive and holistic, using a wraparound approach to meet the youth and family's most critical needs, and developing a continuum of resources.
- Strengthen the ability of the participating youth and their families to help themselves.
- Be available and accessible to the youth and families, using a variety of private, community, and personal resources to create the best use of services.

The Court Unruly Program is divided into two components:

- Component 1 includes an in-home assessment, drug screen (with parental or guardian approval), Individualized Service Plan (ISP), and vendor recommendation for case management.
- Component 2 includes case management services for all low risk/low need youth and families, as determined by their assessment and ISP.

Level of Care:

Once a youth or family is referred to the Service Coordination Process, the system liaison or the Service Coordination Specialist will assess the presenting issues and identify the level of care to pursue. Not all families referred to the Service Coordination process will be appropriate for service coordination. However, no family will be turned away without an appropriate level of referral being made to assist them in meeting the needs of their child.

The Family and Children First Council have a partnership with the Positive Education Program (PEP) through the Alcohol and Drug Addiction Mental Health Services Board of Cuyahoga County (ADAMHSCC)

as well as Cuyahoga Tapestry System of Care (CTSOC) through the Division of Children and Family Services to provide wraparound services to youth and family. In addition, Family Centered Services and Supports (FCSS) is a component that continues the foundation that family involvement in service planning and implementation is critical to successful treatment outcomes, strengthens the existing capacity of families to function effectively, and ensures the safety and well-being of each family member.

In Cuyahoga County, the Vroon VanDenBerg Wraparound model is utilized to provide a family-centered, team approach to serving children with multiple needs. CTSOC and PEP both support this model and have tailored the process to meet the needs of the population served. CTSOC receives referrals from two internal county systems and the Neighborhood Collaboratives supporting the wraparound initiative.

Cuyahoga Tapestry System of Care

Cuyahoga Tapestry System of Care takes a family-centered, team approach to serving children with multiple needs. Rather than looking at what is "wrong" with a family, the family and team look at the family's strengths and take action based on those strengths. It is a process that respects children, parents, caregivers and families, and is sensitive to the family's culture, language, and community. It also values the importance of social networks, "natural" supports, the faith community, and neighborhoods.

Cuyahoga County's system of care involves a coordinated network of community-based services and supports that is organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public systems and private organizations so that services and supports are effective, build on the strengths of the family, and address each family's cultural and linguistic needs.
Using the community wraparound process, the focus in Cuyahoga County is on discovering the strengths, needs, and culture of each individual family, while also tapping into close-to-home community services and natural supports that can sustain the family during the process and beyond. Families, along with their Care Coordinator, develop a team of people who can address each family's individual needs with innovative and non-traditional solutions.

The professional helpers that work with a family who is enrolled in Tapestry include a Care Coordinator and a Parent Advocate. The Care Coordinator is a mental health professional who can help the family in addressing their emotional needs. The Parent Advocate is based out of a community-based agency and can help link the family with resources and supports that can help them during a crisis or in the future. The Parent Advocate is someone who has been through what the family is going through and can give a "real life" perspective about how to cope. In addition to the care coordination and parent advocacy services, families enrolled in Tapestry can also access something called wrap supports. These wrap supports are available to help the family in accomplishing their plan or care and can include things like music lessons, respite, and camp. .

Along with the practice model services, Tapestry also helps to build the capacity of the local community for family-centered practice. Some of the other activities that Tapestry is involved with include training, data sharing, evaluation efforts, and collaborative partnerships.

Cuyahoga Tapestry System of Care Procedures

Referral
Cuyahoga Tapestry System of Care serves children and youth who are identified by one of three referral sources: the child welfare system (Cuyahoga County Department of Children and Family Services), the juvenile court system (Cuyahoga County Juvenile Court), and community referrals (the Care Coordination Network that includes the Neighborhood Collaboratives). The enrollment process for each referral source involves an initial screening to ensure that Tapestry is an appropriate fit for the child, followed by development of an initial crisis plan, and linkage to a Care Coordinator who will work with the family in convening a Wraparound Team and developing their plan of care.

The youth are referred utilizing a screening tool to determine if youth are appropriated for enrollment (see addendum A). An Enrollment Specialist assists both DCFS and Juvenile Court in properly identifying and enrolling children and their families in Tapestry. Enrollment is done via our web-based case management information system called Synthesis.

**See Addendum A for Referral Form*

Notification Procedure for all individual family service coordination plan meetings:
If a family involved with Tapestry System of Care is referred for Service Coordination, then a Family team meeting is coordinated via telephone if needed based on availability of the family and system liaisons. All team members are notified and invited to a family service coordination plan meetings. Notified parties will include family, appropriate staff from involved agencies, appropriate school district, mentor, advocate or support person of the family's choice.

Procedure for a family to initiate a meeting and invite support partners:
The process is family guided and the family or care coordinator have the right to call a meeting at any time and have their team (as they identified) present.

Procedure for ensuring an individual family service coordination plan meeting occurs before an out-of-home placement is made, or w/in 10 days after the placement in the case of an emergency:
All team meetings and Wraparound (WA) Care Coordination share a goal of keeping a young person in the least restrictive, most appropriate community-based placement. If an out-of-home placement seems imminent, Care Coordinators work with the family to determine if a safety plan, respite, or other mechanism could aid in avoiding such a move. If the situation involves our referring systems, DCFS, or Juvenile Court practice around staffing(s) or hearings in which a placement is determined necessary, this would be the catalyst and procedures are in place at each agency around placing youth. The child-placing agencies (DCFS, JC, ADAMHS and DD) ***Note: The ADAMHS board may link youth and their families to the system consultants from the Positive Education Program (PEP) and Catholic Charities for additional resources and support for mental health and alcohol and other drugs.*** Providers require a placement meeting 7 days after placement, which must include the youth, if they have the capacity to participate and the parent(s). The parents can invite any family members or advocates they deem necessary for support. The family Service Coordination Plan meeting will coincide with the placing agency's placement meeting that occurs within 7 days.

Procedure for monitoring progress and tracking outcomes:
All goals/needs identified for a family/youth are monitored and tracked monthly via team meetings. A Plan of Care is the vehicle for this tracking. New needs are identified for the initial Plan of Care and ongoing in subsequent wrap team meetings. The needs are given a start date, which should correspond to the date of the POC meeting. The needs are also given a ranking of 1 through 5. (1 means that the need is not met at all and a 5 means that the need is completely met)Additionally, CTSOC employs a Continuous Quality improvement (CQI) process to promote performance-based contracting and help ensure the fidelity of the practice model. The CQI process tracks performance measures on a quality basis, and this data is used to prioritize areas for practice improvement, skill development, and future planning.

Procedure for protecting family confidentiality:
A Release of Information (ROI) is required for all enrollments into Tapestry System of Care. This release is explained in detail to the family and explains their rights as they relate to confidentiality. A copy of the Tapestry ROI is attached. Individual Care Coordination agencies (agencies that are providing direct service to families/youth) have their own ROI that is also presented and completed by the family. This ROI protects the information being shared at team meetings.

**See Addendum B for Release of Information*

Procedure for assessing the strengths, needs, and cultural discover of the family:
The Strengths, Needs, Culture, Discovery (SNCD) is the most important step of the Wraparound process. A superficial discovery leaves the facilitator and Child and Family Team with only with deficits and therefore a deficit-based plan. Deficit-based plans have likely already been tried without positive outcomes.
Completing a SNCD is like building a house. Goals of the SNCD are as follows:

- Identify strengths, assets, and resources across life domains (listed below)
- Understand family culture & decision making process
- Help family develop Long Range Vision
- Identify & Prioritize Needs
- Discuss potential Team Members
- To further the development of trust
- Inclusion of Professionals involvement, opinions of the family's strengths and needs

<u>Life Domains</u>

Family	Friends
Emotional	Safety
Spiritual/Faith	Financial
Medical	Legal
Residence	Educational
Fun and other needs	

*Always ask: Is there anything else I should know about your family?"

The Process of the SNCD generally takes about two hours and is done at a time and place that is convenient to the family. It is a conversation NOT an intake and involves open-ended questions and explores appropriate life domains. Extended family members, friends, neighbors, and individuals from the family's faith community may all be potential participants in the discovery process.

Every family has a unique culture. Family culture is about legitimate differences between families. It is also about language, habits, preferences, and life. Race/ethnicity has a big effect on culture. In the WA process, we must discover family culture in order to individualize and recognize that family culture changes over time. Culture can include many components including language, arts, habits, learned preferences, dress, rules, beliefs, assumptions, standards, roles, play, and societal expectations.

There is no formal form used for the SNCD, but this information is entered in a narrative format in the client record and is used to build the first and subsequent Plan of Care.

**See Addendum D Strengths, Needs, and Cultural Discovery of the Family*

Procedure for developing a family service coordination plan:
The WA Care Coordination utilizes a Plan of Care (POC) to guide the family (opposed to a family service coordination plan). A Plan is introduced and created by the Team with the family guiding the process. A typical first POC meeting would include: introductions; establishing ground rules; explanation of the SNCD and copies to pass out for all participants to read; a review of the family/youth strengths; the development of a team mission statement or family vision; complete a list of and prioritize needs; reframe into measurable goals for the family; brainstorm options; chose options and assign action steps to team members that can support family/youth in meeting goals; set next meeting and evaluate progress on goals if appropriate.

Description of the process and individual components of the family service coordination plan (or Plan of Care):
The initial Plan of Care (POC) is created within a reasonable time frame (ideally within 30 days of enrollment) and updated quarterly, or as needed. The components of the POC are as follows:

- Client Demographics
- Permanency Plan for Client (i.e. sustain current placement, return home, adoption, independent living, and etc.).
- School information, including current school and grade, monthly school attendance, IEP status if applicable, and other related information.
- Relevant Medical information including any medications, physical health needs, known allergies, primary care physician, insurance coverage, etc.
- Diagnosis, including any IQ information if available, Axis I-V
- Family vision statement
- Family SNCD
- Employment, income, and custody status of the guardian
- POC needs with associated life domain, strengths, and strategies that support need (include ranking when updating POC)

Method for designating service/support responsibilities:
All needs within a POC have a responsible party (team member) assigned to them. These team members are assigned to needs to support the family/youth in achieving goals. The method of assigning supports to service areas/needs is a decision that the team makes together, and likely links those team members that are skilled in areas to the needs that they can provide support with.

Method for selecting the family team member who will track progress, schedule meetings and facilitate meetings:
The WA team process is flexible and lets the family guide how decisions are made and what the team will look like. The Care Coordinator and Parent Advocate help the family early on in the process with tasks such as facilitating meetings and tracking progress. These duties should shift over time once the family has an understanding and knowledge of WA and has built the skills and confidence over time to facilitate their own meetings.

Descriptions of how plans will ensure services are responsive to the strengths, needs, family culture, race, and ethnic group, and provided in the least restrictive environment:
The initial POC contains specific and effective needs statements (statements that are not service based, address an underlying need, and help family and team members understand what help is needed). The needs statements in the plan, when addressed, appear to support the family vision as well as the reason the family is enrolled in the SOC. Action plans and services reflect consideration and inclusion of family and individual strengths. Action plans are specific and clearly address the articulated need. The action plan reflects ways that formal services have been tailored to include family or individual strengths, preferences, and needs. Action plans include help and support from more than formal services, I.e. Include natural and informal helpers as a significant component of the plan.

Plan of Care Reviews are updated quarterly, or as needed based on changes in the family. All Plan of Care updates reflect continued planning for earlier needs as well as any new critical needs that have been identified. All Plans of Care reflect increasing individualization and targeting of help designed to meet family and individual needs. Services and needs are reviewed and updated at each WA team meeting. The effectiveness of the strategies are evaluated and modified by the team as necessary. The Care Coordinator submits all plans to a supervisor for review and then CTSOC conducts an administrative review of the POCs as well as annual qualitative review.

**See Addendum E for Plan of Care*

Description of how timeliness will be established for completing family team goals:
WA Care Coordination guides the team in discussing a specific, measurable goal or outcome that will represent success in meeting the prioritized needs. These goals have timelines for completion. These timelines, however, remain fluid and can be adjusted as the family and youth move through the WA process. The team decides how the outcome will be assessed, including specific indicators and frequency of measurement. The timelines will vary based on the family.

Description of how crisis and safety plans will be included in the family service coordination plan (or POC):
The first Crisis Plan (CP) is due 5 days from the time of enrollment. The initial CP is developed at enrollment and updated upon initiation of the care coordination services. This process is intended to identify anticipated crises, the precursors to the crises, as well as the consequences or functions of the crisis. The CP clearly addresses the identified concern. The CP identifies concrete and specific help that the family can access during a crisis. During the first few months, the CP may change substantially. Often the initial plan is heavily dependent on system resources (i.e. DCFS and/or JC). As the Care Coordinator gets to know the family better, resources that are more informal may be identified to use in preventing or

dealing with crises. After a period, the crisis plan may stabilize. It is still a requirement that a new CP is created/updated each time the POC is updated, even if there are no changes.

**See Addendum F for Family Crisis and Safety Plan*

Positive Education Program, Connections

As a participating member of the SCT Team, the Alcohol Drug Addiction and Mental Health Services (ADAMHS) Board designated and appointed the Positive Education Program (PEP) to act on behalf of the Board as a *System Consultant for* multi-system planning and gate keeping functions relative to residential placements for the children's system. PEP's agency philosophy is rooted in assisting troubled children and youth to successfully learn and grow through the Re-ED approach, blending quality education and mental health services in partnership with families, schools, and communities.

The Connections program evolved in the early 1990's commencing from a demonstration project in collaboration with the former Cuyahoga County Mental Health Board (CCMHB). The goal was to diminish the notion that residential placement was the first and only option to manage children with severe and persistent mental illness. As the historic mindset of residential placement remains, PEP Connections continues to employ least restrictive options emphasizing community based planning. As such, the philosophy and mission of the Connections program embodies the core principle and mission of Service Coordination.

As the system's gatekeeper and SCT designee, the role of the *PEP System Consultant* is to educate and provide insight of alternative options in lieu of residential placement to child-serving partners. If placement is deemed necessary, the *System Consultant* is to extend knowledge of available resources, as well as the benefits of home-based wrap-around care, which is executed upon admission of treatment facilities in preparation for discharge. Least restrictive options are employed with a strong emphasis of community based planning utilizing a wrap-around approach that is individualize fully capturing each child and families strengths. This strengths based approach is a springboard for creative planning unique to other service entities.

Fully embracing the wrap-around methodology, Connections staff develops customized "teams", on behalf of a child and family, encompassing their entire ecology. The aforementioned effort yields an individualized service plan, as well as a wraparound plan specifically designed to address the child's full spectrum of needs. The process of individualizing teams entails contact with school personnel, identification of extended family, natural and neighborhood supports, and lastly formal supports provided by other child-serving entities and agencies. Interventions and care coordination efforts of the Connections staff provide a catalyst for positive change with an optimal outcome of empowerment and sustainability.

Positive Education Program, Connections

As a participating member of the SCT Team, the Alcohol Drug Addiction and Mental Health Services (ADAMHS) Board designated and appointed the Positive Education Program (PEP), Connections to act on behalf of the Board, as a *System Consultant for* multi-system planning and gate keeper of residential placements for the entire children's system. PEP's agency mission and philosophy is rooted in assisting troubled children and youth to successfully learn and grow through the Re-ED approach, blending quality education and mental health services in partnership with families, schools, and communities.

The PEP Connections program evolved in the early 1990's commencing from a demonstration project in collaboration with the former Cuyahoga County Mental Health Board (CCMHB). The goal was to diminish the notion that residential placement was the first and only option to manage children with severe and persistent mental illness. As the historic mindset of residential placement remains, PEP Connections continues to employ least restrictive options emphasizing community based planning. The philosophy and mission of the Connections program embodies the core principle and mission of Service Coordination. The Connections program is a cooperative effort between PEP and child serving systems throughout Cuyahoga County.

The primary goals of PEP Connections are to:

1. Generate positive result for children, families and the community, including:
    a. Preventing out-of-home placements, including a reduction in psychiatric hospitalizations
    b. Returning children currently in placement to their home and/or community
    c. Preparing transitional age youth for successful independent living
    d. Reducing penetration in the juvenile justice and child welfare systems

2. Deliver quality mental health services that are faithful to the wrap around model, system of care values, Sanctuary(trauma informed care model), and the Principles of Re-Education

As the system's gatekeeper and SCT designee, the role of the *PEP System Consultant* is to educate and provide insight of alternative options in lieu of residential placement to child-serving partners. If placement is deemed necessary, the *System Consultant* is to extend knowledge of available resources, as well as the benefits of home-based wrap-around care, which are executed upon admission into treatment facilities in preparation for discharge.

Essential Elements: The elements necessary for Connections to achieve the above goals include:

- Mental Health Assessment (MHA) activities conducted as needed to determine necessity for intensive mental health community support services and to support the development of appropriate plans for services and intervention tailored to the child's and family's strengths, needs, and goals across all life domains

- Community Psychiatric Supportive Treatment (CPST) that includes:
    a. Intensive mental health interventions intended to reduce or eliminate barriers to a child's successful functioning
    b. Crisis response and interventions intended to stabilize a crisis situation or prevent crisis escalation
- Family Interagency and Intersystem Collaboration that:
    a. Involves the family, child, natural and informal supports, representatives from formal agencies and child-serving systems for coordinated and comprehensive treatment
    - Maximizes resources by combining those of multiple agencies/systems
- Case management/care coordination activities to facilitate the team's development of the individualized plan, ensure the plan is implemented and promote frequent communication across team members to identify changing needs

- Wraparound services and the availability of flexible funds to meet specific needs, including crisis stabilization, which are able to be increased or decreased in response to the unique and changing needs of the child

Connections has long recognized the importance of linking children and families to sustainable services and supports within their own neighborhoods and aims to help the child and family access needed resources on their own, and to develop sustainable support networks. While recognizing that natural and community-based supports and services are most effective, there are times when flexible funding of non-traditional services are most effective, there are times when flexible funding of non-traditional services may be needed to meet specific needs. Connections has creatively and cost effectively combined traditional and non-traditional services to address the unique needs and strengths of children and families. By providing adequate supports and services, and improving a family's ability to care for their child effectively, many families are able to maintain children with serious emotional disturbances at home and avoid residential placement.

In addition to the above, Connections' long history of providing flexibly funded wraparound services to keep children in the community has provided a unique opportunity to work closely with a wide range of professional and community based agencies and to collaborate with them to creatively design services to fill gaps and/or meet a child's specific needs.

Intensity/Duration: A Mental Health assessment is general y completed in one to two appointments. Youth enrolled in CPST/care coordination services are generally seen weekly for at least one hour, more during the initial phase of treatment and less as they prepare to transition out of Connections services. Child and family team meetings are held monthly. Along with client contacts and team meetings, care managers frequently meet with parents, school personnel and tap into extended family, natural and neighborhood supports. Most of Connections services are provided on a face-to-face basis in the community at the youth's home, school or a mutually agreeable community site. The service is available 24 hours a day, 7 days a week to respond to a mental health crisis. Each Connections care manager carries an active caseload of 15. There is no defined time limit for Connections' services. The average length of stay is currently 13 months.

**See Addendum A for Referral Form*

Delivery Strategy: The Connections assessment and intake manager screens referrals for appropriateness. A mental health assessment is completed, when needed, to determine necessity for intensive mental health community support. At that time, the program is explained to the child and parent or guardian to ensure they understand the nature and intensity of the program and desire CPST/wraparound services. For those families who do not meet eligibility criteria or who do not want the intensity of services provided by Connections, an effort is made to provide other options to the child and family or person making the referral.

A CPST/care manager is assigned to each child enrolled in the Connections program. At the first meeting, families are welcomed to the program, in addition to: the roles and functions of the care manager and family support liaison are reviewed; a crisis plan is developed with the family; the process of gathering information for the strengths, needs, culture, and vision discovery (SNCVD) is begun.

Charged with the responsibility of coordinating the efforts and services available from all sources to support a child and his/her family, the Connections worker involves representatives from a child's entire ecology in the process of developing a mental health individualized service/wraparound plan of care, specifically designed to address the child's full spectrum of needs.

The mental health interventions and care coordination efforts of the Connections staff person are designed as a catalyst for positive change in the life of a child. In addition, the care manager can directly contract for non-traditional "wraparound" programming, from a pool of flexible dollars that can be sued to augment traditional mental health services. This permit care managers to implement imaginative and resourceful intervention plans that "wrap" services around the individualized needs and strengths of each child. This capacity allows services and supports to be tailored to specific needs and to be quickly increased or decreased in response to the unique and changing needs of the child.

Families and youth are engaged and motivated to participate in treatment as a result of clear respect for parent and youth voice and choice; strength-based, individualized, coordinated and comprehensive planning to meet complex needs across life domains; a focus on empowering families and helping them learn the skills to sustain their health and wellness; emphasis on developing sustainable support networks; and linkage to services provided in the neighborhood where youth and their families reside.

**See Addendum B for Release of Information*
**See Addendum F for PEP's Family Crisis and Safety Plan*

Confidentiality

**See Addendum C for Agreement on Confidentiality and Participant List*

**See Addendum B for a draft of the Business Associate Agreement (BAA).*

Family Support Advocate
Along with CPST and care coordination, Connections also provides parent-to-parent support to the families and children enrolled in the program. The PEP Connections Family Support Liaison (FSL) is a trained parent who has raised a child with disabilities and is employed to support parents and assist in enabling them to improve their skills to help both themselves and their children. The FSL uses personal experience and training to guide families through the journey of getting better. Families decide how much or how little they want the FSL to be involved, from as-needed telephone support to active participation on family teams. The FSL also links families with community support programs and activities and provides information and assistance in accessing community resources.

Family support advocates are also available through NAMI of Cuyahoga County.

Dispute Resolution Process
The Cuyahoga County Family and Children First Council have established a formal process to ensure the rights of families involved with Service Coordination. All families accessing the County Service Coordination Mechanism are informed of the Dispute Resolution Process. The Dispute Resolution Process is available to any family receiving FCFC SC and/or any agency represented on the FCFC. The steps to this process are as follows:

Help Me Grow

Families receiving services through the Help Me Grow program are entitled to accessing the Dispute Resolution process described in this section to resolve conflicts that may arise in the delivery of their services. This process will be initially facilitated through the HMG Contract Manager/Director. At any time, families have the right to file a complaint with the Ohio Department of Health. The Cuyahoga County Family and Children First Council will adhere to all timelines, processes and procedures described in the ODH Rules 3701-8-10 (Parent's Rights in HMG), 3701-8-10.1 (Procedural Safeguards to Ensure Parent's Rights in HMG) and 3701-8-10.2 (Procedural Safeguards to Ensure Parent's Rights in the HMG Early Intervention).

System to System

The process for resolving inter-system challenges with a case begins with communication one-on-one with the caseworkers. The case would get brought to the next level of problem solving only when it is unable to be resolved. The goal would be to resolve conflicts at the earliest level of intervention. For crisis level cases, the goal for resolution would be within **7 working days.** If no crisis exists, resolution needs to be achieved within **30 days.** Each system includes a letter about this process in their intake package to give the families.

If the dispute does not pertain to service coordination, parents/guardians will use existing local agency procedures to address disputes. This process is in addition to and does not replace other rights or procedures parents/guardians may have under other sections of the Ohio Revised Code. Each agency represented on a county FCFC that is providing services or funding for services that are the subject of the dispute initiated by a parent shall continue to provide those services or funding during the dispute process.

The dispute resolution sequence is below:

- Worker to Worker - (if not resolved within 24 hours, engage Supervisors)
- Supervisor to Supervisor - (if not resolved within 24 hours, engage Liaisons)
- Liaison to Liaison - (if not resolved within 24 hours, contact FCFC to engage the System Executives)
- Executive to Executive - (if not resolved within 24 hours, contact FCFC to engage the full Executive Committee)
- FCFC Executive Committee- (if not resolved within 24 hours, contact FCFC to engage the County Executive or the Health and Human Services Director to convene the Mediation Committee)
- Role of the Mediation Committee - (if not resolved within 24 hours, file with Juvenile Court)
- Final arbitration - Juvenile Court Administrative Judge

During this dispute process, families must continue to have access to all necessary services. Families will receive a written determination of findings within 45 days of the original complaint from the system liaisons if is resolved at the system level or the Family and Children First Council if the complaint goes to or beyond the Executive Committee level. The social worker or system liaison will work with their legal departments to file an interagency assessment and/or treatment information, related to the dispute, with the Juvenile Court on the seventh day of the process.

Role of the Mediation Committee

The Health and Human Services Director will chair the Mediation Committee. The Committee will consist of the system Executives who are unable to resolve a case issue, two to three Executives from systems that do not place children in congregate care and the Family and Children First Council Program Director. The number of Executives from systems that do not place children will vary depending on availability and the number of systems requesting mediation. The Family and Children First Council office is responsible for coordinating the meeting and reporting its outcome. The Family and Children First Council Program Director will serve as a resource and be responsible for documenting the process. If a vote is taken, the Family and Children First Council Program Director does not vote.

Procedures for requesting Mediation

1. When a family presents itself to the Family and Children First Council office with an issue regarding accessing services, the liaison of the representative system is to be contacted and the Service Coordination Mechanism is to be followed.
2. The Family and Children First Council office will indicate on their intake forms that the system liaison(s) have been contacted and are involved in the process.
3. The Family and Children First Council and system liaison(s) are to work together according to the guidelines established under the Coordinating System principles until the issue(s) presented is (are) resolved.

4a. If the issue is resolved, the Family and Children First Council office will send a letter of resolution to the systems and family.

4b. If the issue is not resolved, the Family and Children First Council office will coordinate a meeting with the Mediation committee and the family.

5. As with other coordinating systems, the Family and Children First Council office is a resource for consultation and discussion for resolution of difficult cases.
6. Once the presenting issue(s) is (are) resolved, the Family and Children First Council office will have no further involvement in the case.

Protocol for Court Resolution of Family and Children First Council Dispute Resolution

1. R.C. 121.38 shall be followed in dispute resolution.
2. Sworn complaint should be filed with the Clerk of Court within 7 days of a failed dispute. The Juvenile Court is the final arbitrator.
3. One original complaint and a sufficient number of copies to serve all of the systems shall be provided.
4. A copy of the above complaint shall be delivered to the Court Administrator's office immediately subsequent to filing.
5. Service instructions shall be filed with the Clerk at the time the complaint is filed.
6. If the child or children are the subject of current Court jurisdiction, the complaint/motion will be processed as any other motion and be referred to the assigned judge.
7. If the child or children are not otherwise within the jurisdiction of the Court, the complaint shall be processed as any other complaint, including numbering and assignment to a Judge pursuant to the Court's assignment guidelines.

Fiscal Strategies
Cuyahoga County policy requires systems to use a three-tiered model to fund services for multi-system children and families within the Service Coordination Plan.

Tiered Funding
The three-tier funding model is essential to the Service Coordination Plan. The funding model explains when it is appropriate to go outside of your system or collaborative to seek additional funding to assist a family. Wraparound funding is **last resort funding** that is used after a child and his/her family has reached their funding cap within a collaborative or child/family serving public system.

- *Tier One* is a system funding its standard services. Services maybe contracted for, provided on a fee-for-service reimbursement basis, or directly provided.

- *Tier Two* are flexible dollars within each system's budget, that can be used to address unique needs of a child and or family. These dollars may be packaged with contributions from other systems to support a complete service plan. By splitting the cost, expensive multi-system cases may not need to access Tier Three.

- *Tier Three* are blended dollars—Community Assistance or Family Centered Services and Support funding is used to prevent child welfare or juvenile justice involvement, prevent residential treatment, and/or maintain family or kinship placements. Community Assistance funding is administered through the Family and Children First Council office. The Family and Children First Council office and the ADAMHS Board via an interagency agreement with the Family and Children First Council office administer Family Centered Services and Support.

Note: When families are requesting short-term stabilizations or placements without custody, the systems liaisons are contacted to join the family team. If the team agrees that placement is appropriate, the liaisons are able to get authorization to blend system funds to pay for these placements. The family team would monitor the placement service and length of stay.

The Family & Children First Council, the Department of Children and Family Services and the Neighborhood Collaboratives to replace the Family Stability Incentive Program (FSIP) developed the Community Assistance Program in 2004. Each Neighborhood Collaborative has a Resource Specialist who provides information and assistance to families who reside in their community. When the families live outside their community, the Resource Specialist can refer the family to the nearest Neighborhood Collaborative for services. These funds are also available to the public systems that participate on the Service Coordination Team.

Funding for Community Assistance is considered a last-resort resource. Each Neighborhood Collaborative or Public System must show that all other available funding has been exhausted prior to the authorization of this funding

The Service Coordination efforts on behalf of Children's Behavioral Health are to provide collaboration and planning among child serving systems to reduce barriers in service. The aforementioned is part of the Children's Community Behavioral Health (CCBH) initiative formerly called Access to Better Care (ABC),

which is to strengthen Ohio's Behavioral Health Services. As it relates to Service Coordination, the sole purpose in accessing these funds is to ensure that children remain in the community or in a least restrictive setting with a plan to return to the community. Any decision made on behalf of an identified youth is addressed through a family team process with the premises that parents are the primary decision makers in the process. Any decisions relative to funding should be made within a team with consistent monitoring to ensure plans made on the onset are being followed or in need of adjustment.

Family Centered Services and Supports (FCSS) funding is available through Family and Children First Council and the ADAMHSCC.

- To access FCSS funding through the ADAMHSCC, a family team meeting must take place to determine the need for services. The services identified should be included in the individualized family service coordination plan. Once the team meeting has been completed and the requested services have been agreed upon, the following forms should be completed:
    1. Cuyahoga County FCSS Authorization
    2. MACSIS UCI Enrollment/Change Form
    3. Release of Information

- To access FCSS funding through Family and Children First Council office**,** a family team meeting must take place to determine the need for services. The services identified should be included in a service plan. Once the team meeting has been completed, the liaison should contact the Service Coordination Specialist at FCFC and submit a completed application. The liaison or agency staff person will assist the family in arranging for service delivery.
- A verification of the FCSS funding award will be sent to the family, the referent, and the service provider.

Flexible funding is available amongst all of the four placing systems: Children and Family Services, the Board of Developmental Disabilities, Juvenile Court, the Alcohol, Drug Addiction and Mental Health Services Board. The remaining systems who, due to budget constraints, are unable to provide flexible dollars, offer other unique services to assist families.

Cuyahoga County policy requires systems to use a three-tiered model to fund services for multi-system children and families within the Service Coordination Mechanism.

Quality Assurance

The evaluation process will begin at the team meeting level. At the team meetings, the system liaison will document the progress and recovery of the child and family and assessed if there should be any changes or alterations to the treatment direction/plan.

The Executive Committee and the System Coordination Committee will monitor and review the Service Coordination Mechanism. The review will occur on an annual basis. The SCT Subcommittee for child placing systems will review the individual progress of children and their families, as well as provide support for the liaisons.