Cuyahoga County Family & Children First Council

Service Coordination Mechanism

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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 FCFC Executive Committee, the Service Coordination Team, 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 Brochure
5. Parent Advisory Committee and Youth Advisory Committee
6. Service Coordination Team Liaisons will disseminate the mechanism within their own agency/organization
7. Training on the Wraparound Process

This document is based on the mechanism last updated on September 29, 2010, and approved by the Ohio Family & Children First Council. Any omissions or errors are unintentional.

For more information on Service Coordination in Cuyahoga County, please contact:

Denise M. Pietrzak, MSSA, LISW-S
Program Officer 4
Family & Children First Council
Office: 216-443-6115
Fax: 216-698-2870
Email: dpietrzak@cuyahogacounty.us

Or visit fcfc.cuyahogacounty.us

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 planning entity for Cuyahoga County, the Family & Children First Council promotes a collaborative system of care emphasizing coordination across a continuum of family-centered, neighborhood based, culturally competent services to ensure the well-being of every child, and to preserve and strengthen families in their communities.

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, child care, 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 lead can be designated by the family, or team.
- 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.

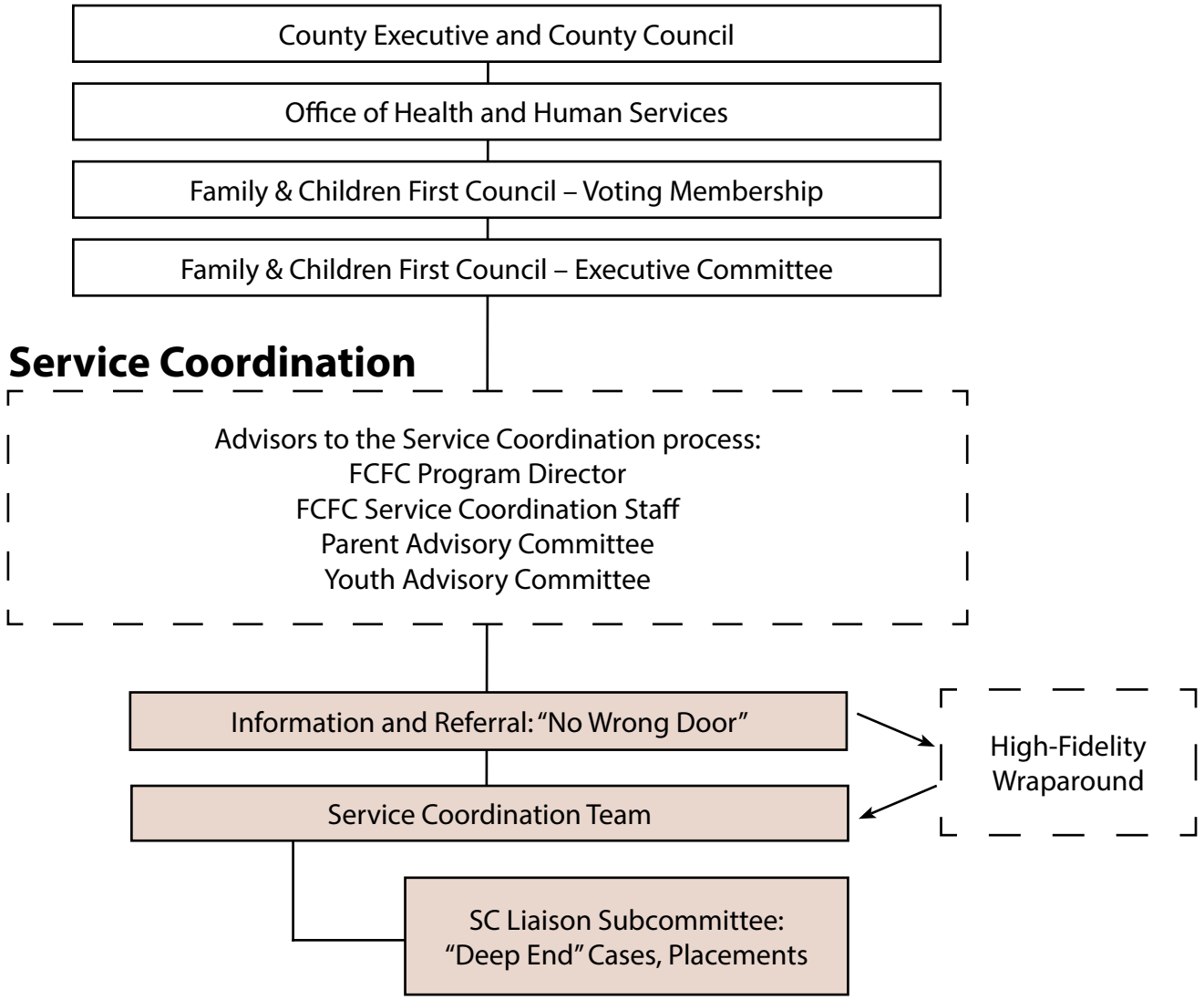
Coordinated Plan

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 membership is set by the Ohio statute 121.37. 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.

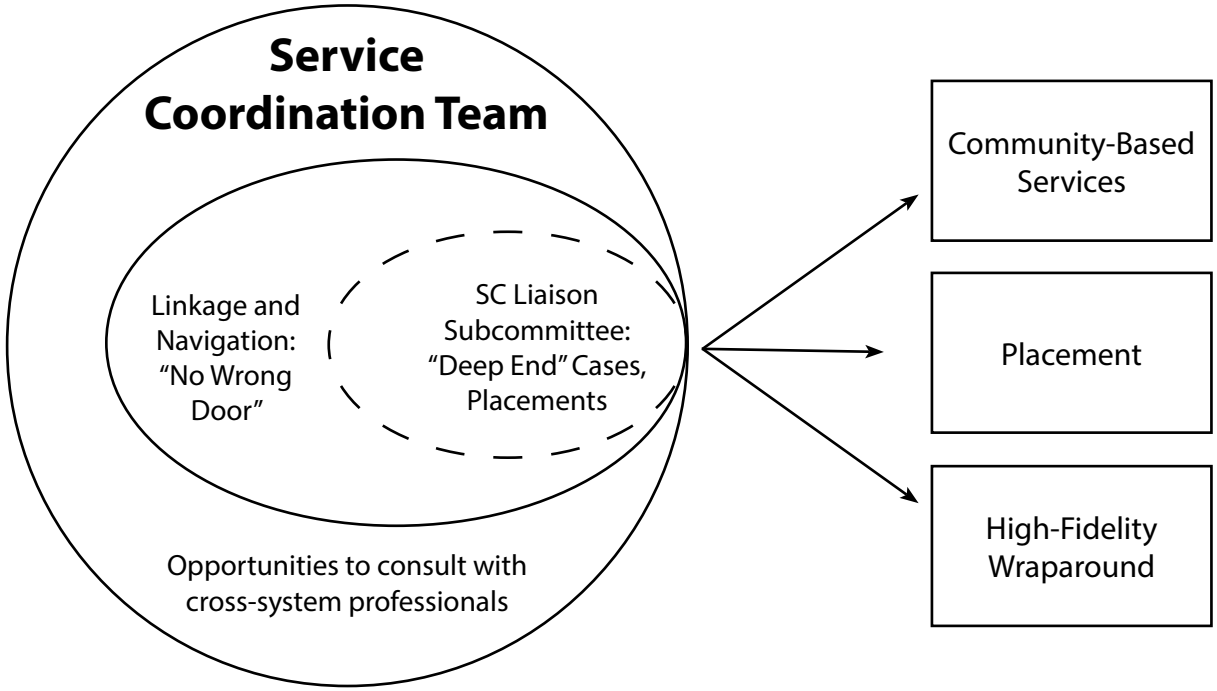
The Service Coordination Team (SCT): exists to help multi-need/multi-system children and their families access appropriate community services and to assure the effective coordination and delivery of services among systems for their best possible health and safety. This team works within the public systems 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 utilization gatekeepers are PEP Connections (Mental Health) and Catholic Charities (Alcohol and Drug Addiction Services), Child Support Enforcement Agency, Cleveland Metropolitan School District, Cuyahoga County Board of Developmental Disabilities, Cuyahoga County Employment and Family Services, Department of Children and Family Services, Department of Justice Affairs, Help Me Grow, Juvenile Court, Starting Point, and Tapestry System of Care.

Each system identified has designated one or more individuals to serve as their System Liaison. They are the planners, coor¬dinators, 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 to professionals both internally and externally 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.
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 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.



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 levels.
- 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.

Service Coordination Team Liaison Subcommittee meeting is attended by the placing systems of the Service Coordination Team. The following systems are involved in this subcommittee: the Department of Children and Family Services, Juvenile Court, Alcohol and Drug Addiction and Mental Health Services Board, ADAMHS board (who are represented by the gatekeeper of the Mental Health System, Positive Education Program and the gatekeeper for the Alcohol and Drug Services, Catholic Charities), Tapestry System of Care, and the Board of Developmental Disabilities. The meeting is facilitated by the FCFC Service Coordination Specialist. The subcommittee meets on a monthly basis. The purpose of the subcommittee meeting is to address ongoing placement needs such as placement discussions, barriers to placement/service coordination, funding, and other placement related issues. 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.

Youth Advisory Committee and Parent Advisory Committee. The Youth and Parent Advisory Committees 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 Advisory Committee 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 Advisory Committee 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 Advisory Committee 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 in the FCFC committee and subcommittee meetings.

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. Families are enrolled in Services Coordination through the Care Coordination Network (Tapestry/Neighborhood Collaboratives), or the Service Coordination Team. Service Coordination referrals are accepted at three levels. Level 1 – Families who are diverted from the system with a onetime financial assistance. Level 2 – Families who receive high fidelity wrap from PEP or Tapestry. Level 3 – Youth who are placed in residential treatment with the assistance of the Service Coordination Team.

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 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 referral and 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 Service Coordination. 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.

Additionally, the Family and Children First Council (FCFC) partners with the Cuyahoga County Tapestry System of Care (CTSOC) and through this partnership, an additional gateway to services is provided for families. 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. The families who are enrolled in CTSOC and subsequently are assigned to a Care Coordinator and Parent Advocate are identified by one of three referral options:

- Children & Family Services
- Juvenile Court
- 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 above and 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.

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. 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. 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 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.

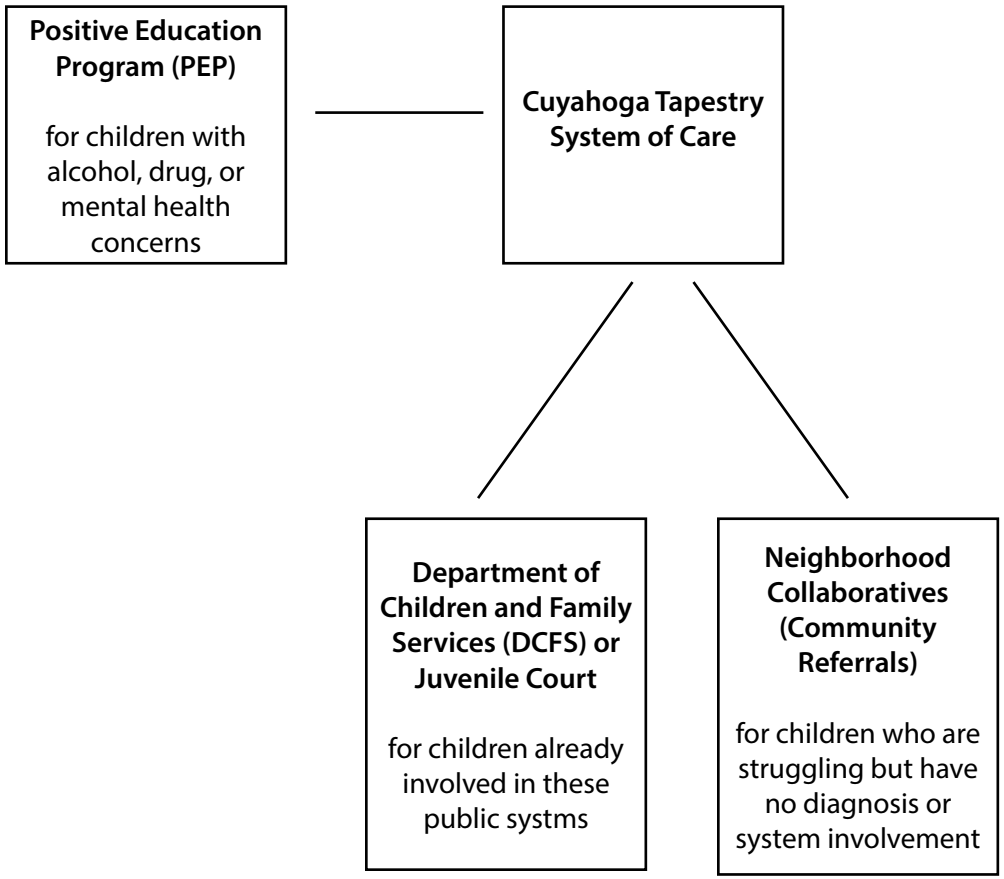
When the liaisons are contacted to sit on a team meeting typically there are issues that have not been able to be addressed at the worker to worker level, or the supervisor or supervisor level. The Liaisons are the persons to resolve cross system issues related to individual issues within each system. They advise family teams about their system's service continuum for short or long-term care. So a liaison may be called to a family meeting, which 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.

Service Coordination



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.

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, but the team must agree that the placement is for a last resort and is for short-term stabilization only.

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's 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. SCT will monitor and evaluate the service coordination mechanism and services provided. They will recommend any changes/update to the service coordination mechanism.

The FCFC Executive 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 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?
All of Cuyahoga Tapestry System of Care programs work 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, therapists, child protective service workers, probation officers, 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?

- A facilitator meets with your child and family to discuss the wraparound process and how it can be used to help you meet your child's emotional needs
- The facilitator listens to your family's story, including your needs, hopes, dreams, strengths and vision for the future
- People who are providing services as well as people who care about and are connected in a supportive role to your child and family are identified and, with the facilitator, you agree about who will come to a meeting to develop a plan and where you should have the meeting

The team will:

- Come up with a Mission Statement about what everyone on the team will be working on together
- Look at your family's needs
- Develop a crisis plan for all families who have an Individual Family Service Coordination Plan.
- Come up with several different ways to meet your family's needs that match up with your strengths
- Agree on who will take on different tasks
- Meet regularly to review accomplishments, make sure the plan is working, makes changes and assign new tasks as necessary
- Plan for the time when your family is ready to move on and no longer needs to meet regularly with the team

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 Case 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 place 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.

Cuyahoga County Juvenile Court utilizes The Court Unruly Program. The Court Unruly Program involves use of service providers to provide an in-home assessment and individualized service plan and case management services for all youth whose unruly cases have been diverted from formal Court action by the Court Intake Officers.

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 from 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 three components:

- Component 1 includes the in-home assessment, Individualized Service Plan (ISP) and vendor recommendation of level of case management.
- Component 2 includes case management services for all low risk/low need youth and families, as determined by their assessment and ISP.
- Component 3 includes case management services for all high risk/high 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) 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. This is one way the FCSS dollars are utilized.

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 wel¬fare system (Cuyahoga County Department of Children and Family Services), the juvenile court system (Cuyahoga County Juvenile Court) and community referrals (the Care Coordination Network which includes the Neighborhood Collaboratives). The enrollment process for each referral source involves an initial screening to ensure that Tapestry is an appro¬priate 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). And 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:

Family team meetings are 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 and mentor, advocate or support person of the family's choice.

Procedure for a family to initiate a meeting and invite support partners:

Wrap Around, Care Coordination and Parent Advocacy are structured in a way that there is no formal procedure for a family to initiate meetings. The process is family guided and they 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 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 Positive Education Program (PEP) and Catholic Charities are the lead agencies for families needing ADAMHS board services. 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

Life Domains

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's 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 (ie. sustain current placement, return home, adoption, independent living, 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 done quarterly, or as needed based on changes in the family.

All Plan of Care reviews 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, more informal resources may be identified to use in preventing or dealing with crises. After a period of time, 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 (PEP)

PEP Connections is a cooperative effort between Positive Education Program (PEP) and child serving systems throughout Cuyahoga County. The program is made possible by funds allocated by the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County and is designed to provide intensive mental health Community Psychiatric Supportive Treatment (CPST) to youth in the county who are experiencing serious emotional difficulties and are determined to be at-risk for deeper system involvement or are returning to home or the community from an out of home placement.

PEP Connections places major emphasis on providing mental health services to youth and their families utilizing an individualized, wraparound approach to care. The Connections staff accomplishes this task while adhering to the tenets of Positive Education Program's Mission Statement: PEP helps troubled and troubling children and youth successfully learn and grow through the Re-ED approach, blending quality education and mental health services in partnership with families, schools, and communities. Among Connections' goals are: an increased voice from parents and other caregivers who support these children and an emphasis on supports and services provided in the neighborhood where the children and their families reside.

The Connections worker is available 24 hours, 7 days a week, to deal with a mental health crisis. A significant portion of all Connections services at PEP are provided to children and families on a face-to-face basis in the community.

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 both a mental health individualized service plan and a child-family-team wraparound plan specifically designed to address the child's full spectrum of needs. Along with regularly scheduled team meetings, this process might entail contact with school personnel, regular home visits to meet with parents or guardians, tapping into extended family, natural and neighborhood supports as well as drawing upon the resources provided by the county's health and human services community. The mental health interventions and care coordination efforts of the Connections staff person provide a catalyst for positive change in the life of a child.

Each child's planning team is expected to develop appropriate outcome goals at the start of Connections involvement. In this way, the child and family will move steadily toward the day when they will be able to access needed resources on their own, and not require the services of an outside professional.

PEP Procedures

Referral

PEP Connections has an electronic record system for recording inquiries of service, Mental Health Assessments, and clinical information for enrolled youth. The assessment department first utilizes a referral screening form via telephone and then schedules an assessment for those youth meeting the basic enrollment criteria. Families are able to complete self-referral to PEP Connections and community partners are also able to complete an initial referral on behalf of a family. However, families make the ultimate decision regarding involvement. To be eligible for services from PEP Connections, a child must be a legal resident of Cuyahoga County, have a diagnosis or evidence of a Serious Emotional Disturbance, have multiple problems and multiple needs resulting from their mental health issues, be at risk of deeper system involvement or returning to their families or the community from a more restrictive placement. When children are found to be ineligible for services based on the criteria, referrals are made to school districts, community organizations and public systems related to relevant information on behalf of the families. This allows families to have their needs addressed in the least restrictive environment available.

*See Addendum A for Referral Form

Notification Procedure for all individual family service coordination plan meetings

No formal notification occurs. SCT meetings are coordinated via telephone if needed based on availability of the family and system liaisons. PEP Connections has been designated to represent the ADAMHS Board in SCT meetings related to Mental Health concerns and PEP receives approval on recommendations through a formal process with the ADAMHS Board.

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

PEP Connections assigns a Care Manager to the family and also has a Family Support Liaison (FSL). The FSL has experience related to parenting a youth with Serious Emotional Disturbance, the Wraparound model, team-based planning, Family Voice and Choice, public and private services and community supports. The FSL is able to support parents in scheduling team meetings, providing relevant information related to the process as well as available services and supports. The FSL and the Care Manager also encourage families to maintain their role as the drivers of the process, which is reviewed during enrollment and on a continual basis. Full Team Meetings occur monthly, however, families are able to initiate additional meetings as necessary. PEP Care Managers typically meet with families more often, on a weekly basis and also provide 24 hour crisis work for all assigned families on a consistent basis while youth are enrolled in PEP Connections. Families are encouraged by PEP Care Managers and the Family Support Liaison to invite other supportive team members to the team so that informal supports are strengthened and can continue involvement with the family beyond the involvement of the formal service providers.

Procedure for ensuring an individual family service coordination plan meeting occurs before an out-of-home placement is made, or within 10 days after the placement in the case of an emergency.

The goal of PEP Connections is to provide the necessary mental health supports and services to ensure that children can remain in the family setting and in their communities. If the youth and family is involved with PEP, PEP participates in the required placement meeting 7 days after placement representing the ADAMHS Board for mental health services. The meeting must include the youth, if they have the capacity to participate and the parent(s). 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 and mentor, advocate or support person of the family's choice. The family Service Coordination Plan meeting will coincide with the placing agency's placement meeting that occurs within 7 days.

The PEP Care Managers 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 Managers work with the family and the public systems to determine if a safety plan, respite, informal supports or other mechanisms can aid in avoiding such a move. If the youth remains at risk for out of home placement, any of the public system partners, such as DCFS, Juvenile Court, CCBDD, or the ADAMHS Board (represented by PEP Connections) can call an SCT meeting to coordinate care. These meetings may also be scheduled to run concurrently with other system mandated meetings such as Juvenile Court's Alternative Case Plan meeting or a DCFS staffing related to custody. In this way, various options are being reviewed, with the goal of least restrictive environment as the goal for the youth. In addition, subsequent weekly meetings can be scheduled when Service Coordination is agreed upon as the method to achieve the most appropriate level of treatment.

A procedure for monitoring progress and tracking outcomes

All goals and needs identified for a family and youth are monitored and tracked monthly via team meetings. An ISP/ Plan of Care is the vehicle for this tracking. New Needs are identified for the initial Plan of Care. 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.

For service coordination, goals are set per the recommendation of the family team related to the treatment necessary and the date for completion. For example, if a youth is receiving treatment in a residential setting, the team identifies up front, the proposed length of stay. Progress is monitored weekly and the plan for the youth to return to home/community is set as well. The end date may be adjusted if the team agrees that further treatment is warranted, however, the goal of the residential treatment is typically a shorter term stay for stabilization, medication adjustment and monitoring and/or further evaluation of symptoms.

A procedure for protecting family confidentiality

A Release of Information is required for all enrollments into PEP. This release is explained in detail to the family and explains their rights as they relate to confidentiality. This release of information is updated with the family each time a new service provider is being considered. Copies are provided to the family and the original document is filed in the client record at PEP.

*See Addendum B for Release of Information

Procedure for assessing the strengths, needs, and cultural discovery of the family

The Strengths, Needs, Culture, Discovery (SNCD) is the most important step of the WrapAround process. This is one of the first steps that a Care Manager completes with the family and guides the development of the ISP/Plan of Care as well as the focus of the team meetings.

- 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

Life Domains

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

The Process of the SNCD generally takes about two hours and is done at a time and place that's 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.

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

Procedure for developing a family service coordination plan

The PEP Care Manager utilizes an ISP/Plan of Care (ISP/POC) to capture the goals of the family. Although this is a formal document that is entered into the electronic record after the team has agreed upon it, the Plan of Care is the living plan related to goals, objectives, strengths used to meet the goals and a thorough assessment of progress.

All of this development begins with the Strength, Needs, Culture Discovery. Therefore, team members are functioning through a strengths-based approach to tackle complicated concerns. Family Voice and Choice is critical to the process and ground rules are established for the functioning of the team. In addition, brainstorming and the prioritization of needs serves an important function to the process.

Description of the process and individual components of the family service coordination plan (or ISP/Plan of Care)
The initial ISP/Plan of Care (POC) is created within a reasonable time frame (ideally within 30 days of enrollment) and updated monthly, 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, 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.
- Mental Health 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)

For families involved with PEP Connections where Cuyahoga County Service Coordination is also identified as a part of the plan; this should be documented as part of the plan related to identified needs and supports to address those needs and persons responsible for addressing the components of the needs.

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 team decision making process, but 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. Most often a Care Manager helps 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 ISP/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 program. 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.

ISP/Plan of Care Reviews are completed monthly, or as needed based on changes in the family's goals or needs. All Plan of Care reviews 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 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 PEP completes an internal Continuous Quality Improvement planning related to the process. In addition, PEP is monitored and audited annually by the ADAMHS Board.

*See addendum E for the PEP's 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
The first Crisis Plan (CP) is established within the first 30 days of enrollment, however, usually occurs very early in the process due to the needs established at referral. A review with the family, which includes a functional assessment of the behaviors that occur in a crisis, as well as concrete and specific supports that the family can access during a crisis, create the plan. During the first few months, the Crisis Plan may change substantially. Often the initial plan is heavily dependent on system resources (i.e. DCFS and/or JC). As the Care Manager develops a relationship with the family members, more informal resources may be identified to use in preventing or dealing with crises. After a period of time, the crisis plan may stabilize. It is still a requirement that new Crisis Plans are reviewed/updated each time the POC is updated, even if there are no changes.

*See Addendum F for PEP's Family Crisis and Safety Plan

Service Coordination for Help Me Grow
All children (ages 0 to 3) enrolled in the Help Me Grow program receive service coordination services in compliance with state and local Help Me Grow policies. The Cuyahoga County Invest in Children is responsible for managing the Help Me Grow program in Cuyahoga County. The Family and Children First Council have an interagency agreement with Invest in Children to manage the Child Well Being Plan. A referral can be made to Help Me Grow by contacting 216-698-7500.

*See Addendum G for Interagency Agreement.

Monitoring Progress and Tracking Outcomes
Service Coordination will track both the progress and outcomes of youth and families in services as well as monitor the overall effectiveness of the Service Coordination process. The Service Coordination Logic Model will help guide the outcomes being tracked.

A pilot project for fall 2010 will document the creative approaches the Service Coordination Team takes to improve futures for children with complicated needs. The Service Coordination Team database will track number of referrals, referrals sources, length of stay for a youth and family in the program, and types of Service Coordination efforts for each child. The database will also be able to generate reports which will be shared with the Service Coordination Team and the Family and Children First Council.

Each of the systems represented on the Service Coordination Team have local policies and procedures that require them to monitor progress and track outcomes. Service Coordination data is collected at three levels. Level 1 – Families who are diverted from the system with a onetime financial assistance. Level 2 – Families who receive high fidelity wrap from PEP or Tapestry. Level 3 – Youth who are placed in residential treatment with the assistance of the Service Coordination Team. The Service Coordination data will be submitted to the state for the purpose of evaluation upon the state's request.

Confidentiality
The system liaison explains confidentiality to the family and obtains releases of information from the guardian to allow communication with the family's natural supports as well as any professional that may be included on the team. The team uses informed consent to ensure that each family knows that the only information to be shared is that information necessary to develop and implement a Service Coordination Plan. At a family service coordination team meeting, the lead system liaison explains confidentiality and obtains signatures from all parties present for the agreement on confidentiality and participant list.

*See Addendum C for Agreement on Confidentiality and Participant List

Each agency involved in Service Coordination has their own Release of Information which is presented to the family and completed by the family. See addendum B for an example of one of the Release of Information utilized by a system liaison.

FCFC is also working with our partners to develop a Business Associate Agreement (BAA) is to allow for data collection between business associates to validate that service coordination is occurring across public systems in Cuyahoga County. This would include tracking our efforts and dollars spent while meeting the needs of youth and their families in the most appropriate least restrictive setting, which may result in short term placement. The BAA will allow FCFC to share client specific information in compliance with HIPAA requirements; whereas the Ohio Revised Code, 121.37 would only allow for general and aggregate data.

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

Family Support Advocate
The need for advocacy on children's issues is ongoing.

The most passionate and educated advocates about those issues are the parents of children.

The Family and Children First Council have attempted to fill that need through the organization of the Cuyahoga County Parent Advisory Committee.

The Parent Advisory Committee will consist of civic minded parents interested in sharing information, concerns, and suggestions to improve the lives of children, families and their community. The goal of the committee is to strengthen families and communities by providing information, education and support. Through information sharing and relationship building, the PAC will be able to champion the needs of all families in Cuyahoga County. A portion of the membership population comes from the eight MyCom communities and a portion of the membership population comes from the community at large. The major focus of the Parent Advisory Committee will be developing leadership skills in the members to prepare them for relationship building with community leaders in the interest of advancing the needs of children. This parent forum will allow the membership to share concerns occurring in their individual communities and allow group problem solving to create a resolution.

As a member of the committee parents complete the Parent as Leaders Training Academy (PALTA). PALTA is a 16 week training designed to help parents, caregivers, and guardians by building communities of peer support and by providing access to the skills, knowledge, and resources that parents need to tackle the issues that affect the quality of life in their families and in their neighborhoods. PALTA is offered through a partnership with the Family and Children First Council (FCFC) and Neighborhood Leadership Institute. After parents graduate from PALTA, there are other training

opportunities available for them to become advocates in the community. A family can request a family support advocate by contacting Neighborhood Leadership Institute or the Service Coordination Specialist at FCFC.

Family support advocates are also available through Tapestry System of Care, PEP Connections, and 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 Project Director. In addition, families can receive support for this process through a Parent Partner supplied through the Help Me Grow program or other advocate of the family's choice. At any time, families have the right to file a complaint with the Ohio Department of Health, Bureau of Early Intervention Services located at The Cuyahoga County Family and Children First Council will adhere to all timelines, processes and procedures described in the Ohio Department of Health, Bureau of Early Intervention Services, Ohio Procedural Safeguards, Part C: Early Intervention Help Me Grow policies.

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 Mediation Committee will be chaired by the County Executive or the Health and Human Services Director. 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 Executive 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 Executive Director will serve as a resource and be responsible for documenting the process. If a vote is taken, the Family and Children First Council Executive 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.

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. Family Centered Services and Support is administered by the ADAMHS Board and Tapestry System of Care via interagency agreements with the Family and Children First Council office.

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 Community Assistance Program was developed in 2004 by the Family & Children First Council, the Department of Children and Family Services and the Neighborhood Collaboratives to replace the Family Stability Incentive Program (FSIP). 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 Cuyahoga Tapestry System of Care 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

A verification of the FCSS funding award will be sent to the family, the referent, and the service provider.

- To access FCSS funding through Cuyahoga Tapestry System of Care, a family team meeting must take place to determine the need for services. The services identified should be included in the individualized plan of care. Once the team meeting has been completed, a service authorization aligning with the goals and needs identified in the plan of care is entered via the web-based case management system. Authorizations are administratively approved via Cuyahoga Tapestry System of Care. The care coordinator assists the family in arranging for service delivery.

Flexible funding is available amongst all of the four placing systems: Children and Family Services, the Board of DD, 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 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.

For more information on Service Coordination in Cuyahoga County, please contact:

Denise M. Pietrzak, MSSA, LISW-S
Program Officer 4
Family & Children First Council
Office: 216-443-6115
Fax: 216-698-2870
Email: dpietrzak@cuyahogacounty.us

Or visit fcfc.cuyahogacounty.us