

SECTION A: Understanding of the Project

1. The Importance of Systems of Care: In her groundbreaking study *Unclaimed Children*, Jane Knitzer (1982) documented the failure of child and adolescent service delivery systems to provide adequate and appropriate care to our nation's children and youth with serious emotional disturbances (SED). At the time, children's mental health received scant attention, involved little collaboration among child-serving systems, and suffered from a lack of family involvement (Kutash & Rivera, 1996). Following publication of *Unclaimed Children*, and the subsequent formation in 1985 of the Child and Adolescent Service System Program (CASSP) of the National Institute of Mental Health, growth in the development of children's mental health services has steadily increased with emphasis on the comprehensive, community-based "system of care" model as an alternative to traditional service approaches (CASSP Technical Assistance Center, 1990).

As systems of care emerged, they were defined in terms of, "a comprehensive spectrum of mental health and other necessary services, which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families" (Stroul & Friedman, 1986, 1994). Recently, the definition has evolved based the understanding of actual experiences of successful system of care communities around the country: "A system of care is an adaptive network of structures, processes, and relationships grounded in system of care values and principles that provides children and youth with serious emotional disturbance and their families with access to and availability of necessary services and supports across administrative and funding jurisdictions" (Hodges, et al., 2007). This definition expands on the original by linking definitional components directly to key areas of implementation including system flexibility, integration, infrastructure, care coordination and collaboration.

There are four major shifts in children's mental health practices: family participation, intensity of services, cultural sensitivity, and the development of community-based service systems (Epstein, et al., 1998). The first shift involves family participation in care. Families were historically viewed as the cause of their children's problems; now they are increasingly recognized as full partners in treatment, implementation, and system change. A second shift involves a change in the understanding of service intensity. Traditionally, intensive services were equated with restrictive residential and inpatient settings. Today, services such as Multisystemic Therapy and mobile crisis response are convincing practitioners that intensity and restrictiveness are independent; youth can receive intensive services in natural community settings. The third shift relates to culturally competent service systems, acknowledging cultural differences and committing to develop services that meet the needs of diverse families. The fourth shift involves the development and implementation of community-based services. While noting these advances, Robert Friedman (1990) commented that, "... there are large discrepancies between what the state of knowledge is and what we are actually doing."

The contemporary system of care model assumes that the needs of children and families are best served through treatment that is family-driven, youth-guided, delivered in the least restrictive, most natural setting possible, and supported by a true partnership between youth and family and

the full array of child-serving systems. The model is based on a framework that mirrors major developmental domains and child and family needs: family, mental health, social, educational, health, spiritual, cultural, vocational and recreational.

Worthington, Hernandez, Friedman, and Uzzell (2001) offered further guidance for system change, identifying consistent themes related to positive outcomes. Briefly, their findings revealed that promising practices essential to successful systems of care could be classified according to three functional categories: *Engagement*—the process of connecting with and maintaining the involvement of children and families in services; *Delivery of Clinical Services*—service elements that lead to the development of effective family / provider relationships and ultimately promote success; and, *Structural and Operational Characteristics*—specific service features that demonstrate system values, including flexibility and a family-driven and community-based orientation. **North Sound Community Coalition** (the Coalition) is fully committed to attend to these functional areas through the planning and implementation of this cooperative agreement in order to build a sustainable system to meet the needs of our children and youth with serious emotional disturbance and their families.

2. Children and Youth with Serious Mental Health Needs: The Coalition will initially prioritize children/ youth in the **project age range age 5 to 19** years and their families across a 5-county region, including the Tulalip Tribes. We anticipate that the majority of our referrals will be for children who are co-enrolled (or in need of enrollment) in mental health and child welfare, and/or special education, and/or the Tulalip Tribes. Our second priority is children/youth with emerging mental health issues.

North Sound Mental Health Administration (NSMHA) Prevalence estimate and Outpatient Service Pattern: NSMHA unduplicated Medicaid-eligible child/youth population in 2007 was 60,409. NSMHA served 5,426 children and adolescents ages 5-19 in 2007, 85% of whom

were Medicaid eligible at the time of the service. SED is experienced by an estimated 6,080 children and youth in our region (DSHS, 2003). Over 1/4 do not receive needed mental health services – leaving a regional service

Race / Ethnicity*	Census 2000 North Sound 5 to 19 Population and percent		North Sound Medicaid Pop.	Wa. State Pop. overall	2007 total NSMHA Medicaid children served		2007 Medicaid North Sound Children and penetration rate	
	Population	Percent			Population	Percent	Population	Percent
African American	3,975	1.73%	3.2%	5%	145	3.1%	1,943	7.5%
American Indian /Native Alaskan	4,558	1.99%	4.0%	2%	166	3.6%	2,439	6.8%
Asian American	14,152	6.17%	3.9%	7%	47	1.0%	2,366	2.0%
Caucasian	173,988	75.84	62.5%	72%	3,528	76.4%	37,748	9.3%
Hispanic	22,763	9.92%	11.1%	14%	273	5.9%	6,722	4.1%
Other/ Unknown	9,976	4.35%	15.2%	n/a	460	10.0%	9,191	10.2%
Grand Total	229,411	100%	100%	100%	4,619	100%	60,409	7.6%

gap of about 1,600 children. **Gender:** Youth ≤ 19 are 51% boys and 49% girls (DSHS, 2006). **Literacy:** Average literacy rate among students 3rd through 10th grade is 77% (Northwest Educational Service District -NWESD, 2007). **Income Level:** 12.2% of the population live at or below the poverty level; the state average is 11.6% (Census, 2007). **Level of Disability:** Disability is reported by 17,867 or 10.5% of children enrolled in the North Sound’s 35 school

districts (NWESD, 2008). **Language:** Spanish is the only non-English spoken by more than 5% of our residents (DSHS, 2007). **Living Situation:** Approximately 1/3 of all children and youth receiving services through the Children’s Hospitalization Alternative Program were living in foster care

environments at some point in during the episode of care. We estimate the same will be true for youth first enrolled in the Coalition.

Service disparities across family and institutional settings for children from racial and ethnic groups: In the North Sound, American Indian/Native Alaskan individuals represent 3.4%

of population and 4.4% are Medicaid eligible.

American Indian /Native Alaskan represent 22% of our children in **foster care**, 16% of our youth in juvenile detention and 20% of our youth in

Race	Juveniles in Detention State/Region		All Child Welfare Services State/Region		CLIP State/Region	
Caucasian	62%	60%	61.5%	68.1%	73.2%	49%
African American	13%	11%	10.5%	6.2%	2.5%	1%
American Indian /Native Alaskan	6%	16%	11.9%	10.7%	7.3%	20%
Asian	3%	5%	1.2%	3.6%	4.9%	10%
Hispanic	13%	12%	10%	11.3%	12.2%	20%

Children’s Long-term Inpatient Program (CLIP, residential treatment).

We serve 165,892 K-12 students in our 5-county region. These students are representatives of 35 school districts and over 300 schools ranging from small, rural districts with fewer than 20 students to large suburban districts with over 20,000 students. Of these students nearly

30% are students of color and over **10% (17,867) receive special educational services.** As shown in the table right, **American Indian/Alaskan Native children and youth are**

Ethnicity (October 2007)	WA K-12 Students* N=1,031,846	NWESD 189 Enrollment N=165,892	NWESD 189 Special Education Enrollment N=17867
American Indian /Alaskan Native	2.7%	2.8%	4.7%
Asian/Pacific Islander	8.4%	7.8%	4.5%
Black	5.5%	3.0%	3.7%
Hispanic	14.7%	11.5%	12.9%
Caucasian (non-Hispanic)	66.2%	72.6%	72%

disproportionally enrolled in special education services (Office of Superintendent of Public Instruction, 2007).

Given these trends, **we estimate 120 annual referrals** as follows:

- **DCFS (child welfare):** We anticipate 15 children/year, including 13% Hispanic, 11% American Indian/Alaskan Native, 62% Caucasian and 11% African American;
- **JRA / County Court (juvenile justice):** We anticipate approximately 11 referrals a year, including 12% Hispanic, 15% American Indian / Alaskan Native, 10% African American, and 57% Caucasian;
- **Schools:** We anticipate 26 children/year, including 6% Hispanic, 73% Caucasian, 5% American Indian/Alaskan Native, and 13% African American;
- **Mental Health System (crisis, urgent and routine):** We anticipate 63 children/year, including 3% Hispanic, 67% Caucasian, 2% American Indian/Alaskan Native, 3% African American, and 6% other; and 19% unknown;

- **Other points of access (law enforcement, primary care, and other medical settings):** We anticipate 5 children/year, including 10% Hispanic, 76% Caucasian, 2% American Indian/Alaskan Native, 2% African American, and 4% other.

3. Current Capacity and Existing Resources:

Formal community supports across our five-county region include:

- North Sound Mental Health Administration - Medicaid and State Plan administrator for public mental health services in 5 counties;
- 1 non-profit parent advocacy group (TRIP);
- 5 child/youth, non-tribal, Washington State Licensed Community Mental Health Service providers with a total of 16 child/youth serving offices;
- 8 Children’s Administration field offices;
- 35 school districts;
- 3 juvenile detention facilities;
- 12 youth chemical dependency providers; and
- 8 Tribal Nations

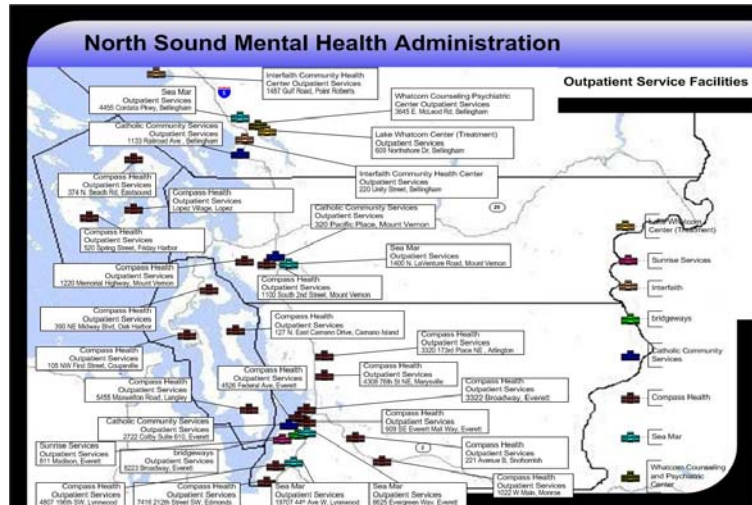
Mental Health Treatment: Despite the many challenges faced by North Sound youth and their families, an inventory of available services shows the primary building blocks for a system of care are in place. However we are lacking in both capacity and the extent to which current services are integrated, accessible, family-driven, youth-guided, and evidence-based. We struggle to find community resources and supports for youth when discharging from community hospitals or the Children’s Long-term Inpatient Programs (CLIP) with or without Medicaid coverage. While 16% of Washingtonians ≤ 19 live in the North Sound, our children account for 25% of the statewide child/youth inpatient utilization. The current lack of intensive, fidelity-based Wraparound Care Coordination leaves many youth without adequate support to safely remain or return home resulting in a pattern of cycling in and out of the hospital system. For the non-Medicaid population, this lack is amplified as there are a limited number of slots accessible within the entire mental health system with the necessary service intensity. Wait-lists for high-intensity mental health programs are routinely 4-6 months long. Children either discharge to their home without adequate supports to sustain the transition, or remain in a hospital setting until select service programs have openings. Foster youth are especially vulnerable due to the lack of placement options for youth discharging from hospital settings.

In January 2008 our region was awarded a Washington State DSHS **High Fidelity Wraparound pilot grant**. We are currently implementing this initiative in Skagit County with the support of Dr. Eric Bruns and Janet Walker, both leaders in the National Wraparound Initiative. Region-wide wraparound care coordination for both Medicaid and non-Medicaid eligible youth will expand community-based options supplying an incredible difference in service capacity; thus, reducing the overall need for hospitalizations and increasing the likelihood that our children can stay in their community and work towards recovery.

The map right shows the physical location of our public mental health offices across the region and our unique geographic challenges – 50.8% of the Medicaid eligible population resided within 5 minutes drive time of a North Sound provider facility and 75% within 10 minutes. Region-wide, 93.57% of Medicaid eligible residents live within 30 minutes of a mental health facility. Of the areas not within 30 minutes travel time, most are areas classified as “large rural” with less than 20 people per square mile. Some island communities appear to be within

reasonable commuting distances of provider facilities but are not due to ferry schedules.

The **Tulalip Tribes Behavioral Health Program** has three programs addressing the needs of children and adolescents. The Healing the Family program provides crisis intervention, stabilization, and conflict resolution for at-risk youth and families. Parenting classes for parents of young children and adolescents are also available. Five case managers provide care coordination. In addition there are 5 youth chemical dependency counselors. The Tulalip Tribes Indian Child Welfare program “beda?chelh” has 8 mental health therapists working with children individually and 1 therapist working with domestic violence victims, including children. The ICWA program has 8 case managers working directly with children who are in dependency. It is the case managers’ responsibility to work directly with families toward re-unification. All Tulalip Tribes behavioral health staff are trained in the fundamentals of wraparound care coordination.



Child Welfare: Many children are co-served by mental health and child welfare; known as Children’s Administration (CA). Within CA, there are 12 separate voluntary and involuntary services and supports; children, youth, and families may be simultaneously eligible for multiple services. Of the 12 categories, Behavioral Rehabilitation Services (BRS) focuses on children and youth with SED. In 2008, BRS was provided to 164 local children (\$37,512 average cost/client). Average length of stay in BRS is 18 months; many interventions and coordination activities are ineffective with 32% of the children re-enrolling. (DSHS, 2008 Number 11.136. 010)

Collaboration: North Sound child and family-serving agencies, Tulalip Tribes and Lummi Nations have an established track record and demonstrated commitment to partnership and collaboration, but we have lacked the infrastructure and resources to truly integrate services across agencies in a family-driven, youth-guided manner. Currently, the proposed Coalition partners operate independently and manage many interrelated contracts, MOU, and informal agreements. Many successful initiatives have been put in place, including mental health services for children and youth currently provided in schools, juvenile detention, Court programs, and integrated primary care settings. Collaborations such as the Children’s Policy Executive Team CPET are actively supported, although not always sustained, as child-serving systems come together to address the needs of our children and youth with complex needs.

4. Significance of the Proposed Project – Gaps and Barriers: In 2006, the CPET re-formed to address these cross-system issues and the development and implementation of a children’s System of Care. Membership featured decision makers from each of the regional child-serving agencies the Tulalip Tribes, and family advocates. During the planning process CPET, along with an expanded group of parents, providers, Tulalip Tribes representatives, juvenile court representatives, child welfare representatives, county government, Educational Service District, local school districts, and early childhood services representatives identified the following

priority gaps and barriers:

- Lack of integration and coordination in access, screening, and assessment, with particular lack of coordination at key transition points (across child-serving agencies, between the child and adult mental health systems, youth returning from out-of-home placements);
- Family and youth involvement is inconsistent and happens idiosyncratically; at a system level, families and youth are not seen or treated as partners;
- Disproportionate racial/ethnic population receiving institutional care;
- Limited acute inpatient mental health capacity for children/youth and a lack of community-based short-term residential options - any family whose child receives inpatient care must travel out of the region;
- Current crisis services do not adequately incorporate family or child strengths and community-based resources. As a result, we utilize more child/youth inpatient bed days than any other region in Washington. This, despite the lack of local inpatient psychiatric facilities for children/youth.
- Our region uses the second highest amount of residential treatment facilities (RTFs) bed days in WA (CLIP, 2005, 2006, 2007); though we do not have child/youth RTFs in our region.
- Access to alcohol and other drug use treatment and consultation is limited- there is a lack of integrated treatment for youth with co-occurring needs;
- School involvement in the mental health system is limited; specific contracts and agreements exist, with need more coordination;
- Lack of coordinated community-based intensive services for our many military children, and;
- While our High Fidelity Wraparound pilot holds promise, providers currently offer a range of support called “wraparound,” few of which are currently implemented to the standards of the National Wraparound Initiative.

Moving from collaboration to integration: While our community strongly values collaboration (multiple overlapping cross-agency forums and many examples of successful partnering exist) key agencies and providers face challenges in working together effectively. At best, we are a collaborative system rather than an integrated “system of care.” Factors related to this include:

- Family support organization anchored to one system (unable to support families across systems) and no formal youth support organization to impact efforts to involve parents, caregivers, and youth in the system;
- Collaboration and integration are not formalized, so successful collaboration requires the ongoing involvement and intervention of high-level stakeholders and agency leaders; and
- Diminishing fiscal resources in past years have forced child-serving agencies to restrict intensive treatment to children with only the most intense impairments.

The North Sound Community Coalition is prepared to implement systems change to address these priorities and to ensure that children, youth and families across the 5 counties and 8 tribal nations in our region have access to a System of Care. Our diverse geography includes: the U.S./Canadian border; the majestic Cascade Mountains; fertile agricultural valleys; 179 islands; an urban setting with 696,600 residents located within 40 minutes from Seattle; and Tulalip Tribes located adjacent to our most populated city. We have one peninsula community that is only accessible by crossing the U.S./Canadian border, *twice*. Many thriving island towns are only accessible by plane or ferry boat with multiple significantly populated towns located an hour’s drive or more from our principal interstate and centrally located services. Unfortunately, the

geographic features that make our part of the country so unique, also create barriers to care coordination for our children/youth and their families.

5. Catalyzing Statewide Change: Collaboration with Federal, State, and Local Initiatives:

The opportunity to develop a new system of care in the North Sound region comes at a critical time in Washington’s statewide mental health transform efforts. The convergence of federal, state, and local initiatives for change within Washington (detailed in later sections of this application) has created a decisive tipping point and an unprecedented opportunity for demonstrating transformed practices and developing real-world strategies for sustainability:

- **Washington’s Federal Mental Health Transformation State Infrastructure Grant (SM57468).** Washington State is one of six states currently implementing Mental Health Transformation State Infrastructure Grants (MHTSIG).The State’s transformation goals are aligned closely with the goals of North Sound Community Coalition’s proposed project.
- **Recent Legislation Developing Systems of Care for Children’s Mental Health Services.** Washington State’s legislature in 2007 passed House Bill 2SHB-1088. The legislation prioritized expanded access to mental health services and expanded funding in future years for children’s mental health services (particularly empirically-supported practices), established an Evidence-Based Practice Institute at the University of Washington, mandated expedited re-enrollment for Medicaid services for youth in the juvenile justice system, expanded pilots for Wraparound Care Coordination, and supported development of integrated screening and assessment protocols.
- **Multiple Department of Social and Health Services (DSHS) Initiatives.** Washington’s state government integrates services for children and families primarily through three of DSHS administrations: the Children’s Administration (CA), which provides child welfare services; the Juvenile Rehabilitation Administration (JRA), which provides juvenile justice services; and the Health and Rehabilitative Services Administration (HRSA), which provides Medicaid, mental health (through the Mental Health Division – MHD), and substance abuse services (through the Division of Alcohol and Substance Abuse – DASA). These administrations are working together to promote evidence-based practices listed below:

Evidence Based Programs and Best Practices Currently Available	
<ul style="list-style-type: none"> ▪ Adolescent Dialectical Behavioral Therapy ▪ Cognitive Behavioral Therapy ▪ Parent Child Interaction Therapy ▪ Motivational Interviewing ▪ Multi-Systemic Therapy ▪ Family Integrated Transitions ▪ Solution-based Casework 	<ul style="list-style-type: none"> ▪ The Incredible Years ▪ Multidimensional Therapeutic Foster Care ▪ Trauma Focused Cognitive Behavioral Therapy) ▪ Functional Family Therapy ▪ Wraparound (fully NWI fidelity) ▪ Global Assessment of Individual Needs-Short Screen

Partnership with Tribal Governments: All of the above efforts have all been carried out in partnership with the 29 federally recognized Tribes located in the State. The Centennial Accord signed in August, 1989, provides a framework for government to government relationships between the State of Washington and each sovereign Tribe. The Lummi and Tulalip Nations are signatories to that accord, and their willingness to join the comprehensive planning process of the Coalition is a tremendous opportunity. In addition, a Tulalip Tribes representative currently chairs the North Sound Mental Health Administration’s Quality Management Oversight

Committee. All Coalition partners are furthermore committed to following DSHS Policy 7.01 providing a framework to work with our local tribes.

SECTION B: Implementation Plan

1. Infrastructure Development

a. Cross-Agency Infrastructure: The partners in the North Sound Community Coalition have come together to realize our vision of: *An integrated system of care to provide comprehensive, community-based mental health services and supports for all North Sound region youth, including children and youth from the Tulalip Tribes, with serious emotional disturbances and their families. Services will be available in the community and feature family involvement in all aspects of care and care coordination.* The CMHI represents an unparalleled opportunity for change across 5 counties and the Tulalip Tribes:

- We will initially prioritize service to youth age 5-19 with SED and involvement in the child welfare, special education, and/or juvenile justice systems as well as youth experiencing co-occurring substance use challenges. Native American and Hispanic youth, children of parents serving in the military, and youth in transition will be a specific focus.
- Our system of care will be governed through a multi-agency **Governance Team** featuring consensus-based decision making with youth and family representatives as full partners.
- The Governance Team will feature five core sub-teams: the **Youth Development Council, Family Development Council, Cultural Competence Council, Care Review Council** and **Program Development Council.**
- Implementation will be led by an **Administrative Team** reporting to the Governance Team.
- We will implement **Wraparound Care Coordination** in full accord with NWI standards supported through implementation of the **Wraparound Fidelity Assessment System (WFAS)** under the leadership of Dr. Eric Bruns, Co-Coordinator of the National Wraparound Initiative and Director of the University of Washington Wraparound Evaluation and Research Team (see letter of support in Appendix 1).
- Development and implementation of our system of care will be organized around the **Partnerships for Success (PFS)** community planning process, also led by Dr. Bruns. The PFS process will bring our community together to analyze gaps and needs, identify appropriate EBPs, with implementation across the partner agencies of the Coalition.
- Dr. Peter Selby of TriWest Group will lead the **local evaluation** team. Dr. Selby has evaluated other system of care communities, and will work closely with the PFS process.

We understand that a functional system of care cannot exist without vital structures and supports. This infrastructure aligns with the contemporary system of care definition presented on page 1 of this application (Hodges, et al., 2007;) and consists of four critical components:

- **Network** – A set of linkages across people, organizations and communities;
- **Structures** – Specified roles, responsibilities and authorities that define and enable an organization to perform its functions;
- **Processes** – Methods of carrying out organizational activities often involving sequences of inter-related activities; and
- **Relationships** – Trust-based links creating connectedness across people and organizations.

b. Governance: Local leaders of five participating Counties; Tulalip Tribes; local parent and youth leaders; mental health, child welfare, and juvenile justice agencies; and the Educational Service District came together in the planning of this proposal and formed the North Sound

Community Coalition Governance Team. A representative of Washington State’s federal Mental Health Transformation Project and local evaluator TriWest Group will participate in the Governance Team as ex officio members, along with key Coalition staff. The Governance Team will include family members and youth as equal partners in all decision-making throughout the six-year grant period. Initially, due to the realities of our current system, the Governance Team will be made up of a majority of professionals. However, through the formation of a **Youth Development Council** and a **Family Development Council**, strong youth and family organizations will be developed enabling youth and families to gradually form the majority of Governance Team voting members. Through training and support, the Councils will fully equip youth and family members to advocate in meetings and other settings and to participate as equal Governance Team partners. We anticipate asking each of the key partnering organizations to engage and support a youth and family member to participate on the Governance Team. This will help us start off with reasonably equal representation of youth, parents and professionals. Support and technical assistance of the Statewide Action for Family Empowerment of Washington (SAFE WA) and Youth ‘N Action!, a non-profit statewide partnership that provides training and support to youth who have been involved in the system and to the organizations that serve them, will be critical to this effort. This support is documented in the letters of support provided by each organization.

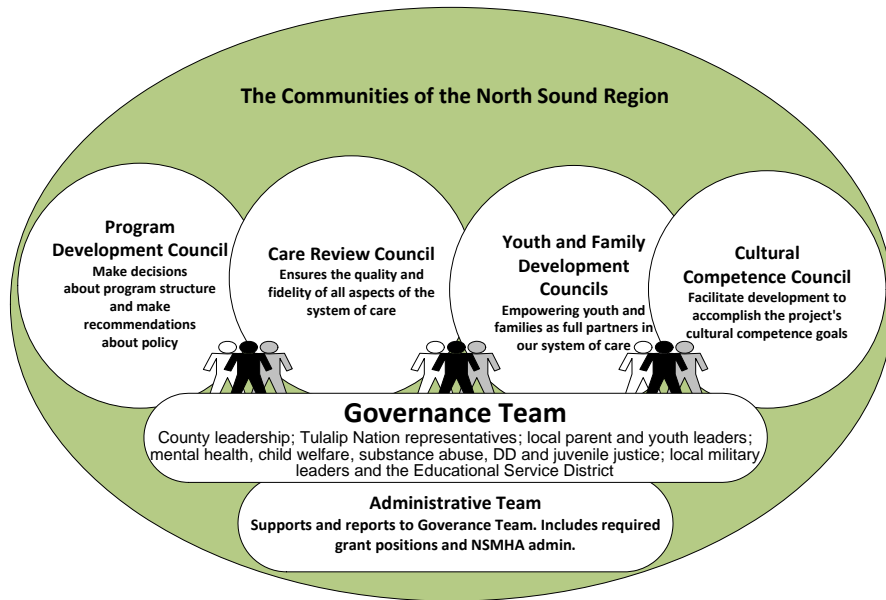
The North Sound Community Coalition Governance Team will:

- Develop and uphold formal agreements among all Coalition partners;
- Hold each other and the broader system of care accountable for meeting high standards of care, including standards for cultural and linguistic competence and family and youth involvement, as well as standards of effective practice;
- Ensure that cooperative agreement funds are expended appropriately;
- Maintain awareness of and active involvement in Washington State mental health system reform efforts, and ensure that our Coalition is model for effective system reform; and
- Collaborate with local evaluator TriWest Group and the University of Washington Wraparound Evaluation and Research Team to monitor clinical and functional outcomes.

Cultural and linguistic competence in governance will be demonstrated by ensuring that members of the governance team are representative of the primary populations that will be served and by ensuring youth and family participation. Meetings will be held in community settings chosen primarily by youth and family representatives. Additionally, meeting information that may be of community interest will be published in our newsletter, available online, and through various other methods designed to reach our diverse population. Materials will be disseminated in both English and Spanish.

The figure below presents an overview of the governance structure, showing the Governance Team and Youth and Family Development Councils, as well as four other core operational teams to be explained in more detail below: the Administrative Team, Program Development Council, Care Review Council and Cultural Competence Council.

As the region's Medicaid and State Mental Health Plan administrator, the North Sound Mental Health Administration (NSMHA) is the Coalition's administrative agent. NSMHA is directly responsible for all contracting, fiscal, and management information systems activities. NSMHA reports directly to the NSMHA Board of Directors, the



Consumer Advisory Board, the State of Washington, and to community stakeholders. All key personnel will either be employed or contracted directly by NSMHA. All candidates for key personnel will be approved by the Governance Team. The regional Children's Policy Executive Team (CPET) forms the foundation for the Coalition's governance body. CPET was originally established in 2000 and reorganized in 2006 as part of the planning for our children's System of Care. Current membership in CPET includes: Training Resources in Partnership (TRIP; professional parent organization); NSMHA; Regional Administrators for Children's Administration, Division of Developmental Disabilities, and Division of Alcohol and Substance Abuse; Northwest Educational Service District 189; County Representative; Tribal Representative; Juvenile Justice Representative, National Alliance for the Mentally Ill (NAMI) administrator, school superintendent, and mental health and child welfare contracted providers. Each of our 5 counties will be represented.

Five key councils will be established to support and guide the Governance Team. These councils are: **Program Development**, **Care Review**, **Youth & Family Development**, and **Cultural Competence**. The Program Development Council will make decisions about program structure and recommendations about policy. The Care Review Council will ensure the quality and fidelity of all aspects of the system of care. The Youth & Family Development Councils will empower youth and families as full partners in the system of care. The Cultural Competence Council will facilitate the process to accomplish the project's cultural competency goals.

c. System Integration Procedures: Interagency Collaboration. The Coalition will promote system integration and formalize commitments to the collaborative process through Memoranda of Understanding (MOU) among the community's child-serving agencies and providers. Governance Team members will execute MOU to formalize their commitments. At the system level, the purpose of these MOU will initially be to engage the members in an ongoing, multi-

system, strategic planning process focusing on coordination of multiple funding streams, integration of provider networks, and joint policy formation. Agreements will specify each partner's role in the system of care, their financial and in-kind contributions, official representation in governance, service coordination and delivery structure, and staff assigned to carry out each partner's responsibilities under the agreements. When state or federal agencies are represented, the agreements will address any limits on their representatives' authority and any special requirements or procedures for consenting to or endorsing the Coalition's recommendations and decisions. More specifically, MOU include commitments to:

- develop and adhere to a common set of principles and values;
- a shared purpose, mission, target population, goals, and measurable objectives;
- share program funding and in-kind supports;
- coordinate federal benefits/entitlements;
- contribute staff time and knowledge in the writing of grants, RFP responses, etc.;
- value diversity and adapt to the diversity and cultural context of communities served;
- comply with all requirements of the SAMHSA Child Mental Health Initiative Grant;
- participate as active members in the North Sound Community Coalition
- participate as active members of the regional Children's Policy Executive Team;
- participate in county-based Family Intensive Resource & Strategy Teams;
- monitor and share data and outcomes;
- to communicate openly, honestly, and often with each other to resolve challenges;
- participate in training in systems of care development, implementation, and sustainability;
- obtain training in Wraparound with fidelity to the National Wraparound Initiative;
- NSMHA operating as the Administrative Agent for the Coalition.

MOUs have been secured with Children's Administration Region 3 and local Juvenile Rehabilitation Administration representatives, authorized through the letter of support from Interim-Secretary Stan Marshburn on behalf of the Department of Social and Health Services.

With respect to consolidation of funding streams, all partners agree that all federal, state, and local funds targeting services to youth with serious emotional disturbance and their families will be "on the table" to the extent allowable by law. All State Plan and 1915(b) Waiver mental health services for Medicaid eligible children will be covered through NSMHA and provided by contracted children's mental health provider agencies. State mental health funds will be used to provide additional supervision and placement costs and county funds will be combined with Medicaid and state funds to support expanded implementation of evidence-based and culturally specific practices detailed below. With respect to integration of provider networks, all partners agree that our community's goal is to integrate currently separate, but overlapping, network development resources and activities to develop a unified process for provider contracting, credentialing, monitoring, and evaluation. With respect to joint policy formation, all partners agree that the Coalition's goals are to reduce and ultimately eliminate barriers to access and to promote system of care core values and guiding principles among all levels of participating entities.

System integration will be supported by an **Administrative Team**. This team will include the Principle Investigator, Project Director /State Liaison, Family Coordinator, Youth Coordinator, Cultural and Linguistic Competence Coordinator, Social Marketing Coordinator, Technical Assistance Coordinator, Local Evaluators, and administrative support staff. This team will be

selected by, and report to, the Governance Team. The Administrative Team's responsibilities will include:

- Support the Governance Team in development of a strategic plan in coordination with Dr. Eric Bruns (Univ. Washington) and the Partnerships for Success model (described later);
- Budget, manage, and expend service funds as approved by the Governance Team;
- Integrate funding streams to the fullest extent possible under state and federal law;
- Manage contracts for service delivery, training, TA, evaluation, and communications;
- Use findings from the national and local evaluations to support the Governance Team in directing ongoing and future programs, practices and policies, under the direction of local evaluation team lead Dr. Peter Selby (TriWest Group).

Service Integration: Ultimately, the measure of integration will be the experience of each youth and family served. The Coalition will promote (and evaluate) an integrated but decentralized care coordination capacity implemented across the region by provider agencies. Through contractual agreements and MOU, the Coalition will direct care management and Wraparound Care Coordination for all youth with SED and their families, regardless of referral source or point of entry. We use the term care coordination to make clear that this role involves more than the coordination of "treatment." Wraparound teams will craft a plan of care that addresses all system of care components. NSMHA currently contracts with 2 community mental health providers (Compass Health and Catholic Community Services Northwest) to provide Wraparound Care Coordination. Based in four counties, only one, Skagit County, is funded to a level considered to be in compliance with fidelity standards. Under our current system, wraparound facilitation and parent partnering is available *only* through mental health providers. We will expand access so that credentialed facilitators will be available through education, child welfare, all 5 county health and human services, and parent-driven networks. The Coalition will enhance access, quality, training, and evaluation policies and practices. The Coalition will work with wraparound consultants Vroon-VanDenBerg and Dr. Eric Bruns from the University of Washington to ensure fidelity.

The Coalition will work towards a team of bilingual, bicultural Wraparound Care Coordinators to facilitate individualized youth and family teams. At least half of the members will be chosen by the youth and family, including the youth and the youth's primary family caregiver. Plans of Care developed by these teams will ensure youth and family safety, as well as the delivery of culturally responsive services through a mix of formal and informal supports aimed at meeting the unique needs of each youth family. This proposal also includes a pool of "flex-funds" that can be used for typically non-reimbursable service items to meet cultural and other individualized needs. To ensure that services are accessible, our policy will be to provide Care Coordination activities in the youth and families' homes, and to arrange for home-based or neighborhood-based support services as much as possible. When families must access office-based services, Care Coordinators will ensure that convenient transportation and childcare are available or arranged.

Mental health services will be provided in settings such as schools, detention and foster homes, which are more accessible to youth and families and conform to service delivery needs in the partner system settings (child welfare, juvenile justice, schools). Structures will be in place ensuring that agencies work together to support and partner with youth and families. Cross-training will be provided across partner agencies to ensure that all understand the services and

supports which will be provided as well as each others' capabilities, limits, and mandates.

Care Review: The proposed Coalition structure includes a cross-system **Care Review Council**. This group ensures the protection of consumer rights and adherence to the system of care core values and guiding principles; monitors progress toward achieving individualized Plan of Care goals; and develops recommendations to improve the adequacy, appropriateness, and quality of services and procedures. The Care Review Council will also establish care review protocols and criteria. The intent is not to review every youth's care, but to select Plans of Care that exemplify the variety of needs being addressed and the typical barriers and difficulties encountered; thus, barriers are identified and overcome and best practices maintained and expanded. The Care Review Council will interview youth, family members, care coordinators, and others and examine the Plan of Care. The Council, made up of youth, family members and professions will:

- Monitor appropriateness and quality of individual Plans of Care;
- Monitor fidelity to system of care and National Wraparound Initiative principles;
- Ensure that living and service placements for children are in the least restrictive, most normative, clinically appropriate, and safest environments;
- Monitor the degree to which care management and other services enhance the strengths, resilience, and well-being of youth and families; and
- Ensure compliance with all federal and state funding rules, including regulations under 42 CFR 438 governing Medicaid Prepaid Inpatient Health Plans, Title rules and regulations for electronic exchange of information and for confidentiality of case records as required by the Health Insurance Portability and Accountability Act (HIPAA).

Access, Financing, Workforce Development and Community Leader Support: To ensure the Coalition's sustainability, we have been careful to budget the available SAMHSA CMHI funds for capacity building and not to rely on them for long-term operating costs. We have studied the CMHS report on sustaining systems of care beyond the federal investment (Koyanagi, 2000) and the 2004 Matching for Sustainability report; our proposal is built with those lessons in mind. Procedures for flexible funding will include braiding DCFS, JRA, and NSMHA funds, determining how youth and family needs will be identified, and developing policies for accessing the funds. All partner systems will be educated and informed on practices ensuring access to all services and supports available to youth and family. **Financing** will be addressed through the use of in-kind resources and multiple funding streams from participating agency representatives. The Coalition will braid funding resources from the following sources: Medicaid Mental Health Services, State Mental Health Funding, Children's Administration, juvenile court, County Sales Taxes for Mental Health and Drug Treatment Services, pilot project funding for evidence-based practices, and in kind supports from schools, developmental disabilities, community mental health centers, counties, and parent advocate groups. 1/10 of One Percent Funds: **All 5 counties** in the Coalition have recently passed a **1/10 of one percent sales tax** measure allotted to address funding gaps for mental health and chemical dependency treatment. Based on 2006 data we project \$14,136,373 in *new* tax revenue. Tulalip Tribes will provide \$250,000 of in-kind match through employees who work for Tulalip Tribes. These tribal employees include: child therapists, case managers, youth and adult chemical dependency counselors, individuals who run the Social Services Program. Skagit Wraparound Pilot: This state-funded project gives us a head start on braiding funds from multiple agencies including mental health, child welfare, and county health and human services. Flexibility of Funds: NSMHA has allocated \$41,200 for children enrolled in the public mental health system. An additional \$10,000 is allocated to flex funds

through our Washington State funded wraparound pilot in Skagit County. **Workforce Development** will pursue the following outcomes: (1) All staff at each partner organization will develop a shared understanding of important program concepts; (2) Support professional development across the system of care to shift from a professionally-centered service model to a family-centered, family-driven service model. **Community leader support** will include the leadership of the five participating Counties and Tulalip Tribes and outreach to leaders in the business and philanthropic community.

d. Replication: Washington State is in the midst of transforming its mental health systems. In her letter of support, Governor Christine Gregoire talks about how the North Sound Community Coalition aligns with two major statewide initiatives at the heart of this transformation: the SAMHSA-funded Mental Health Transformation Project (MHTSIG) initiated in 2006 and the legislatively-driven promotion of systems of care under the 2007 House Bill 2SHB-1088.

- The 2005 Joint Legislative & Executive Mental Health Task Force carried out a statewide review of mental health systems, leading to both a restructuring of responsibilities for regional mental health authorities to comply better with Medicaid managed care requirements under 42 CFR 438, and to setting the stage for Washington's successful application for the Mental Health Transformation State Infrastructure Grant awarded in 2006.
- Building on earlier SAMHSA Children's Mental Health Initiatives in King County and Clark County, legislation (2SHB-1088) passed in early 2007 established a statewide infrastructure of prioritized funding, Wraparound Coordination pilots, and a statewide center of excellence grounding fidelity and monitoring outcomes for child and family best practices (the Evidence Based Practice Institute at the University of Washington).
- In support of replicating this framework statewide, DSHS contracted with TriWest Group (the local evaluator for the Coalition) to review its State Medicaid Plan and recommend strategies for sustaining empirically-supported practices. The Final Report from July 2007 prioritized expansion through Medicaid funding of fidelity-based Wraparound and EBPs including Multisystemic Therapy, Multidimensional Treatment Foster Care, Parent-Child Interactive Therapy, and Trauma-Focused Cognitive Behavioral Therapy.

The Wraparound Evaluation and Research Team (WERT) at the University of Washington serves as the state's hub for replication. In 2004, Washington State was fortunate to become the home of Eric Bruns, PhD, Director of the WERT, as well as co-coordinator of the National Wraparound Initiative (NWI). Dr. Bruns offers the **Partnership for Success (Pfs) Community Process and Consultation Model** for helping communities plan and develop local systems of care. Aligning our Coalition with the Pfs approach builds on momentum within the state for implementing systems of care and provides a critical opportunity for comprehensive reform across a diverse region that includes the several tribal governments, and a vast geography encompassing numerous small towns across a major agricultural region. We believe that the diverse coalition assembled for the North Sound Community Coalition can be a critical tipping point in statewide transformative efforts.

e. Developing the Structures in a System of Care: In August 2007 Vroon-VanDenBerg conducted a Readiness Assessment demonstrating that our region has a high-level of collaboration, but lacks the supports to reach full system integration. This effort, along with the upcoming (January 2009) Community Supports for Wraparound Inventory through the University of Washington and Portland State University, lays the groundwork for successful

development of the structures for a System of Care.

Structural changes necessary to build and sustain a system of care include specifying roles, responsibilities, and authorities enabling the system to perform its functions. Collaborative structures include budgetary authorities that facilitate flexible, cross-agency, and family-friendly decision making and infrastructure that facilitates smooth transitions for youth and families across system boundaries and service levels. More concretely, the clinical network, administrative team, training, performance standards, and information sharing capacity are critical elements of system structure. The **Clinical network** development by the North Sound Community Coalition will be led by the **Program Development Council** of the Governance Team and supported by community mental health provider agencies within the region and Tulalip Tribes Behavioral Health Program. They will participate in ongoing planning with core initiative Councils and the Governance Team.

We propose three levels of coordination: (1) clinical/direct service, (2) agency management, and (3) system level. Clinical and direct service coordination will center on Wraparound Care Coordination (with fidelity to NWI principles). The management level, which will include the Project Director, will be responsible for regular reviews and reports on system challenges to provision of coordinated and integrated care to youth and families. It will carry out resource sharing authorized by system-level coordinators. System-level coordination will include the Governance Team and other agency leads with fiscal control. System-level members will have the authority to endorse resource sharing and braiding. They will also have the authority to implement policy changes in their respective agencies.

System integration will be supported by a carefully selected **Administrative Team**. This team will include the Project Director, Family Coordinator, Youth Coordinator, Cultural and Linguistic Competence Coordinator, Social Marketing Coordinator, Technical Assistance Coordinator, State-Local Liaison, Local Evaluators, and administrative support staff. In addition, the NSMHA Executive Director, Fiscal Officer, and Information Systems/Information Technology Administrator will sit on the Administrative Team. The administrative team will be co-located in a central office adjacent to NSMHA in Skagit County (located equidistant from most other counties in the region). This team will report to the Governance Team. The Administrative Team will include direct participation by Dr. Eric Bruns (WERT/NWI) and Dr. Peter Selby (TriWest Group).

Training capacity will be developed through pooling agency resources and by developing a training schedule that addresses the shared needs of those involved in the system of care. Coalition partners commit to include youth and family members in cross-agency training including. We have identified a Wraparound trainer and coach, Vroon-VanDenBerg, whose model has demonstrated fidelity through the Wraparound Fidelity Index, and who has worked closely with Dr. Bruns. All partner organizations will participate in training based on NWI principles to build a culture of understanding around the core aspects of our system.

Performance standards will be developed by the Program Development Council with the assistance of Vroon-VanDenBerg, Dr. Bruns, and our local evaluator. Standards will be enforced by the Care Review Council ensuring that youth and families have consistently high-quality experiences across the system of care.

Management Information System: As the administrative agent, NSMHA will assist the Coalition in developing and managing the information systems used to collect and report data. NSMHA is a state leader in providing a meaningful information system with current and reliable access to data. In addition, we will coordinate with the Mental Health Transformation Project (as committed through their MOU) as they implement the new Client Services Data Base; an effort to integrate administrative data across state and local agencies allowing system monitoring, management reports and research across agencies and institutions.

Locations of service are community-based across the 5 counties of the region and Tulalip Tribes. The system of care will prioritize services outside of clinics in places convenient to youth and families such schools, homes, juvenile justice agency sites, DCFS sites, and other community settings depending on the individual needs of the youth and families.

f. Collaborating with Other Child-Serving Systems: The Coalition is a collaborative effort of child-serving systems, family, and youth. Funding from this grant will assist our transition from “collaboration” to “integration”. The mental health system currently collaborates with multiple systems through individual contracts and agreements so that mental health services are currently accessed in *some* community schools, *some* child welfare agency sites, and *some* juvenile justice venues. A primary goal for our Coalition is to move situation-specific collaboration to consistent system-wide collaboration. The Program Development Council will develop policies, protocols and agreements to support this shift. For development of this proposal, MOU and letters of commitment were provided by:

Tulalip Tribes	Division of Juvenile Rehabilitation
Sens. Cantwell Murray	NW Educational Service District 189
Reps. Larson and Inslee	North Sound Mental Health Administration
WA Department of Social & Health Services	Division of Developmental Disabilities
U. of Wash. Evidence Based Practice Institute: WERT/PfS/NWI	Children’s Administration, Region 3,
WA Mental Health Transformation Project	Division of Alcohol & Substance Abuse, R3
WA State Rep. Dickerson	Island, San Juan, Snohomish, Skagit, & Whatcom Counties
Youth N’ Action!	Skagit County Human & Youth/Family Services
Statewide Action for Family Empowerment	Skagit County Public Defender
Training Resources in Partnership	Catholic Community Services/ Compass Health
Juvenile Rehabilitation, Region 3	Cuyahoga Tapestry SOC
Triwest Group	Vroon-VanDenBerg

g. Training, Technical Assistance, and Social Marketing: Training: To support the development of an integrated system of care, we will implement training in Wraparound Care Coordination and specific evidence-based practices. We commit to participate in the **Partnership for Success (Pfs) Community Process and Consultation Model** led by **Eric Bruns, PhD**, of the University of Washington Evidence Based Practice Institute as a foundation for the planning our efforts to support the development of the system of care. Through this process, community needs will be assessed and a service array will be developed to address those

needs. This process will identify the most appropriate EBPs for our community and build links with purveyors to participate in training to ensure fidelity.

Coordinated with this broader effort, Wraparound Care Coordination training will be provided through Vroon-VanDenBerg's High Fidelity Wraparound model that includes: (1) new techniques for training staff, (2) coaching practices that are outcome focused, (3) supervision skills that support practice change, (4) information management that documents a strength-based assessment, team approach, and an individualized plan of care and outcomes, and (5) agency culture change. Wraparound Care Coordinators and their supervisors will participate in an intensive ongoing coaching process to support fidelity.

We also seek to provide training in fidelity monitoring and cultural competence. The cultural competency training would go beyond the surface level training that most providers receive to confront underlying issues of racism at both the individual and institutional levels. We will emphasize cross-system training in family, youth and professional partnerships. Given the need to adapt most empirically-supported practices when they are applied cross-culturally, training in cultural competence will begin with assessment of the cultural competence of each empirically-supported practice implemented, following a multi-level approach (Stewart, 2007).

Technical Assistance: The Coalition will seek technical assistance (TA) to build efficient integrated administrative structure addressing MIS, sustainability, working successfully with youth and families as equal partners, maximizing non-federal match, and incorporating youth development strategies into the system of care. TA in consensus building and team development will be provided to the governance structure. TA on computer infrastructure development will be sought with the assistance of the Mental Health Transformation Project. Guidance and TA related to integrated systems and service teams and addressing HIPAA concerns will also be sought. As noted above, TA through the **Partnership for Success (PFS) Community Process and Consultation Model** will help us to understand and identify specific needs and empirically-supported practice models that fit our community. In addition, TA from the Wraparound Evaluation and Research Team and the National Wraparound Initiative, coordinated by Eric Bruns, PhD (see letter of commitment) will support high quality Wraparound. We have also engaged Sue Boehrer of the Oklahoma Federation of Families to address the sustainability of the Parent Partner role. Our local parent-network, TRIP, will train system administrators, providers, and other stakeholders in Family-Driven Care and Parent Partnering. TRIP is a member of the Statewide Action for Family Empowerment, a Statewide Family Networks Grant awardee.

Social Marketing: Culturally appropriate efforts will target the general community, the health care providers, and local and political leaders. Our social marketing plan will follow a developmental progression, starting with awareness of mental health as a common challenge faced by young people in our communities, and moving over time to address stigma and promote access to available referral and treatment services. A social marketing plan will be developed in the first year with youth input and will address how the community will be informed about the project's goals, vision and progress. Social marketing efforts are already underway in many Coalition member agencies. For example, NSMHA and the Tribes of the North Sound Region are co-hosting the 9th annual Tribal Mental Health Conference. Coalition administrative, governance and program council members will participate in the conference and Tulalip Tribes will present on Wraparound in American Indian/Native American communities. In September of 2007, NSMHA sponsored its first Youth and Family Resiliency & Recovery Conference; titled

Empowering Youth & Families. TRIP's Director helped plan the conference and was a speaker with other Parent Partners.

h. Capacity and Quality of Services: The North Sound Community Coalition will first seek to increase system capacity and quality through high-fidelity Wraparound Care Coordination across the region. We plan for a total of 7 new Wraparound Care Coordinators distributed across the 5 counties in the region, with at least one Care Coordinator within Tulalip Tribes Behavioral Health Program. Once trained and in full swing, this will provide capacity to serve approximately 120 Medicaid eligible children/youth and 20 children/youth who do not meet state-defined clinical eligibility criteria per service year. An estimated 600 individual children/youth and their families will be enrolled in the Coalition over the 6-year period. Mental health caseloads currently average around 35. Coalition caseloads for the wraparound facilitators will be a maximum of 8. Capacity will also increase by implementing an integrated system that better defines need and better monitors attainment of specific targets in order to ensure that resources are efficiently utilized.

The capacity of key components such as intensive home-based services (MST, FFT, and FIT), crisis intervention, school-based day treatment, therapeutic foster care (potentially employing the Multidimensional Treatment Foster Care model), and expanded respite care are also targets for expansion. Access to key outpatient services including Parent-Child Interaction Therapy and Trauma-Informed Cognitive Behavioral Therapy are already available through network providers; capacity will be assessed and additional capacity added as needed. Core to the overall assessment of clinical need and prioritization of clinical system development efforts will be the **Partnership for Success (PFS) Community Process**. This process will guide the Coalition's decision-making and goal setting in year one and identify targets and strategies for expansion for specific services. Cultural and racial disparities will be addressed at the system-level through community involvement in the PFS Community Process to select services and delivery locations that meet the needs of our diverse communities. At the service-level, the Wraparound Care Coordination model supports cultural competence as it is driven by the youth and family – this approach and the culture that surrounds it will help move our service capacity towards fairness, respect and responsiveness.

We are committed to increasing the pool of non-relative caregivers and mental health providers who reflect the racial and ethnic diversity our children. Efforts are currently underway with the Lummi, Skagit, Samish, Stillaguamish and Tulalip tribes; the Lummi and Tulalip Tribes have developed internal programs to expand their ability to place children within their own tribal areas.

i. Participation in Plan Development: State and local child-serving agencies and community leaders: Leaders from the mental health, child welfare, juvenile justice, education, and drug /alcohol treatment systems met regularly as a whole and in workgroups to develop this plan. The Tulalip Tribe participated in planning and has committed to fully participate in the comprehensive planning process to be carried out during year one. **Family members and family-run organizations and advocates:** TRIP, NAMI, WA-DADs, along with SAFE-WA and independent caregivers of youth with SED participated in planning our Coalition. **Youth** involved in multiple systems, and involved in making the transition from dependence to independence, participated in the planning process for this proposal. Tamara Johnson, Co-Director of Youth 'N Action!, participated in our planning process and commits to support

development of the Youth Development Council.

j. Interagency Collaboration and Nonfederal Matching Dollars: There currently are five primary contributors of non-federal cash contributions: Children’s Administration, North Sound Mental Health Administration, State of Washington, Counties, and Tulalip Tribes. In-kind staff, facility, and training resources are specific contributions from: The Northwest Educational Service District 189, all 5 Counties, Division of Developmental Disabilities, the Division of Alcohol and Substance Abuse, Tulalip Tribes, Training Resources in Partnership (a local parent network); SAFE-WA (a statewide parent network), Youth ‘N Action! (a statewide youth network), Mental Health Transformation Project, Compass Health, and Catholic Community Services. In our budget justification we project readily meeting our required match amounts, largely through increased funding for EBPs and other mental health services contemplated under 2SHB-1088 and the support of the above-mentioned partners.

k. Governor’s Letter of Assurance: Please see the Letter of Assurance from Governor Christine Gregoire in Appendix 2.

2. Service Delivery

a. Access to Services: Access to services will be managed by a cross-system Care Review Council serving as “barrier busters” by providing oversight to resource allocation issues and resolving issues that present barriers to effective cross-system services provision. The Care Review Council will include youth, parents, and a core of agency representatives from the Region 3 Division of Child and Family Services (child welfare), NSMHA (Medicaid and state-funded mental health), Tulalip Tribes Behavioral Health Program, local community mental health providers, juvenile court (both juvenile justice and dependency), substance abuse/chemical dependency treatment providers and schools. The group will represent the full range of regional major ethnic and racial diversity (Hispanic, Native American, African American, Caucasian). The group will be augmented by ad hoc panel members representing DSHS Department of Developmental Disabilities, chemical dependency, and DSHS Region 3 Juvenile Rehabilitation Administration (state level juvenile justice agency). Enrollment procedures will be consistent across the system of care and initial screening, review of need, resource coordination, and outreach will not require formal entry into the public mental health system. Youth will be eligible regardless of their financial or insurance status. Referrals may be made by the youth or their family, caseworkers, counselors, hospitals, schools, Family Court, juvenile justice staff, child welfare, law enforcement, or faith-based organizations.

b. Service Components: The Governance Team will develop an effective, community-based provider network, through the following primary strategies:

- Participation in the **Partnerships for Success Community Planning Process** to (1) establish benchmarks for change; (2) create a realistic profile of current programs, services, and activities; and (3) produce a strategic plan for change within the community.
- Development of services or alternatives within available resources to address gaps.
- Building of an integrated provider network from the currently separate but overlapping networks used by the major child-serving state agencies.
- Developing and establishing a quality assurance and improvement process to monitor and promote integration across the system, services delivery, and funding allocations. This system will be organized around the Wraparound Fidelity Assessment System to be implemented within our community by Dr Eric Bruns of the Wraparound Evaluation and

Research Team and National Wraparound Initiative, and supported by the local evaluation infrastructure provided by Dr. Peter Selby and TriWest Group.

- Work within the legislative mandates of 2SHB-1088 and the parameters of Washington's State Medicaid Plan to broaden the range and capacity of community-based services this network offers to address the eight dimensions of service identified in the system of care model (Stroul, 1986). A 2007 review of Washington's Medicaid State Plan found the plan to support the delivery of Wraparound Care Coordination and the empirically-supported practices noted above (TriWest Group, 2007a). Expanded state funding contemplated under 2SHB-1088 and coordinated strategies for supporting empirically-supported practices under the Medicaid State Plan are currently anticipated for the 2009-2011 funding biennium, taking effect in July 2009. This timing creates a unique and fortunate opportunity to build sustainability for services into the region's new system of care from the middle of the first year of the grant ongoing, as described in more detail in Section B.3 of this application.
- Promoting the adoption of SAMHSA's system of care core values and guiding principles through an aggressive training and technical assistance program.
- Establishment of a Program Development Council to design the system structure, establish policies and standards, identify gaps and needed services, and support implementation.
- Development of policies to ensure consistency in service delivery and operations. Policies will provide a process to measure system variables through the local evaluation.
- Education of provider clinical staff on the Coalition's structure, expectations, standards, policies, access points, screening/assessment process, and care coordination model.
- Social marketing to understand the system of care and reduce stigma.
- Enhancement of cross-agency information sharing, communication, and reporting.

Required Mental Health Services and Supports; Optional Services, and; Non-Mental Health Services: Partners conducted a review of required, optional and non-mental health services. This review incorporated current status and desired status of each service and improvement strategies for each. Due to page limits, we will present an extremely abbreviated summary of the results of this process in response to this question.

Required Mental Health Services:

Diagnostic and evaluation services: At present, available *only* through the 5 child-serving community mental health providers and several tribes in the region. The Program Development Team will analyze system gaps and resources in order to achieve an integrated and coordinated set of assessment protocols and tools.

Cross-system care management processes: Child Welfare, Juvenile Justice, and Mental Health provide case management under their mandates to serve specific populations within categorical funding streams. An integrated care coordination model will be developed using Wraparound Care Coordination and supported by training, coaching and fidelity monitoring.

Individualized service plan development inclusive of caregivers: Public mental health providers are inconsistent in individualized treatment planning; multiple plans exist across systems. Uniform cross-system individualized care plans will be developed with fidelity to NWI.

Community-based services: The majority of services are provided in traditional office-based settings and are funded by Medicaid, CHIP, and private insurance. Although EBPs are present, few therapist or mental health professionals in this community are trained in evidence-based practices. The PFS Community Planning Process will identify and address system gaps and evidence-based models will be adapted to be responsive and sensitive to the local culture.

Emergency Services: Emergency care will be enhanced to feature a coordinated continuum of 24 hour crisis services including: child and family specific mobile in-home crisis with short-term follow-up; community-based and short-term residential options;

Intensive Home-Based Services: Available through child welfare or combined child welfare and mental health efforts; waitlists are often 3 months long. Increased capacity for intensive, evidence-based services will be coordinated across mental health agencies.

Intensive day treatment services: Intensive Day Treatment, or an appropriate alternative, must be purchased or developed on an individualized basis. The PfS process will determine needs and appropriate response in this area.

Respite Care: Available through child welfare or combined child welfare and mental health efforts; region-wide lack of formal respite providers. In order to build capacity, funding mechanisms for respite care will be identified and we will recruit and train respite providers.

Therapeutic Foster Care: Provided through child welfare or combined child welfare and mental health efforts; wait lists are often 6 months long. The PfS process will determine needs in this area and we anticipate adapting training to local culture and provide to local providers.

Independent Living Skills: Services are focused on foster care youth transitioning to adulthood. In order to increase program capacity to serve all transition age youth we will engage in coordination between child and adult systems and seek alternative funding sources.

Family advocacy and peer support services delivered by trained parent/family advocates: Since 2005, NSMHA has funded Training Resources in Partnership (TRIP). The Youth and Family Development Councils will work with the Program Development Team, TRIP and state organizations (SAFE- WA) to develop a plan in this area.

Optional Mental Health Services

Screening assessments to determine whether a child is eligible for services: EPSDT screen through medical providers are currently required. We will expand coordination with schools, child care providers and primary care to target children at risk of mental health problems.

Therapeutic recreational activities: Currently available at one site during summers and school breaks only. Will be expanded utilizing flexible and local grant funding to design individualized recreational options for youth and collaborate with recreational organizations in our community.

Customized suicide prevention and intervention approaches: Mental health providers are required through state regulations to have an individualized crisis plan for all at-risk youth. Youth and Family Teams will facilitate greater individualization and use of natural supports.

Inpatient Hospitalization: There are no hospitals in our 5-county region that accept children or youth on psychiatric units. Resources are available in a neighboring region.

Non Mental Health Services

Educational Services: All districts provide psychological evaluations to assess need for specialized services and eligibility under IDEA, Sec. 504 and as needed during the IEP process. IEPs will be integrated with the youth's individualized care plan. Wraparound Care Coordinators will participate in the education planning process and advocate for youth.

Health Services: While medical services are readily available, medical case management is not. Medical providers will be involved in the treatment teams for children when significant medical case management issues are identified.

Substance abuse prevention and treatment services: Stronger relationships need to be developed between substance abuse and mental health providers to improve outcomes for dual-diagnosed youth. We will include prevention and dual-diagnosed youth as part of a planning and

design team and braid funding as much as possible for flexibility for services.

Out-of-home services such as acute inpatient and residential: There are no hospitals or long-term residential treatment centers in our 5-county region that accept children or youth on psychiatric units. The Pfs process will lead to a strategic plan to address this area.

Vocational counseling and rehabilitation and transition services offered under IDEA: NWESD and the Northwest Regional Learning Center have formed a cooperative to ensure compliance with IDEA and other relevant statutes/laws. We will coordinate mental health services with IEP treatment plans, and integrate plans and outcomes from the two systems.

Protection and advocacy, including informational materials: The Coalition's social marketing effort will coordinate with local NAMI group and SAFE-WA.

c. Strategies to Implement Key Service Activities Diagnostic and Treatment Planning: A culturally competent Care Coordinator will coordinate strengths-based assessments to identify each youth and family's strengths and needs, and the resources they have available to meet them, including the family's formal and informal support systems. Family members will be supported to discover their strengths and assume an active role in decision-making, rather than having services "prescribed" by professionals. All partner agencies will share information to reduce the need for families to tell their story repeatedly. Based on this, the child and family team will seek the best set of supports and providers from the integrated network to match the child and family's particular needs, strengths, culture and preferences.

To support these processes, the Program Development Council will adopt a common screening and intake protocol to be used across the system of care. It will be based on proven tools already implemented in Washington's mental health system, including the GAIN-Short Screen. Assessments will be completed by certified Children Mental Health Specialists (Washington's mental health system certifies mental health professional as children's specialists based on specific experience and training requirements). Facilitators and parent partners will be trained in a wraparound-based Strength, Needs, Cultural Discovery process (SNCD).

Community-Based Services: All network providers have committed to providing services in the least restrictive and most ecologically valid method possible. Often, this will involve meeting with the youth and family in their homes or other community locations. Care plans will prioritize natural supports in treatment whenever possible. Formal network services will include individual, peer group, and multigenerational family counseling services. Youth and families will have a choice of providers to provide meaningful choices and promote cultural compatibility. Services will be provided at home, clinic, office, school or other appropriate location, and will include consultation with psychologists, psychiatrists, and developmental pediatricians, as well as monitoring and management of medications. Wraparound teams will emphasize informal community-based resources that will continue to support the child and family after the formal episode of care is complete. Specific services for enhancement will be identified by community members through the Pfs Community Planning Process.

Culturally Competent Assessment: Culturally competent Care Coordinators will coordinate all assessment activities. To ensure that assessments recognize gender and cultural differences, all network providers will receive training on, and be required to adhere to guidelines that will make each provider responsible for ensuring a culturally competent as well as gender and age-appropriate assessment. Whenever possible assessments will be conducted by a clinician whose gender and ethnicity matches the preferences of the consumer. Given the broad diversity of the

people across the North Sound region, in some cases there will not be a full cultural match between clinician and consumer. For example, while most Hispanic residents in the region may have a Mexican American heritage, the overall population represents multiple regions and communities within Mexico, as well as multiple nations and cultures across Latin and South America. To help bridge any remaining cultural gaps, the Coalition will also provide access to consultation for ethnic minority specialists. The following strategies for culturally competent assessment will be employed:

- Determination of the language preferences of the individual, family, and key supports;
- Assessment of the level of individual and family acculturation versus assimilation;
- Incorporation of culturally relevant assessment results into treatment planning and services;
- Use of cultural norms in differential diagnosis, assessment, and service planning;
- Incorporation of the individual’s natural supports and beliefs into the treatment process; and
- Incorporation of traditional cultural practices and alternative medicine interventions.

Training: The Care Review Council will review the credentials, qualifications, and training of network providers. This review will emphasize the qualifications of each clinician to deliver evidenced-based treatments and appropriately apply DSM-IV diagnostic categories. To ensure high quality care, our proposal includes a substantial investment in training and technical assistance coordinated through the PfS Community Planning Process. Through linkages to purveyors of selected EBPs supported and coordinated through the EBP Institute at the University of Washington, we will ensure fidelity-based training, coaching, and ongoing monitoring is provided to clinicians. Overarching Wraparound Care Coordination training will form a basis for shared understanding and practice around a culturally and linguistically competent, family-driven, and youth-guided system of care.

Evidence-Based Practices: Eric Bruns, PhD at the Washington State Evidence Based Practice Institute at the University of Washington will lead the **Partnerships for Success (PfS) Community Planning Process**. This well-researched process will strategically enhance community capacity for implementation and sustainability of evidence-based practices. The term “Evidence-Based Practice” (EBP) is an umbrella term that has several underlying components. Typically, there must be substantial evidence of effectiveness. Programs also must be practical to implement within a community structure. Finally, there is often a component to ensure fidelity.

Inherent limitations in the research base for EBPs (for example, a lack of research that addresses the complexities of typical practice settings) often lead providers, caregivers, youth, and other stakeholders to question the extent to which EBPs are relevant. In addition, many families and youth are understandably concerned that having policy makers specify particular approaches might limit the service choices available; many providers are reluctant to implement EBPs due to the costs and risks involved. The challenges of adapting such practice across culture include the need to adapt most empirically-supported practices when they are applied cross-culturally; our systematic approach to these issues was discussed above.

The Partnerships for Success (PfS) model was specifically designed to help communities select and tailor EBP implementation to their local needs, resources, and cultures. The basic tenets of the PfS model are described directly below:

- **Underlying Principles** – The model is community



based, participatory, based on data-informed decisions, and designed to balance a holistic continuum of approaches.

- **The Community Process** – The process involves three phases: Planning (across four phases, including: mobilization, needs assessment, resource assessment, and strategic plan development), Implementation and Evaluation, and Sustainability.
- **Expected Outcomes** – PfS targets the following outcomes: (1) development of sustainable cross-agency planning entities, (2) creation of local training and coaching consortia to support EBP implementation, (3) increased adoption and implementation of EBPs, (4) development of data collection infrastructures, (5) increases in external grant funding, and (6) leveraging, braiding, and pooling of previously “siloes” funding sources to support EBP implementation.

While we look forward to the PfS process, coalition partners have initially prioritized implementation of the following EBPs: wraparound informed, in full fidelity with the NWI; Solution-Based Casework; Functional Family Therapy (FFT), Dialectic Behavior Therapy (DBT), and Trauma Focused Cognitive Behavior Therapy (TF-CBT). These services were selected with multi-system and parent input after reviewing the 2005 WA DSHS Report of Evidenced-based Practices.

d. Care Coordination / Individual Service Plans

Reflecting the individualized needs of each child, adolescent, and family: Coalition care coordination efforts will strictly adhere to National Wraparound Initiative (NWI) standards and principles. Care coordination efforts will elicit each family member’s ideas, priorities, needs, strengths, and desired outcomes, allowing them to fully explore and express their perspective. These intentional efforts will begin during the engagement and orientation phases of service and continue through the Wraparound process. Care Coordinators will be mindful of factors that could marginalize or discount family members’ roles in this process and will support the family in working through these concerns when they occur. In particular, coordination efforts will ensure that youth and family members’ perspectives have sufficient impact within the collaborative process and can carry the weight of having the primary influence over decision-making. These efforts are especially important in supporting youth in expressing their priorities and perspectives. Coordination efforts will be grounded in the principle that the people who have a long-term, ongoing relationship with a youth should have the greatest influence over the care coordination and service planning process.

Every family is unique in terms of its strengths, culture, needs and goals. The NWI-based Wraparound process is tailored to emphasize the unique features of families and their individual members. Key tasks for the Care Coordinator include thoroughly reviewing each family member’s strengths, including their capabilities, knowledge, skills and insights; gaining their perspective on their needs; respecting and building on their culture, values and beliefs; and exploring their goals and how best to achieve them. In addition, the Care Coordinator will support family members in identifying potential team members drawn from their network of natural supports (such as friends, neighbors, extended family, church members, and others). Emphasizing these natural and enduring family supports adds a level of individualization beyond the typical array of formal and professional supports. With family members’ guidance, the Care Coordinator will contact potential team members from the family’s natural and formal supports, explain the care coordination and service planning process, and encourage their participation as a

team member. For those who agree to participate, the Care Coordinator will explore their perspectives on the family's strengths and needs, as well as learn about the team member's needs and preferences for meeting. Service planning meetings will be scheduled at a time and place of the family's choosing, and the meeting itself will be guided by ground rules established by the entire team emphasizing the importance of promoting family and youth voice and choice. The planning process will be grounded in the family's strengths; a review of the family's vision provides a foundation for setting a team mission.

Provider Training: The Coalition commits to cross-agency training of all provider and targeted cross-agency staff in the Wraparound process. Training has begun and will continue with multiple community sessions for providers and community members. Next, providers will participate in ongoing coaching centered on supervisors, with the trainer working with each supervisor to develop specific practice strategies that support the culture of each team.

Individualized Service Plans: A service plan will be developed over the course of one or two meetings with the Wraparound team. The planning process will be grounded in the family's strengths — family members should feel that their voices are being heard, that the chosen needs are ones they have prioritized, and that selected strategies can help them meet their needs. The Facilitator will guide the team to define what would represent success for each need. The team will discuss how outcomes will be assessed, including identifying specific indicators and when to measure them. Intrinsic in this process is the implication that team members will demonstrate mutual respect for one another, focus more on assets than on deficits, and appreciate the value each person brings to the team. Strategy and resource options will extend beyond formal services; family members' nominations for natural supports among their interpersonal and community relationships will be prioritized. Action steps – small activities that move strategies forward – will be identified and assigned to specific team members.

Addressing safety concerns and potential crises is a key part of the individualized service plan. The Care Coordinator will review family members' needs in relation to crises and safety concerns, gather additional input from knowledgeable people (including the referring source), and guide a discussion with all team members on how the team will maintain safety for all family members.

Coordination with IDEA: The Northwest Education Service District 189 (NWESD) is a committed Coalition partner. IDEA requires coordinated, comprehensive, multidisciplinary interagency programs to provide early intervention services to all children with disabilities. Multi-system, family-driven, child-centered team meetings are fundamental to wraparound and IDEA Part B. Individual Education Plans (IEP) will be integrated with the Wraparound process. Care Coordinators will be trained to participate in the IEP process and advocate for youth and families. Family members will have access to educational training and support to understand and exercise their rights under IDEA. A Response to Intervention framework will guide planning.

Coordination with the Title IV-B Family Preservation and Support Program: Children's Administration (CA) representatives are core members of our proposal planning process and Governance Team. Their MOU specifically commits CA to coordinate and ensure access to the Title IV-B services for eligible youth. Family preservation services are contracted to develop individualized service plans for families in which risk of abuse and neglect has been identified or there is risk of disruption due to developmental, medical, or mental health needs.

Individualized Service Plan Components: The Coalition understands that Individualized Service Plans form a foundation for effective care and must include the following components:

- **Description of the need for services** – During the initial phase Wraparound, the Care Coordinator meets with family members to elicit their experiences and gather their perspectives on what they need. As needs are identified, efforts are made to build on and expand family members’ assets (positive self-regard, hope, self-efficacy, resilience, and others), interpersonal skills, expertise, and knowledge. Needs identification is an ongoing and evolving process, and as progress occurs or challenges emerge, re-evaluation will occur.
- **Recognition of existing strengths of the child and the child’s family** – Recognizing existing strengths of the youth and their family begins with honoring the family’s voice and choice. The act of valuing each child and family’s perspectives, priorities and choices is a fundamental recognition of their strength, commitment and influence over making positive changes for their family. Often inquiring about interests, identifying who has been helpful in the past, or how the family effectively helped themselves can reveal important resources and examples of resiliency and self-efficacy. Obtaining similar input from the family’s natural supports and other team members expands the array of strengths even further.
- **Development of objectives that meet the needs and build upon the existing strengths of the child and the child’s family** – As needs are identified and prioritized to a manageable number reflecting the family’s priorities, team members collaborate on identifying objectives that would best reflect success in meeting them. The team explores ways to define and monitor outcomes for identified goals. Potential strategies are then generated through creative problem solving and guided by identified strengths and resources for the family. The team then evaluates which strategies would be most effective in achieving the family’s goals. Priority is given to the natural supports of the youth and his or her family. Achievable action steps are then developed and assigned, with progress reviewed routinely. In all cases language used will be clear and make sense to youth and family.
- **Development of customized interventions for the child and the child’s family if the child’s history indicates that the child is at risk for suicide** – Crisis and safety planning is a mandatory early component of the individualized service plan. Information gathering from the youth and other family members will determine the immediate level of risk, including whether the youth has a plan for self-harm, the level of lethality of the plan, the level of lethality of past suicide attempts, and whether there are lethal objects available in the household. In addition, key supports – both natural and formal – will be identified and included in the crisis/safety plan. Contingency plans for more intensive levels of care will be explored in order to clarify when these resources need to be used. Routine review of progress and safety will occur on a more frequent basis.
- **Development of methodology for meeting objectives** – The Care Coordinator guides the team in a process to think in a creative and open-ended manner about strategies for meeting needs and achieving outcomes. The Care Coordinator uses techniques for generating multiple options, which are then evaluated by considering the extent to which they are likely to be effective in helping reach the goal, outcome, or indicator associated with the need; the extent to which they are community-based; the extent to which they build on youth and family strengths; and the extent to which they are consistent with family culture and values. The team will establish accountability and will review progress at each meeting, ensuring that there is a process to address concerns or issues that might impede progress.
- **Provision of non-mental health services** – Collaborative relationships and agreements will

need to be cultivated with such organizations and services. The Care Coordinator will support the youth and family team in identifying when it is most appropriate to use non-mental health services. These services might range from medical or dental supports, to substance abuse or chemical dependency treatment through a network provider, to vocational rehabilitation, mentoring, or other informal community services.

- **Designation of the lead agency responsible for care management/coordination of services** – The Care Review Council will have responsibility for system oversight; however we plan to implement a decentralized system where youth and families can access Care Coordination through five systems and multiple sites across the region and Tulip Tribes. In all cases, the Wraparound Team will define lead agency responsibility.

Quality Assurance Process: We believe that quality assurance at multiple levels – in terms of fidelity to NWI wraparound principles, maintaining compliance with agency, local, state and federal regulations, and ultimately in terms of making a difference in the lives of youth and families served – is critical to the Coalition’s success. Care Coordinators will be responsible for reviewing with the youth and family team the services being provided at regular intervals. This review will include an assessment, using available data, of progress being made towards goals, including the child and family’s satisfaction with the services. When the team determines that current strategies and services are not working (or no longer working), the steps above will be repeated to identify and access a new set of services. We will be supported in this process by the full application of the Wraparound Fidelity Assessment System and the local evaluation.

Grievance Processes. Families will have formal options to discuss or appeal service decisions directly to the Care Review Team. The Care Review Team will determine the most appropriate course of action in partnership with the youth and family. All grievance procedures will be documented and comply fully with county, state, and federal regulations, including fair hearing and Medicaid managed care complaint and grievance provisions under 42 CFR 438. We are committed to ensuring a friendly easy-to-access system that will meet the families concerns with respect and responsiveness, and we will view regular access to and use of the grievance process as a sign of the health of the system.

e. Family Driven Care

Family Partnerships: The Governance Team will include family members as equal partners in all decision-making. Family members have been involved throughout the development of this grant proposal, facilitated through Training Resources in Partnership. In order to nurture and prioritize family partnership, the partnership will fund a full-time Family Coordinator, one of the first activities of the Governance Team will be to establish a Family Development Council to engage and support family members in taking part in the system of care. Our goal is that the Governance Team be comprised by a majority of family and youth members by Year Three.

CMHS-funded Statewide Family Network: The only CMHS-funded network in Washington State is Statewide Action for Family Empowerment of Washington (SAFE WA), and the Coalition has requested technical assistance and support from SAFE-WA (funds are budgeted to purchase such assistance and a letter of support from SAFE-WA is included). Our local partner, Training Resources in Partnership (TRIP) is a Network Member of SAFE WA.

Financial support for family participation and the family organization: NSMHA currently funds Parent Partner staff within the provider network as well as a non-provider parent-network

Training Resources in Partnership (TRIP) to provide parent support/resource groups and educational trainings for parents. We will expand support for TRIP and explore needs for another family support organization in the first year of the grant. Parent partners will be compensated for their time, travel and other reasonable expenses.

f. Youth Guided Care: “Nothing about us, without us.” Coalition partners commit to meet the simple, but challenging, standard set forth by the five words of this motto. Youth-guided care is demonstrated first by acknowledging that youth have the right to be educated, empowered, and given a decision-making role regarding their care as well as the policies and procedures governing care for all youth in their communities. We recognize that youth need and deserve a voice in planning their futures and in planning the care they receive, as well as the systems in which that care is delivered. Former children’s mental health clients participated in planning and we consulted with Tamara Johnson, Co-Director of Youth ‘N Action, a state-wide youth network. We intend to move forward with the immediate establishment of a Youth Development Team as a core function of the Governance Team at the outset of Year One.

Full-Time Youth Coordinator: If funded, the Youth Coordinator will be a member of the administrative team and participate in Governance team meetings and will lead the Youth Development Council to facilitate full youth participation in the governance of the initiative. He/she will be provided with understandable, accurate, and complete information to facilitate shared and equal power, resources, authority, control, and responsibility for outcomes.

A Strong Partnership Between Professionals and Youth: Across this proposal we have enumerated multiple ways that youth will be involved in the planning, management, and evaluation of our system of care. We are committed to making the necessary changes to the process to accommodate and sustain youth involvement. As we discussed the observation about youth and long, “boring” meetings among our Coalition partners, everyone agreed that shorter, more focused meetings would benefit, not just to youth, but to the system as a whole. The youth at the table through our application development process helped keep our focus on the need to make a real difference in the lives of the youth we serve, and we are confident that their voices will remain strong. When the youth in our system see that their opinions count and can help create a positive change, they will want to be involved. When the professionals and community members see the positive outcomes and the mutual benefit of these partnerships, we will move closer to becoming a Youth-Guided community.

g. Cultural and Linguistic Competence Compliance with Title VI of the Civil Rights Act: The North Sound Community Coalition recognizes its obligation under Title VI of the Civil Rights Act and is strongly committed to deliver services and function in full compliance with both the letter and spirit of that mandate. The Coalition defines cultural linguistic competence as a set of congruent behaviors, attitudes, and policies that enable effective work in cross-cultural situations. The involvement of the Tulalip Tribe, the diversity of our planned Governance Team, our commitment that the care coordinators employed reflect the language and cultural diversity of our region, and the representation in our provider network of the Tulalip Tribe Behavioral Health Program all represent concrete evidence of the Coalition’s commitment.

Compliance with Cultural and Linguistic Competence Standards: The Coalition will work to provide services that are culturally and linguistically appropriate, and its policies and procedures will strongly reflect our shared belief that cultural or linguistic differences should not pose a

barrier or restrict access to services, but should instead be a resource in support of resiliency and health. Washington's mental health system has made a strong commitment to linguistic accessibility, requiring published materials and supports to be available also in available in Cambodian, Chinese, Korean, Laotian, Russian, Spanish, and Vietnamese, as well as alternative formats for people with visual impairments and people speaking sign language. Our clinical materials and social marketing strategy will reflect the needs of the diverse client and stakeholder population of the region, and our activities and outputs will be in compliance with Title VI of the Civil Rights Act; DSHS requirements; U.S. DHSS National Standards on Culturally and Linguistically Appropriate Services; and SAMHSA's Cultural Competence Standards in Managed Mental Health Care Services. Additionally, we will adapt EBPs as needed when they are applied cross-culturally, following a multi-level approach (Stewart, 2007) that ensures compliance with the following standards:

- Are language and/or culturally-specific variants of the practice available?
- Does the practice have external / ecological validity that relates to the specific needs and strengths of the community targeted?
- Has the practice been developed with a representative sample?
- For a diagnosis-specific practice, does the practice address cultural variants in diagnosis?
- Does the practice include orientation, outreach, and engagement strategies that fit with the needs and preferences of the targeted community?

We propose the formation of a Cultural Competence Council comprised of individuals from the client and stakeholder population who will participate actively in all phases of program design and service delivery oversight. This group will be integrated into the decision-making process of the project, and will influence the formation and implementation of the Coalition's structure and functions. This Council will be staffed by the project's Cultural and Linguistic Competence Coordinator, a full-time commitment that will be created and given the responsibility – and authority – for working with the project's governance and management structures, stakeholders, service populations, and outside contractors to ensure that culturally and linguistically appropriate practices are followed throughout the local system of care.

Culturally and Linguistically Appropriate Practices in the Individualized Service Plan. The collaboration model and the Wraparound approach will provide a framework for individualized care and acknowledgment of family strengths and experiences within a climate of respect. During Year One, we will survey the provider network for cultural diversity and language competence. Providers, including non-traditional providers, will be recruited and credentialed in ways that remove barriers to participation. Practitioners that families choose will be added to the provider network, utilizing alternative funding mechanisms when traditional funding requirements otherwise would restrict access. These providers will include traditional healers, with quality standards defined by the cultural groups associated with those healers.

Participation in the System of Care: As noted above, the primary mechanism to accomplish this will be the formation of a Cultural Competence Council. This Council is planned to be a permanent component of the system of care to be developed by the Coalition. **Incorporation of Diversity within the Management Plan, Staffing Pattern, Project Organization, and Resources:** The Cultural Competence Council will have oversight responsibilities for the implementation of the Cultural and Linguistic Competence Plan, which will include the following steps recommended by Cross (Cross, et al, 1989):

- **Assess the Environment.** Assess the cultural sensitivity of attitudes and existing policies.
- **Develop Support.** Inform, sensitize and clarify values and build a network to support change within the broader community.
- **Develop Resources.** Identify capital and human resources to promote change.
- **Develop Leadership.** Identify system and community leaders to facilitate change.
- **Mission and Action.** Articulate values, mission and goal statements.

The Cultural and Linguistic Competence Plan described above will be integrated as a part of the overall project management plan. The Plan will incorporate other diversity-related issues such as language, age, gender, and sexual orientation. At all levels of the project, every effort will be made to have representatives of all of the communities served by the project involved in key positions. In-service training will be ongoing and the Coalition will conduct cultural and linguistic competence self-assessments to guide policies regarding how cultural and linguistic competence will be addressed throughout the proposed project. Cultural and linguistic competence will be woven into every aspect of the proposed system of care from the governance structure (e.g., members are representative of the populations being served) to service delivery (e.g., services provided the preferred language of the families being served).

Provider representativeness: We will first assess the cultural and linguistic resources of each provider as part of the Cultural and Linguistic Competence Plan. The Coalition will engage in targeted recruitment for service providers for the project, to include radio, television and newspaper publications that have a large minority following or subscriber rate. Partnerships will be established with additional service providers that represent the minority community and any providers identified by families will be invited to be included in the network, as described above.

Addressing Disparities: The identification of youth of color – particularly Hispanic youth and American Indian/Native American youth – as a primary focus of the proposed system of care, was a direct outgrowth of our review of current service delivery trends and the identification of these two populations in particular as overrepresented in restrictive child welfare and juvenile justice placements. The Coalition’s broader strategy for addressing disparities related to access to, quality and availability of, and satisfaction with services centers on the Cultural Competence Representative Council – a fully authorized committee of the Governance Team. Staffed by the Cultural Competence Coordinator, this group will participate actively in all phases of the program design and service delivery oversight process. In addition, the Cultural Competence Coordinator (as staff to this Council), will work with the project’s governance and management structures to ensure that any disparities found are addressed.

We recognize that access is not just a matter of making services available, but also relates to the extent to which those services are seen as desirable and appropriate by families. In order to truly address disparities, the North Sound Community Coalition is undertaking the **Partnerships for Success** model for community-based service planning so that all facets of our community are involved in planning a service system that balances state of the art EBPs with a holistic continuum of approaches incorporating context, mind, body and spirit.

Service Provision Plans: NWI-based Wraparound provide a strong framework for the development of service plans reflecting the cultural and linguistic context of the youth and family. While a service plan can call for the provision of culturally and linguistically appropriate services, care must also be taken to ensure that such services are actually available. In order to

support this process, service requests will include questions about language preference, and if a non-English language or minority clinical staff person is requested, the request will be honored as fully as possible. Consultation will be sought when assigned care coordination or treatment staff do not possess the specific competencies required to serve a youth or family. Finally, the Cultural Competence Coordinator(s) will have the responsibility and authority to ensure that culturally and linguistically appropriate services are prioritized and monitored.

Cultural Competence Coordinator: The Coalition will dedicate 1.0 FTE to the position of Cultural Competence Coordinator to lead the project's Cultural Competence Council and advise the Governance Team. We have gone beyond the 0.5 FTE requirements because we recognize the centrality of culture in our lives and commit to developing a system of care that provides not only *access* to services, but access to services that are desirable and appropriate for the youth and families we serve. The North Sound region encompasses a unique mix of peoples – including immigrant and U.S.-born Hispanics, as well as the several tribal nations and many other smaller racial and ethnic groups. We are open to the possibility of hiring not one, but two individuals to work together to fulfill the functions of the Cultural Competence Coordinator. As demonstrated in our budget, we are seeking individuals with a high level of skill and clinical experience who can truly lead our enhancement of cultural competence.

Strategies and infrastructure: A **Cultural Competence Council** will be comprised of individuals from the client and stakeholder population who will participate actively in all phases of program design and service delivery oversight. This group will be integrated into the decision-making process of our overarching Governance Team. To ensure that culturally and linguistically appropriate practices are prioritized and adhered to throughout our system of care, one strategy will be the development of a **Cultural and Linguistic Competence Plan**.

3. Sustainability and Linkages with Statewide Transformation Efforts and Other Relevant Federally-Funded Programs

a. Linking Coalition Goals / Objectives with Transformation and Statewide Reform Efforts

Multiple linkages with statewide transformation and reform efforts have been enumerated throughout this proposal. Given page limitations, rather than reiterate that detail here, we will focus on the following linkages with key State Personnel and other State leaders:

- **Washington's federal Mental Health Transformation State Infrastructure Grant** (SM57468). The primary linkage for this coordination is Ron Jemelka, signatory to the Memorandum of Understanding (see Appendix 1) between the Coalition and the Mental Health Transformation Project. The Coalition has multiple linkages to the Transformation Project through NSMHA, provider, and child-serving agency leader involvement.
- **Second Substitute House Bill (2SHB)-1088 for Children's Mental Health Services.** State's Mental Health Division (MHD) is charged to implement 2SHB-1088. In addition, the University of Washington Evidence Based Practice Institute under the direction of Eric Trupin, PhD, and the Wraparound Evaluation and Research Team (WERT) within the EBP Institute under the direction of Eric Bruns, PhD, are key actors in the implementation of 2SHB-1088 mandates. Both Dr. Trupin and Dr. Bruns have provided letters of support for this project and both have committed to be personally involved in that support (see Appendix 1).
- **Coordination Across the Department of Social and Health Services (DSHS) Initiatives.** The letter of support provided by the acting DSHS Secretary underscores alignment of our

Coalition with current DSHS initiatives and pledges the administration support and division leaders in support of the grant activities. The primary linkages within the Coalition for coordinating with these state leaders include Charles Benjamin, NSMHA Executive Director; Randy Hart, Children's Administration Regional Director/ Interim Assistant Secretary (DCFS); and Jennifer Paddock, Regional Administrator, DASA.

b. Strategies for Ensuring Project Sustainability after the Sixth Year: We intend that the North Sound Community Coalition will endure as an autonomous entity after the end of the six-year grant period. While the exact legal structure of the Coalition is subject to decision-making by stakeholders during the planning year of the grant and ongoing as new challenges and opportunities emerge, our focus is on building an enduring infrastructure to support the Coalition's mission. We have been careful to budget the available SAMHSA grant funds for capacity building and not to rely on them for long-term operating costs. In addition, we have studied the CMHS report on sustaining systems of care beyond the federal investment (Koyanagi, 2000) and the 2004 Matching for Sustainability report and built our proposal with those lessons in mind.

Funding for the administrative positions of the grant will be picked up by the Coalition partners through savings, primarily to state-funded programs. Regarding expanded services, we are very optimistic about the possibility of expanded state and Medicaid funding for children's mental health services given the mandates of 2SHB-1088 and the opportunities within Washington's Medicaid State Plan and 1915(b) Waiver. A 2007 review of Washington's Medicaid State Plan (TriWest Group, 2007) found the plan to support the delivery of Wraparound Care Coordination and the all of the empirically-supported practices noted within this proposal (MST, FFT, DBT, PCIT, TF-CBT, and MTFC). In the case of Wraparound Care Coordination and MTFC, only the treatment components covered by the Medicaid State Plan can be covered, but Washington's Medicaid benefit has been extended to cover treatment within foster care settings with adequate protections to prevent payment for child welfare activities supported by other federal funding streams (such as Title IV-E funds). Given that the authors of that 2007 review, TriWest Group, have committed to serve as local evaluators for the Coalition, we look forward to making use of their expertise to maximize funding through existing funding streams. Expanded state funding contemplated under 2SHB-1088 and coordinated strategies for supporting empirically-supported practices under the Medicaid State Plan are currently anticipated for the 2009-2011 funding biennium, taking effect in July 2009. This creates a unique opportunity to build sustainability for services into our new system of care from the middle of the first year ongoing.

c. Coordination with Other Federally Funded Initiatives: The North Sound Community Coalition is eager to coordinate with the SAMHSA CMHI funded initiative with our neighbors, Lummi Nation. Lummi Nation's initiative is specifically focused on Lummi youth enrolled in the Lummi Nation Youth Academy and on developing culturally competent EBPs for American Indian/ Alaska Native youth and families. Children/youth who graduate or otherwise relocate from the Lummi Nation Youth Academy may be eligible for the North Sound Community Coalition as implemented in Whatcom County.

In addition, Washington has several other federal initiatives with which the Coalition will coordinate development efforts, particularly regarding sustainability and reform of state-level policies and regulations. Within the comprehensive framework of the Mental Health Transformation Project and 2SHB-1088, Washington has aligned all of its federal, state, and

local initiatives through its Community Mental Health Services Block Grant Plan and Washington's Mental Health Plan for Children and Adolescents with Serious Emotional Disturbances. NSMHA has been active on two MHTSIG Workgroup Subcommittees – Children, Youth and Families, and Youth in Transition. NSMHA and the Coalition Administrative Team will continue to provide input to the Mental Health Transformation Project (MHTP) as requested. Ron Jemelka, MHTP Director has offered to be a member of the North Sound Community Coalition Governance Team. Finally, we will coordinate with the Northwest Educational Service District 189 (Coalition partner), a recipient of the SAMHSA sponsored Safe Schools, Health Students grant.

SECTION C: Project Management and Staffing Plan:

1. Capability and experience of applicant organization: For approximately 14 years, the North Sound Mental Health Administration (NSMHA) and Children's Administration (CA) have collaborated to fund the Children's Hospitalization Alternative Program (CHAP). For children with intensive and complex mental health needs, CHAP is able to offer therapeutic foster care, mental health treatment, and crisis respite. A multi-agency committee, including a parent or parent advocate, decides admission to CHAP. The ultimate goal is to provide resources to children and their families allowing the child to remain in their community with people who love them and to prevent or decrease the need for inpatient psychiatric care. In 2007, NSMHA, CA, and Snohomish County began collaborating on a Short-Term High Intensity Program for children/youth. The program focus is to provide up to 90 days of intensive crisis stabilization and/or relative and fictive kin searches. Families are key members of the planning /decision-making team. The model is built on Family Preservation and Wraparound principles to provide child and family-specific crisis outreach and care coordination. All families have Parent Partners available during this process. **Parent and Consumer Partnerships:** NSMHA has an active consumer-run Advisory Board. Additionally, the multi-system Children's Policy Executive Team (CPET) has consumer-parent/advocate members. Since 2006, NSMHA has funded Training Resources in Partnership (TRIP), a parent-driven network that supports parents of children with complex needs. TRIP's Director participates in NSMHA program development committees; she presented at our first Youth and Family Resiliency & Recovery Conference held in September of 2007. The North Sound Community Coalition commits to utilizing culturally diverse children/youth/parents and/or parent advocates in the design and delivery of NWI-based wraparound; it is our goal that future parent partners and advocates will be wraparound graduates.

2. Staff positions for the project: Project Director/State Local Liaison: A full-time position responsible for (at a minimum) : (1) oversight and development of the ongoing strategic plan; (2) creating, implementing and sustaining cooperative agreements; (3) ensuring comprehensive mental health service delivery for children/youth and their families; (4) establishing the organizational structure; (5) hiring staff; (6) providing leadership in all facets of system delivery; and (7) guiding the establishment of interagency collaborations with other child-serving agencies. This individual must be experienced and grounded in the principles and values of Systems of Care and serves as the liaison between state and local community. This position works to develop and/or change interagency agreements and other public policies relevant to the creation of the system of care. He/she serves as the official responsible for the fiscal and administrative oversight of the cooperative agreement and is accountable to the funded community for the proper conduct of the cooperative agreement. This position requires a

Master's Degree plus experience. This position will be employed by NSMHA. Lead Family Contact: A full-time position responsible for working with an established family-focused/family-run organization that represents the cultural and linguistic background of our population. This position serves as member of the program development council to ensure that program policies and practices are family-friendly. The individual provides cross-system training and participates in quality assurance protocols. This position has full inclusion on the governance team and will lead the Family Council. Trainings and technical assistance for the benefit of Coalition-related staff will be conducted by the Lead Family Contact. The position requires two (2) years working in a family/parent-driven organization. This position is likely to be filled by a current or future employee of TRIP – our parent network. Youth Coordinator: A full-time position responsible for developing and implementing activities to represent the voice of youth with SEDs. This position has full inclusion on the governance team and will develop and lead the Youth Council. Trainings and technical assistance for the benefit of Coalition-related staff will be conducted by the Youth Coordinator: This position requires a high school diploma or equivalency and skills necessary to communicate effectively with both youth and policymakers. He/she will be able to demonstrate competencies in the cultural and linguistic background of our population. The position is an integral component to affecting the current culture of systems administration by demonstrating the value and purpose of youth-guided care. Youth who have received formal community services and supports are a wealth of knowledge and bring a level of expertise not otherwise available. The Youth Coordinator will assess our system's needs from a youth perspective and develop strategies for implementing change. The Youth Coordinator will conduct trainings and technical assistance for the benefit of program-level youth mentors and systems-level administrators. This is an entirely new position in our system; the Youth Coordinator will be supported by the well-established Youth N Action!. This position may be filled by a future employee of TRIP – our parent network or by NSMHA. Applicants between the ages of 18-25 will be encouraged to apply, though people of all ages will be considered. **Family Partners**: Family Partners will directly assist families and youth navigating the mental health and related service systems, engaging in advocacy and developing natural supports. **Youth Mentors**: It is our goal to develop direct service Youth Mentor roles to partner with youth on Wraparound Teams in a similar capacity to Family Partners. Social Marketing-Communications Manager: A part-time position responsible for the development and implementation of a comprehensive marketing strategy. This position is responsible for: (1) developing a social marketing strategic plan; (2) public education activities; (4) overall promotional outreach activities; and (5) coordination with the national communications campaign contractor. This role will be incorporated into sustainability planning activities and will be called on to deliver information to diverse audiences. He/she will be able to demonstrate competencies in the cultural and linguistic background of our population. This position requires a Bachelor's Degree plus experience in social or closely related marketing and will be employed by NSMHA. Technical Assistance Coordinator: A part-time position serving as the primary link with the Technical Assistance Partnership; serves as the point person within the system of care for strategizing and assessing the technical assistance needs of the community. This includes cultural and linguistic competency, leadership/partnership collaboration, strategic planning, care plan development processes and sustainability. Technical assistance is intended to help the Grantees enhance a product, program or practice that builds organizational infrastructure and/or capacity and includes advice and resources, product review, and product development. This position requires a BS/BA plus experience. This position will be employed by NSMHA. Cultural

and Linguistic Competence Coordinator: A full-time position or a part-time position collaborating with NSMHA's part-time Tribal Liaison (position currently unfilled). Efforts will be made to recruit a single FTE for this role vs. two part-time individuals. Responsible for demonstrating leadership and collaboration with other management staff, families, youth, contractors and all system partners in ensuring culturally and linguistically competent practices in all aspects of the system. Serves as team leader and facilitates the organizational and developmental process to accomplish these goals and heads the Cultural Competency Council. This position requires a Bachelor's Degree plus experience. Either NSMHA or Tulalip Tribes will hire this position.

Key Evaluation Staff: The Coalition has engaged TriWest Group (locally located) to conduct the evaluation. Led by Dr. Peter Selby, their organization brings a strong track record of successful implementation of the CMHI system of care evaluation in a CMHI community now in its sixth year.

3. Key staff experience with the population of focus: Key staff for the Coalition will be selected with an absolute requirement of demonstrated experience serving the populations emphasized in this proposal. Recruitment efforts will be taken to encourage applicants for Key staff positions who represent our region's cultural diversity. Bilingual Spanish and English applicants will also be encouraged to apply. TriWest Group evaluation staff includes a recognized expert in cultural competence (*Jesús Sanchez, PhD*) and a member with extensive direct experience with Spanish-speaking populations (*Socorro Martinez-Parham, M.Ed*).

4. Resources for the proposed project: NSMHA will be the fiscal and administrative sponsor for the Coalition. NSMHA is the public mental health administrative entity for the region. NSMHA has an 8,000 square foot office centrally located in Mt. Vernon, WA (Skagit County). The Project Director and other administrative staff will be housed at this location. Additional office space (currently available) will be rented in the building. These additional staff will be supported by our existing IT/IS Manager, IT/IS Support Tech, and related equipment including existing or additional laptops and Blackberries to increase communication and access to Key staff. NSMHA's existing 5-member clerical staff, 3-member fiscal staff, and Data Analyst will also support the Coalition (a place is held in the budget to potentially increase resources in this area). Wraparound Care Coordinators, Family Partners, and Youth Mentors will be contracted to the various Coalition partners such as: Children's Administration, Catholic Community Services, Compass Health, County-based Health & Human Services, Tulalip Tribes, and Northwest Educational Service District 189. These agencies have the existing infrastructures to support the proposed program expansion.

Partner provider agencies, responsible for care coordination and provision of direct services have facilities in full compliance with the American with Disabilities Act and all necessary facilities to meet basic services requirement and support the goals of the Coalition. The evaluation team has secure physical office locations, as well as the necessary office and computer equipment and staff support to successfully carry out the proposed evaluation activities. The evaluation team is experienced in working with various agency and provider databases; it is skilled in the use of current analysis tools.

SECTION D: Evaluation Plan

1. Implementation of the National Evaluation: Commitment and Capacity: The North Sound Community Coalition will comply with all of the terms and conditions of the National Evaluation. To carry out that commitment, we have engaged an evaluation firm with a proven track record implementing evaluations of SAMHSA grants: TriWest Group. TriWest’s prior work as evaluator for the CMHI grantee in El Paso, Texas (Border Children’s Mental Health Collaborative) has been described as “exemplary” by Brigitte Manteuffel, Ph.D., Vice President & Principal Investigator for the national evaluation through Macro International and as “outstanding” by Michele Herman, Project Officer, Child, Adolescent and Family Branch, SAMHSA (2005 letters submitted to El Paso County Commissioners Court). Under the lead of Peter Selby, PhD (locally based), TriWest Group will conduct the local evaluation as a core member of the Administration Team. TriWest will implement the data-gathering and reporting infrastructure in a manner that incorporates contributions of youth and families, and will do so within the context of culturally competent evaluation practices. The specific evaluation activities and procedures TriWest will employ are described below. Additional detail is provided in Section H: Confidentiality and SAMHSA Participant Protection / Human Subjects.

2. Using National Evaluation Data to Improve the System of Care

Improving the service system. Data from the National Evaluation will be used to provide timely feedback and actionable recommendations to the Governance and Administrative Teams. National Evaluation data (such as that from the System of Care Study and the Services and Costs Study) will be used to perform gap analyses to identify needs in the service system. Results will be integrated into regular updates and annual reports to help the partners understand the effects of their efforts, to build on successful strategies, to target areas for improvement, and to improve decision support capacity over the life of the grant and beyond. We will also incorporate this data into the Partnership for Success (PFS) process to be led by Dr. Eric Bruns, of the Wraparound Evaluation and Research Team (WERT) within the EBP Institute at the University of Washington. The role of the evaluation within the PFS process will vary by the project phase:

- A. Planning Phase (9 months).** During the planning phase, TriWest will work with Dr. Bruns and the Coalition to define broad targets for change (targeted impacts) and factors (risk, protection, and assets) that are closely associated with the selected targeted impacts. Data from the System of Care Study will be used (supplemented by additional targeted data collection) to help create a realistic profile of current programs, services, and activities related to the targeted impacts identified in the needs assessment. Based on this comprehensive analysis, the Governance Team will produce a strategic plan that indicates how best to address the targets for change within the community. The Coalition will then work with Dr. Bruns, and the local evaluation to develop a community prevention/intervention plan, document program logic, define anticipated outcomes, and be prepared to begin implementation.
- B. Implementation and Evaluation Phase (2 years).** Beginning late in Year One and continuing into Year Three, an implementation phase will begin with the definition of program outcomes, most of which will be derived from the National Evaluation data. Evidence-based prevention and intervention efforts will be implemented and responsive to ongoing community needs assessments and fidelity and quality assessment, which will be implemented through the local evaluation. Social marketing strategies will also be incorporated, and an initial report on outcome achievement pulling together all of these sources will be produced by the end of the Implementation year. The local evaluation will also monitor training and implementation of selected EBPs.

C. Sustainability Phase (ongoing). Throughout the six years, evaluation data will be used to track progress and outcomes, as well as to update annual strategic plans based on current needs assessment and outcome evaluation findings. Implementation efforts will continue, supported by both National Evaluation and local evaluation data.

Increasing the quality of service delivery: Coalition partners and TriWest plan to introduce mechanisms to continually improve the quality of service delivery processes and outputs. As described previously, the Coalition will implement a quality assurance and improvement process to monitor and promote integration across the system, services delivery, and funding allocations. This system will be organized around the Wraparound Fidelity Assessment System (WFAS) to be implemented through the local evaluation infrastructure provided by TriWest, with technical support and guidance by Dr. Eric Bruns of the Wraparound Evaluation and Research Team and National Wraparound Initiative (see letter of commitment in Appendix 1). Data from National Evaluation clinical instruments will be integrated into the service planning processes, and local evaluation activities will develop a comprehensive fidelity monitoring and feedback system to improve service planning and delivery. Findings from the National Evaluation will also be integrated into the quality improvement process, for example, by using findings from the System of Care Study to help assess adherence to system of care principles.

Developing systems of care policies in the local community: Members of the Coalition have a strong history of making use of evaluation findings to inform policy decisions. Findings from the National Evaluation, coupled with local evaluation findings, will help refine policies for new service development, provider network management, interagency collaboration, and other issues in a manner consistent with System of Care principles.

Sustaining the system of care beyond the 6-year period of Federal funding: The evaluation will provide accessible information to share with decision-makers for key payers (Medicaid, youth corrections, child welfare, and state legislature) and broader social marketing efforts. TriWest will implement cost analyses to assess the cost effectiveness of new services provided against current costs and service provision, and other comparisons with model programs will help enhance the credibility of collaborative accomplishments. We expect that evaluation findings in this area will be useful in engaging current and new payers in the long-term sustainability of the Coalition. As described earlier, TriWest is uniquely positioned to help based on its work in 2007 with the State Mental Health Division (part of HRSA, within DSHS) (TriWest, 2007a) to complete an analysis of its State Medicaid Plan, 1915(b) Waiver, and overall mental health benefits to prioritize strategies for enhancing funding for EBPs. During that review, TriWest worked closely with the actuarial firm contracted by DSHS for its Medicaid waiver and has developed initial cost models to help develop rates to support these EBPs.

3. Ability to Collect and Report on Required Performance Measures. TriWest Group has the necessary abilities and experience to report performance on the required measures, and has done so successfully on our current system of care project in El Paso, Texas, which just completed its sixth grant year. The proposed evaluation team, under the lead of Dr. Selby, includes clinical and research experience and qualifications to fully complete all aspects of the evaluation, and its key members (Dr. Jesús Sanchez, and Ms. Socorro Martinez-Parham) have participated in extensive training on the complex National Evaluation protocols currently being employed to assess System of Care communities. The evaluation will also recruit, train and support independent, culturally competent, bilingual youth and family evaluation team members. In regard to the use

of the CMHS NOMs Consumer Outcome Measures for Discretionary Programs, TriWest will ensure that the Coalition complies with data collection and reporting requirements, as well as data requirements of the National Evaluation. Because NOMs baseline interviews are to be conducted within seven days of service enrollment, compared to within 30 days of enrollment for National Evaluation baseline interviews, NOMs forms will be completed via face-to-face data collection at enrollment and at the required follow-up data collection points (including at discharge), by the clinician working with each service recipient. TriWest will track data collection deadlines, as well as enter data from these forms into the TRAC Web system within seven days of data collection for the NOMs forms and within the guidelines of the National Evaluation for its data collection forms.

Data will be regularly and securely transported to the TriWest office and keyed into electronic form by trained and supervised evaluation staff. Over the course of the grant period, electronic data collection and transmission will be implemented, in a HIPAA-compliant manner, to include web-based surveys for local and National Evaluation protocols as appropriate. Data will be maintained in password-protected electronic databases that will be kept on removable media and backed up and stored under lock and key. All data collection, entry, storage, analysis, and retention policies will be reviewed and approved by the Institutional Review Board (IRB) prior to implementation.

TriWest is also experienced in working with agency and provider databases, and will make use of services and costs data provided by Coalition partners. TriWest will ensure the accuracy of the extracted data, understand discrepancies, determine limitations, clean and recode the data, and ensure that files are managed and secured appropriately. Evaluation team members are skilled in the use of current database and analysis tools, including Microsoft Access[®], SPSS[®] and Crystal Reports. Summary analyses and recommendations will be distilled through a rigorous internal peer review process involving multiple members of the evaluation team and Coalition partners. We will submit required data and reports to TRAC and the National Evaluation through timely data entry and secure electronic data transfers, with a regular feedback loop to the Coalition's Governance Team and key managers to share emerging findings and help administrators, clinicians, and other stakeholders use evaluation findings for project management, social marketing, and other decision-making.

In addition to TriWest Group's expertise in this area, NSMHA has a long history of collecting and reporting on data to meet external reporting requirements and internal quality improvement and management needs. As such, it recognizes the importance of evaluation, and is in a good position to work closely and collaboratively with the evaluation team. We are familiar with and implement rigorous data collection and maintenance protocols to ensure data integrity, and are confident that we will be able to facilitate the evaluation's efforts not only to comply with evaluation requirements, but also to be able to respond quickly and accurately to other data requests and contribute to an enhanced set of evaluation products about consumer care and related activities yielding actionable feedback.

4. Managing the Project and Assuring Continuous Quality Improvement: TriWest's direct participation in the Governance and Administrative Teams ensures a direct link to management and quality improvement structures. TriWest will integrate cross-site and local evaluation findings into the quality improvement process nested within the PfS process. In addition, TriWest will establish linkages at the provider level to share findings from the WFAS to support

Care Coordinators through the supervisory process. National Evaluation findings will also be a part of the feedback system aimed at improving the quality of service planning and delivery. Data will be provided to program supervisors, project managers, and oversight committees on a regular basis to allow for timely practice and policy changes. The project will follow a continuous quality improvement cycle of collecting/analyzing data, planning, implementing new training, practices or policies, and then re-evaluating through further data collection and analysis. If issues are not successfully resolved through one cycle of this continuous quality improvement process, then cross-functional, cross-systems groups will be initiated for a more focused resolution to the issues.

5. Conducting the Performance Assessment as Specified in Section I-2.6: The local evaluation for the North Sound Community Coalition will seek to improve the process and outcomes of service delivery by the Coalition at multiple levels. In order to reduce the burden of the evaluation on service recipients and stakeholders, the project will make use of NOMs and National Evaluation data whenever possible. The local evaluation will address process questions related to the extent to which project implementation matched the implementation plan; deviations from the implementation plan, their causes, and their effects; and services and costs provided by the project. During the project planning period, formative evaluation activities will feature infrastructure development to support the National Evaluation, as well as participant observation, stakeholder focus groups, implementation monitoring, and targeted surveys to support needs assessment, planning, and service delivery infrastructure development. All of this will be integrated with the PfS efforts in collaboration with Dr. Bruns.

A major component of the local evaluation will focus on Wraparound fidelity tracking, using the WFAS, as specified by the National Wraparound Initiative (the Wraparound Fidelity Index is included in Appendix 3). Because a clear link has been established between fidelity, intervention quality and system and client-level outcomes (Henggeler et al, 1999), local evaluation efforts focusing on fidelity will enrich understanding of the relationship between wraparound fidelity and indicators tracked by the National Evaluation. The evaluation will use the WFAS as a springboard to develop a comprehensive process fidelity monitoring system for all evidence-based practices targeted under this grant, working closely with the PfS process.

Outcome aspects of the local evaluation will also address questions related to the effects of evidence-based interventions on participants; program, contextual and individual factors associated with outcomes; and durability of effects. Fidelity tracking coupled with Coalition partner service and outcome data collected as part of the National Evaluation, will contribute to a more complete understanding of these questions. Because the longitudinal component of the National Evaluation protocol is comprehensive, the local evaluation will be able to make maximum use of data collected as part of this longitudinal effort to answer important outcome questions while at the same time limiting the evaluation burden on the Coalition, as well as the youth and families it serves.