

# Statewide Children's Wraparound Initiative Biennial Legislative Report

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# Executive summary

**This Statewide Children’s Wraparound Initiative report fulfills the requirement in ORS 418.985 (4). That statute requires the Oregon Department of Human Services (DHS) and the Oregon Health Authority (OHA), in consultation with the Advisory Committee, to report biennially to the Governor and the Legislature on the progress toward and projected costs of fully implementing the Wraparound Initiative.**

The focal point of the Statewide Children’s Wraparound Initiative (SCWI) is to bring Wraparound, an evidence-based practice model, to all communities’ children with the highest levels of need and their families. The SCWI intensive care coordination model engages a creative and collaborative process to develop a flexible, coordinated and individualized plan of services and supports. These are geared to meeting each young person’s needs and strengths. Wraparound moves away from the historically limited array of client services and toward coordinating a variety of services and supports to best meet the child’s individual needs.

SCWI was launched at three demonstration sites in July 2010: Mid-Valley WRAP (Linn, Marion, Polk, Tillamook and Yamhill counties), Rogue Valley Wraparound Collaborative (Jackson and Josephine counties), and the Washington County Wraparound Demonstration Project (Washington County). More than 579 children have been served since the project began.

Over the past two years SCWI has accomplished much. It has used an intensive care coordination model for cross-system planning of children’s service and support needs. Data have demonstrated that children in SCWI have:

- » **Better health** as reflected by the prescription rate for psychotropic medications decreasing over the course of SCWI participation.
- » Children have **better care** when they are able to move out of facility-based care and into long-term family settings. These settings can be either with the child’s biological family or through adoption. Families experience **better care** when they no longer need child welfare involvement in their lives, are receiving better supports and children are released from state custody.
- » The system is able to provide services at a **lower cost** through participation of many systems. The intensive care coordination model can reduce higher-cost services. This allows more children to be served at reduced cost.
- » The increase in the level of dignity and respect with which families are being treated within the Wraparound process is evident through anecdotes and family stories. This area could benefit from further qualitative measurement.



SCWI's next phase will focus on approximately 1,400 children in the custody of Child Welfare who have complex needs that can be met only through an integrated system solution of culturally specific services and supports. An additional general fund investment of between \$7 million and \$10 million is required to expand to statewide implementation for the identified population of children in the care and custody of Child Welfare.

As described in the Early Childhood and Family Investment Transition Report, there are also opportunities within the Early Learning Council for innovative approaches that are very consistent with SCWI.

# Introduction

Passed in 2009, House Bill 2144 created the Statewide Children's Wraparound Initiative (SCWI). SCWI is the result of many years of hard work by youth, families, treatment providers, and local and state agencies. The initiative supports Governor Kitzhaber's agenda to integrate and streamline state services in health care and education to deliver better outcomes at lower costs. The Statewide Children's Wraparound Initiative is consistent with health system transformation and other strategies changing the structure and mission of state agencies. These agencies provide health, social services and supports, education and juvenile justice. The statute identifies the Oregon Department of Human Services, the Oregon Health Authority, the Oregon Department of Education and the Oregon Youth Authority as partners in implementing the initiative.

Oregon is building a community-based, coordinated system of services and supports for children with complex behavioral health needs as well as their families. Oregon's goal is to have a fully functional System of Care — implemented using a Wraparound planning process — in every community. Wraparound consists of an intensive care coordination process for children with emotional and behavioral disorders who are involved in multiple systems. These systems include mental health, addictions, child welfare, juvenile justice and education. This nationally recognized practice has been implemented in several regions of the state with great success. Wraparound is a team-based, strengths-based practice to organize a child and family driven system of services and supports. Through active care coordination, Wraparound's goal is to ensure children and youth with high behavioral health needs remain at home, in school, with friends and out of trouble. The desired outcome is family and youth driven, culturally and linguistically competent care that serves children in their home communities. The goal is for children to be in a family setting with all systems fully integrated.

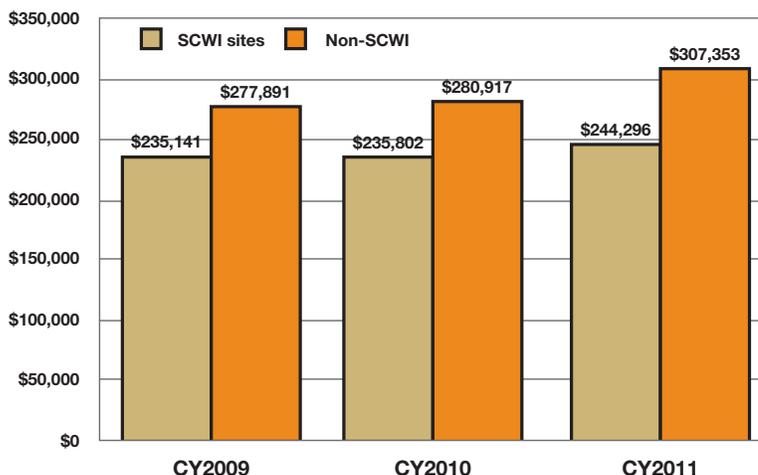
# Fiscal analysis\*

A Wraparound model goal is to provide services and supports to help children successfully return to their families and communities instead of moving into higher, more costly levels of care. Results of a 2012 study of mental health services provided to children enrolled in OHP suggest that in Oregon the Wraparound model did have an impact on the cost of these services.

**Figure 1**

## **OHP children's mental health services All levels of service:**

Total billed per 1,000 members age 0–17  
Calendar years 2009–2011



Source: Medicaid Management Information System; data pulled Oct. 18, 2012

Combined results for all levels of service show that SCWI sites were cost-effective for children's mental health services. As seen in Figure 1, in 2009 and 2010, the cost per child was 15 percent and 16 percent lower at SCWI sites than non-SCWI. In 2011, after Wraparound was fully established at all three demonstration sites, this differential jumped to 21 percent. Between 2010 and 2011, the amount billed per child enrolled in OHP only increased by 3.6 percent at SCWI sites. This was much less than the 9.4 percent increase observed in non-SCWI areas of the state.

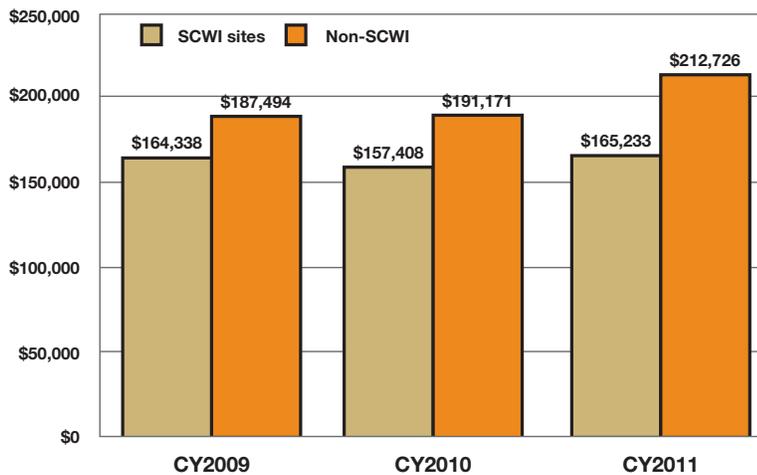
\* Data in this section (fiscal analysis) is the most recent available and pulled from cleansed paid Medicaid encounters during the time period spanning just before and during early implementation and well into full SCWI implementation.

A pattern of outpatient service costs is apparent in Figure 2. These costs account for more than two-thirds of combined costs (67.5–69.5 percent). Again, outpatient costs in SCWI appeared to avoid the steep cost increases occurring in the non-SCWI group.

## Figure 2

### OHP children’s mental health services Outpatient services:

Total billed per 1,000 members age 0–17  
Calendar years 2009–2011



Source: Medicaid Management Information System; data pulled Oct. 18, 2012

\* Data in this section (fiscal analysis) is the most recent available and pulled from cleansed paid Medicaid encounters during the time period spanning just before and during early implementation and well into full SCWI implementation.

## Individual and systemic outcomes

*When her mother married Tom, Haley was 10 years old. She had diagnoses of pervasive developmental disorder, attention deficit hyperactivity disorder and mood disorder. The transition to a blended family was difficult. It included moving to a new community and leaving her therapists. She began to have “meltdowns” daily that included yelling, throwing things, hitting and kicking her family members and being destructive to property, including punching holes in the walls of the family home. Her aggression became so severe, she was a safety risk to her younger siblings and could not ride in the family car or share a room.*

*Through Wraparound, Haley’s mom, Heather, learned about collaborative problem-solving and other skills to increase the quality and consistency of her parenting and to help Haley regain self-control. Haley was connected with new therapists. Today, after two years of Wraparound-based care coordination, Haley has had no meltdowns in more than 90 days, can ride in the car, is no longer violent, and is using coping skills learned in therapy to manage her anxiety and other issues. Heather says, “I am so immensely grateful to the Wraparound team for all of their support, trust and knowledge. My family would not be where we are today if it was not for them. The community is lucky to have people who care so much about the mental health of our children.”*

To ensure the effective implementation of Wraparound, a strong quantitative data measurement system is essential. A Web portal, called the Children’s Progress Review System (CPRS), was created to collect and house information from the child and family team. CPRS is used to store data from a progress review and administration of an assessment called the Behavioral and Emotional Rating Scale, Second Edition (BERS-2). This is a standardized tool measuring behavioral and emotional strengths of children and youth. The progress review is a standardized questionnaire compiled from information shared by the child’s parent or primary caregiver at the child and family team meeting. It measures and monitors the child’s progress on selected indicators of improved stability and mental health. Progress reviews are collected when a child begins, every 90 days while in the project, and when the child leaves Wraparound. The child’s parent or primary caregiver completes the BERS-2. The report tracks progress indicators. They show improvement in key areas of behavioral and emotional competence or stability such as residential stability, academic performance, risk of harm to self and others, risk or history of running away, risk or history of delinquency, substance use, availability of caregiver supports, caregiver’s estimation of progress, and BERS-2 ratings. These real-time data have effectively demonstrated improvements the Wraparound program is making in children’s lives. Data for each young person are entered in CPRS when they come into the program and every quarter. This measures a youth’s progress toward his or her ability to reach three key goals: to be at home, attend school and stay out of trouble.

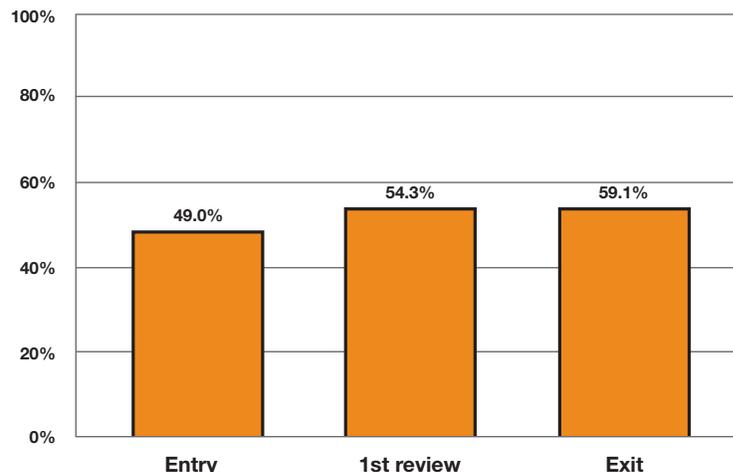
## **Better health\*\***

### *Psychotropic medications*

A high percentage of children who enter this program also may need treatments such as psychotropic medications. Psychotropic medications are psychiatric medicines that alter the brain's chemical levels. This affects attention, mood and behavior. These medications include antidepressants, antipsychotics, mood stabilizing agents, and ADHD and antianxiety agents. Other medications include those that calm the child's peripheral nervous system. At the time of entry, 51 percent of the children received treatment with psychotropic medications. However, at exit, 39.9 percent of the children remained on psychotropic medications (see Figure 3.)

**Figure 3**

### **Children in Wraparound who are NOT currently prescribed psychotropic medications**



*Results for 208 children with assessment at entry into Wraparound, first progress review, and at exit, between July 2010 and January 2013*

The need for psychotropic prescribing appears to lessen because the child's mental health conditions greatly improve. Individualized care, as well as increased professional and natural support from a team working to help the child and family, helps decrease the likelihood that a child will need to be medicated. The child's diagnosis and treatment will also determine the likelihood of needing medication to improve her or his mental health. Decreased reliance on psychotropic medications within the first 90 days can reflect the increased availability of a primary care provider. It can also reflect implementation of changes in a child's treatment plan.

\*\* The data in sections marked with a double asterisk were compiled on 208 children who entered the Wraparound project, had at least one quarterly review and left the project with an exit review. These data are taken from a report issued in January 2013. Data covers the time frame of July 2010 through January 2013.

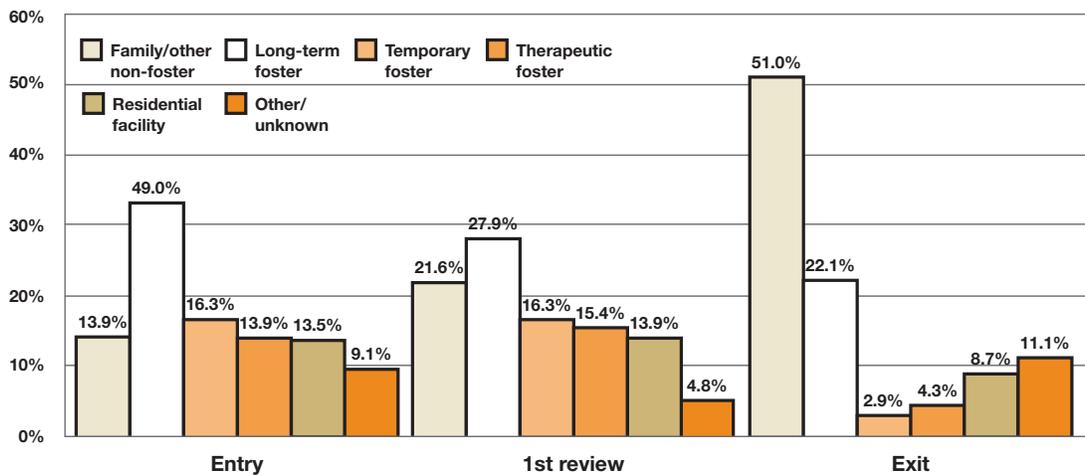
## Better care\*\*

### Residence

Children served in Wraparound at the present time are in the custody of Child Welfare. It is extremely important that children remain with or return to their families or extended families. These children's lives already have been significantly disrupted. They are in need of stable family and living arrangements.

Figure 4 shows that only about 14 percent of children entering the project are able to live with their immediate families or relatives in non-foster care settings. After 90 days, this increases to 22 percent. By the time they exit the Wraparound project, 51 percent of youth can live with their own families rather than in therapeutic foster care or residential treatment.

**Figure 4**  
**Current living arrangement**



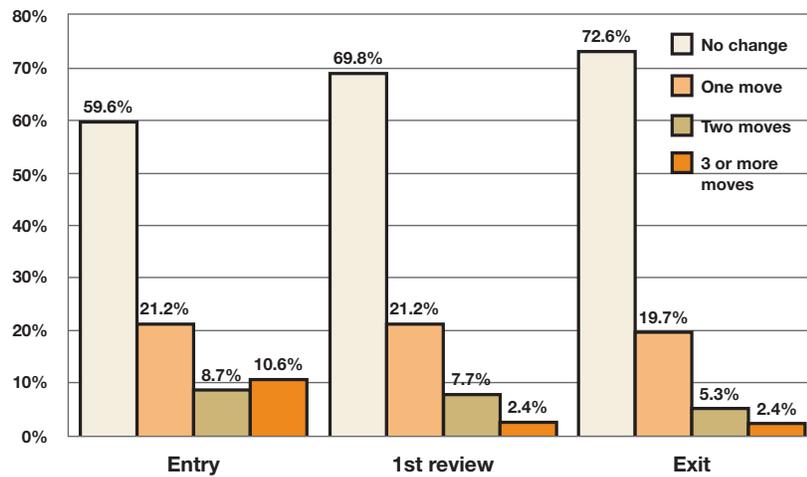
Results for 208 children with assessment at entry into Wraparound, first progress review, and at exit, between July 2010 and January 2013

\*\* The data in sections marked with a double asterisk were compiled on 208 children who entered the Wraparound project, had at least one quarterly review and left the project with an exit review. These data are taken from a report issued in January 2013. Data covers the time frame of July 2010 through January 2013.

Figure 5 below shows that as treatment progresses, living situations stabilize. The proportion of youth who did not change residence during the previous 90 days rises from 60 percent when they enter Wraparound to 73 percent when they leave. At the same time, the number of children who moved three or more times drops from 11 percent at the first review to just over 2 percent when they leave the program.

**Figure 5**

**Residence changes in prior 90 days**



*Results for 208 children with assessment at entry into Wraparound, first progress review, and at exit, between July 2010 and January 2013*

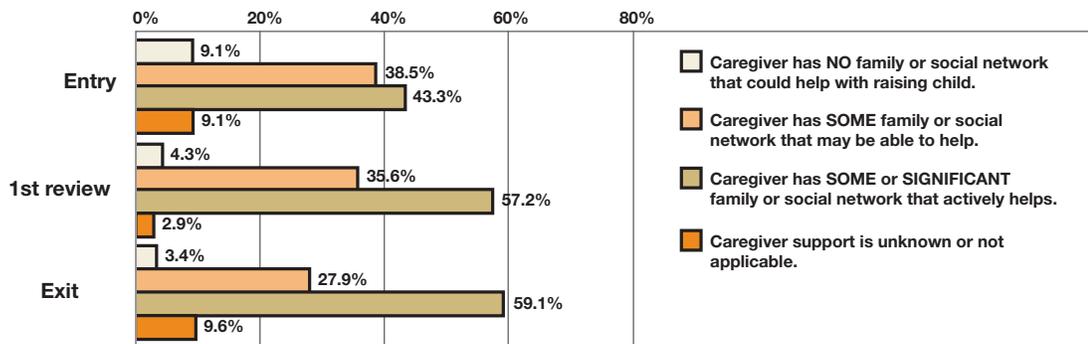
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### Support available to caregivers\*\*

The family or social network available to caregivers of children who have significant behavioral disorders is key to successfully caring for their children. These charts illustrate that caregivers participating in Wraparound felt more supported over time. The percentage of caregivers who said they have active help from family or social networks was 59 percent at the end of the program, compared to 43 percent at the beginning (Figure 6).

**Figure 6**

### Caregiver family/social network support in past 30 days



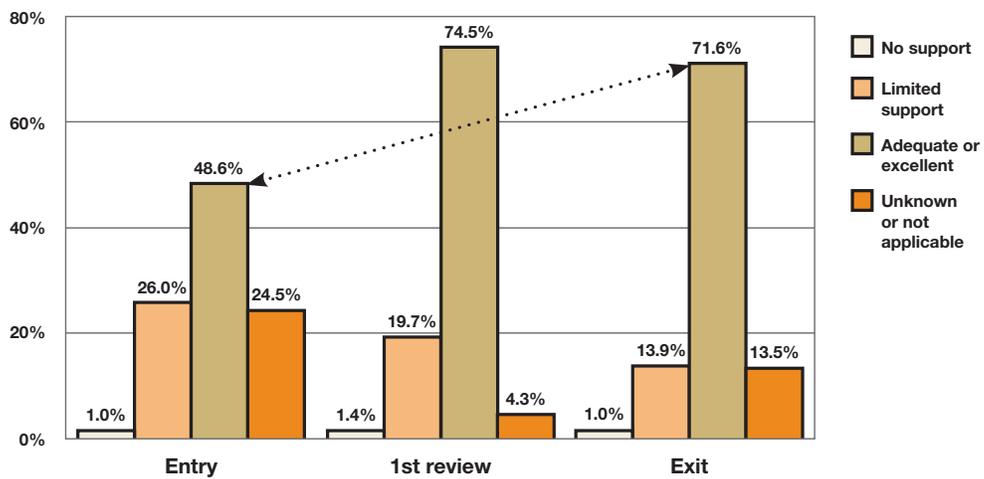
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Caregivers' support for addressing their children's problem behaviors also increases with each stage of Wraparound. This is especially true between entry and the first progress review (Figure 7). This increase in support is consistent with children being able to transition to family living situations through the Wraparound process.

**Figure 7**

**Caregiver support to address problematic behaviors**



*Results for 208 children with assessment at entry into Wraparound, first progress review, and at exit, between July 2010 and January 2013*

\*\* The data in sections marked with a double asterisk were compiled on 208 children who entered the Wraparound project, had at least one quarterly review and left the project with an exit review. These data are taken from a report issued in January 2013. Data covers the time frame of July 2010 through January 2013.

# Training and the Wraparound practice model

A key element to SCWI's success has been its partnership with Portland State University (PSU). PSU is nationally recognized for expertise in training to the Wraparound model. PSU staff provide direct technical assistance to each project site and the state core implementation team. The PSU System of Care Institute collaborated with each site to develop an individualized training plan. A little more than a year after beginning implementation, each site was able to show fidelity to the evidence-based practice model. Fidelity, or an ability to replicate the model, is critical to achieve the desired outcomes of any evidence-based practice.

Fidelity tools, or scales, are an important way to make sure that an evidence-based practice is remaining true to the model's research base. A fidelity scale verifies that an intervention is being implemented in line with the treatment model or with the research that produced the practice. Evidence shows the scale is reliable and valid.

Fidelity to the Wraparound model was measured in early 2012 through the Wraparound Fidelity Index (a fidelity tool). All three demonstration sites scored at or above the national mean for Wraparound fidelity, as measured by the National Wraparound Initiative.

System-level indicators were measured for baseline in fall 2010 using the Community Supports for Wraparound Inventory (CSWI). The National Wraparound Initiative, a research and training organization supporting fidelity implementation of Wraparound as a model, developed CSWI. This tool assesses a community's readiness to operate within a System of Care. System level indicators measured include community partnership, collaborative action, fiscal policies and sustainability, access to needed supports and services, human resource development and support, and accountability. This community-level measurement of systemic readiness and implementation ability is an important component of SCWI and System of Care (SOC) success. Results of these inventories are posted on the SCWI webpage ([www.oregon.gov/OHA/amh/pages/wraparound/main.aspx](http://www.oregon.gov/OHA/amh/pages/wraparound/main.aspx)) under the subheading "Community Supports for Wraparound Inventory."

# Project site implementation — initially and under CCOs

In 2010, the 28 Oregon counties that applied to be SCWI demonstration sites showed a major interest in and commitment to System of Care (SOC) values and Wraparound processes as innovative ways to meet the needs of youth and families. SCWI launched three demonstration sites on July 1, 2010. These sites are Mid-Valley WRAP (Linn, Marion, Polk, Tillamook and Yamhill counties), Rogue Valley Wraparound Collaborative (Jackson and Josephine counties), and Washington County Wraparound Demonstration Project. In the first year, the projects collectively maintained a census of 375 children and youth.

The criteria for the clients served by the initial demonstration were youth who had been in the custody of DHS Child Welfare (CW) for at least a year and who had been in four or more placements, or youth in their first year of DHS custody whose needs required the highest levels of care in either system. The criteria initially used were restricted to Child Welfare and Mental Health and Addictions involvement. This created a barrier for families and youth involved in other systems.

Over the past year, these criteria have been broadened and are governed by local need. Participants still must be in DHS custody. A broader population invites more engagement from many system partners at both the state and local levels. It also gives communities more latitude to serve the children of highest need.

The current picture in state government is one of transformation. Multiple child-serving state agency initiatives are working toward the same or similar goals: coordinating and integrating services and supports to improve outcomes for children and families. The following are establishing key strategies to improve services and supports to children and their families: the Early Learning Council; the Youth Development Council; Health System Transformation within OHA and DHS initiatives such as Differential Response; Strengthening, Preserving and Reunifying Families; and the Casey Family Project. Oregon Youth Authority and the Department of Education are also transforming their agencies and delivery systems independently of this initiative.

Coordinated care organization (CCO) implementation for health system transformation gives all sites a unique opportunity and challenge. One site, Washington County, has successfully applied the model to all children requiring intensive mental health services, including those in the SCWI project. The successes, lessons learned and positive growth at both the state and local levels are useful as communities transition to the CCO structure and should be integrated to ensure sustainable practice. Communities need help with strategies that leverage what has been learned.

# Governance and accountability

State leadership and support for SCWI is a joint commitment between OHA's Addictions and Mental Health (AMH) Division and DHS's Child Welfare (CW) program. DHS/OHA identified a state lead and a local site lead to provide guidance and leadership specific to the program at the community level. State leads also provide collaboration, direct support and technical assistance to each demonstration site. A portion of two AMH staff positions and one CW staff position have been assigned to provide this guidance, leadership and collaboration with the sites. State leads assigned to each site have taken on this responsibility in addition to their existing program analyst roles.

Accountability is enhanced through engagement of the youth and families served who have a critical role in shaping policy and practice in their communities through their membership on, and involvement with, committees in the governance structure. Child mental health and child welfare systems highly value a System of Care and Wraparound model.

A critical Wraparound and System of Care component is system-level collaboration. Legislation identified DHS Child Welfare and OHA Addictions and Mental Health as lead agencies in implementing this initiative. In response, DHS Child Welfare and OHA Addictions and Mental Health dedicated existing resources to support SCWI. As a result, OHA and DHS have stronger collaboration and communication within the demonstration sites. The initiative will be even more effective as other system partners are engaged in working with OHA/DHS.

The core SCWI implementation team of DHS/OHA Initiative co-leads (one administrator from each agency) and state and local site leads meet biweekly with partners to coordinate the initiative. Partners include Portland State University, the Family Partnership specialist, Oregon Family Support Network, Youth M.O.V.E. leadership, DHS field representatives, an OYA representative and a DHS Developmental Disabilities representative. Shared leadership helps convey information, identify opportunities and highlight local- and state-level growth and development areas. This leads to community-based implementation. Coordinated local- and state-level guidance and leadership are critical for system change. An advisory committee required by statute includes representation from the statutory partner agencies, stakeholders, youth and families, and SCWI providers.

Each demonstration site collaboratively chose its mental health organization (MHO) as the demonstration's administrative service organization. These MHOs are being phased out during health system transformation. Coordinated care organizations (CCO) are required under contract to maintain and move forward with the existing Wraparound sites. All three sites created an advisory committee with youth and family, provider agencies, partner agencies and advocate representatives. CCOs' start in 2012 brought about some changes for the participating demonstration projects.

All sites are affected by the transition to CCOs. However, two of the sites are experiencing structural challenges because each is shared by more than one CCO. For example, the administrative service organization administering one of the projects no longer employs a local site project lead. CCOs are being informed about SCWI and the value of the Wraparound model, as well as about efforts to continue with the creation of a statewide System of Care. The handout on page 24 has been distributed to CCOs. A presentation was recently made to the CCO medical directors, quality improvement managers and other CCO administrative staff.

The three demonstration sites selected for SCWI represented a wide range of geographical areas, diverse demographics, and experience with Systems of Care and Wraparound. Each demonstration site's strategies were individualized to the community and the populations served. Progress made at one site illustrates more sustainable gains than a single county can make, as opposed to a multiple-county approach. Specific examples include system integration, cross-system partnerships, interdisciplinary practice, referral processes and funding structures. An area for consideration is how to structure system design and delivery of services and supports to allow for multiple or cross-county implementation. This is even more important as CCOs are implemented because CCO coverage areas are not bound by county lines. In addition, some single counties are covered by multiple CCOs.

This initiative was based on implementing the Wraparound model as an intensive care coordination process. In order to fully implement the law and support cross-system efforts under way in Oregon, we need to focus on developing and implementing System of Care (SOC) values and principles across agencies and initiatives. The three core values of SOC provide a meaningful way to integrate efforts across agencies: family driven and youth guided, culturally and linguistically responsive, and community-based. In an effort to create a true statewide SOC, both DHS and OHA need to glean lessons learned from work force development, technical assistance, and the perspective of families and youth within the program.

System of Care (SOC) is a system-level collaborative framework that creates the structure needed at the agency level to implement comprehensive, effective programs. Wraparound is a planning process that puts System of Care into operation at the practice level — within communities where it touches the people who need it most. It is important to recognize the interconnectedness of the two while helping communities appreciate the need to implement strategies for both. It is evident in the SCWI demonstration project that communities may think the two terms are synonymous. Creating a clear understanding of SOC framework provides a structure for related initiatives to thrive (i.e., Differential Response, coordinated care organizations (CCOs), SB 964-Strengthening, Preserving and Reunifying Families, Early Learning Council).

These specific Child Welfare practices integrate well into the System of Care and Wraparound Model:

- » *Family Find* supports the identification and engagement of family members as a supportive system for children who are involved in the Child Welfare system as a whole.
- » *Strengthening, Preserving, Reunifying Families (SB964)* is an avenue for communities to collaborate with DHS to develop a culturally specific, community-based service array to meet the needs of families.
- » Implementing a *Differential Response* to Child Protective Services (CPS) investigations will allow CPS to intervene with families in a more collaborative and less intrusive way. This will support the Wraparound family engagement model of family driven case plans without requiring a CPS abuse finding or disposition.
- » Finally, one of Oregon's federal IV-E waiver demonstration projects focuses on engaging CPS clients with *Parent Mentors* at the onset of an investigation. The use of non-traditional helpers such as *Parent Mentors*, who are former clients who have been successful in the CPS system, gives an opportunity to engage clients using their unique experiences. This practice mirrors the Wraparound model of clients using natural supports and working with professionals that encourages client engagement.

A cornerstone of effective Wraparound models, natural supports can be individuals or organizations in the family's community as well as kinship, social or spiritual networks such as friends, extended family members, ministers, neighbors, and others of significance to the family. While not always readily available, the presence of natural supports is critical to a family's ability to move forward and sustain gains once Wraparound services and supports are no longer formally needed. A person who is a natural support would ideally be a member of the child and family team to offer a distinctly non-professional perspective.

# Cultural competence in a family and youth driven model

*Annie was first seen in outpatient mental health at age 9 and diagnosed with mood disorder, oppositional defiant disorder and parent-child conflict in the home. Things got worse for her between the ages of 11 and 15. She ended up in foster care and began to commit crimes: assaulting authority figures, shoplifting, petty theft, running away. She was referred to Wraparound and began receiving individual and family therapy, skills training, 24-hour crisis support and medication management.*

*Things did not go smoothly for Annie. She ended up needing residential treatment, but progress continued with Wraparound support. After returning home, a violent fight led her to call for support and she was moved to a placement for some breathing room. Life got worse for Annie and her family as the lack of stability caused the situation to spiral out of control.*

*She returned to psychiatric residential treatment and the Wraparound team identified a new plan. She connected with Independent Living resources for transition-age youth. The team assigned a family partner to help empower Annie to overcome her mental health disorders and to begin to learn how to advocate for herself. Since this plan began, Annie has followed through with therapy and transition-age youth services and completed her GED. When the judge at a recent hearing asked her what changed, she replied, "I finally got it that what my parents can't do, I can do; I can use my skills to help me make right choices."*

It is a fundamental principle of System of Care and Wraparound that family and youth drive the services and supports in their plan. However, child-serving systems must be able to hear solutions created by the youth and their families. These solutions identify strengths and needs and deliver services based on these qualities. Families and the youth themselves are key to the solutions.

The use of youth and family voice, which informs the way services and supports are provided to children and their families, is growing in Oregon. Through consistently emphasizing and stating the core values of System of Care, the SCWI demonstration projects have supported and fostered greater youth and family voice at multiple system implementation levels.

The efforts to include youth and family voice within the sites will continue to positively affect other initiatives and system-level transformation. Project sites have actively hired family and



youth support partners as peers. Peers are family members or youth with personal experience in behavioral health settings, training and credentials who work directly with the child and family team as part of the planned Wraparound services and supports. Youth peer specialists were recently hired at one of the demonstration sites by Youth M.O.V.E. Oregon, providing peer-to-peer support in that geographic area.

Families and youth are also increasing their roles in policy and oversight. The state has partnered with the Oregon Family Support Network and Youth M.O.V.E. Oregon to increase system capacity for meaningful youth and family involvement.

Being culturally responsive is a core value associated with System of Care and Wraparound. Each demonstration site has implemented strategies to support cultural and linguistic competency. An indicator was added to the Children's Progress Review System for caregivers to rate whether or not their family's language and culture has been addressed in Wraparound planning.

The Community Supports for Wraparound Inventory's (CSWI) baseline finding in fall 2010 assesses readiness to operate within a System of Care. Communities' perceptions of the needs of their county or region are inconsistent. For instance, all demonstration sites responding to the inventory rated themselves low in cultural and linguistic competency. However, some community stakeholders felt that this was not a high-priority area. To address this discrepancy, it could help to adopt the three core values of System of Care (family driven and youth guided, culturally and linguistically competent, and community-based) as non-negotiable at the state, regional and local levels. To measure growth in this area, a second CSWI survey could be administered. Cultural responsiveness is critical to reducing health disparities.

# Work force development

Work force development is available to all sites to help achieve fidelity to the evidence-based Wraparound model. Portland State University provides community- and practice-level training, coaching and technical assistance. In addition, support has been offered to create tailored work plans at each site to meet the specific strengths, needs and cultural considerations of each community served. This support is provided at multiple levels including practice and supervisory groups, community advisory groups and leadership councils.

PSU provides strategic consultation to SCWI through tools, resources and expertise in developing and implementing a statewide System of Care. PSU helps gather feedback from demonstration sites. This feedback helps evaluate and improve the current model as well as collect lessons learned for future expansion.

SCWI work force development and training has been successful due to the efforts of Oregon Family Support Network, PSU and DHS/OHA. These partnerships could be further strengthened by equitable and clearly defined funding. This funding should support collaboration consistent with the values and principles of System of Care and Wraparound. Incorporating other child-serving system services and supports such as detention diversion, individual education plans and family housing systems would also support success.

## Service array

Intensive and active care coordination is required for high-fidelity implementation in the Wraparound model. The initiative has established a caseload ratio of one care coordinator for up to 15 children. The care coordinator facilitates the Wraparound team and coordinates the service array. The care coordinator also monitors to ensure necessary services and supports are available for children with highly complex behavioral health needs.

The service array, also called the integrated service array, is a full continuum of coordinated, culturally competent mental health services. These services are available to children based on family choice and medical appropriateness. The service array is delivered in the child's most natural environment. Services chosen from this continuum are delivered in a coordinated, flexible and individualized manner. The service array includes the following: mental health assessment, psychiatric evaluation and medication management, care coordination, home- and community-based individual and group skills training and therapy, home- and community-based family therapy, respite care and family support, crisis services, behavioral support services, psychiatric day treatment or partial day treatment (in funded communities), psychiatric residential treatment services and acute or sub-acute psychiatric hospitalization.

The local community in each demonstration site has the authority to coordinate the available service array through the Child and Family (Wraparound) Team. Children in the project have the full array of child welfare and mental health services available. They also have other child-serving system services and supports such as tutors, mentors, individualized educational plans, behavioral rehabilitation services, or diversion from detention.

This model creates a flexible, coordinated, individualized plan of services and supports that draws on each young person's strengths and meets his or her needs. Families and youth partner with a care coordinator, family and youth partner, natural supports and other professionals to devise a plan. All are accountable for carrying it out. There is a strong emphasis on accountability, using strategies to remove barriers, foster independence and engage natural supports.

# Data sharing

The law outlines requirements to collect and evaluate data by establishing a committee. Its duties are to review and choose outcomes or performance measures, create data-sharing agreements, and support the acquisition of information technology that allows local entities to share real-time data.

A fundamental need (and a legal requirement) of an integrated System of Care is sharing information across child-serving systems. Development of the Children's Progress Review System allows real-time sharing of case- and system-level data. Integrating state government information systems should be a high priority. This should result in adequate information sharing among systems at the case and system levels. State- and local-level standard data-sharing agreements still need to be developed to address confidentiality laws and information system technology barriers. This has become significant with the restructuring of the health system under the coordinated care organizations.

At the outset of this initiative, ways to collect and track data were established at the case and system levels. Methods to review processes were also used as the initiative progressed. Measures were defined to determine key indicators at the child and system levels. The project sites have used CPRS and other data measurement tools to demonstrate the individual, systemic and fiscal success indicators of this initiative.

# Costs of full implementation

DHS and OHA have reinvested current financial and staff resources to begin implementation. However, the agencies need new resources or existing resource reinvestment to maintain the current sites, continue implementation and expand project sites and populations as statutorily mandated by 2015.

The Governor's Balanced Budget provides funding to continue enhanced care coordination in the three project sites. However, it does not include additional resources that would be needed to expand the project:

- » Work force development and training;
- » Flexible case-level resources;
- » Family and youth peer-delivered service support;
- » Enhanced culturally specific services;
- » Further information system integration; and
- » State agency staff positions.

An additional 1,400 children in Child Welfare custody have complex needs best met through an integrated system of culturally specific services and supports. Nearly every county has developed a multi-agency community plan to better organize and administer its local System of Care. The goal is for children and their families to receive necessary services and supports to stay home, in school, with friends and out of trouble. An additional General Fund investment of approximately \$13 million is necessary to expand statewide implementation for identified populations of children who are cared for by Child Welfare or other child-serving systems such as juvenile justice.

The Oregon Health Authority's work to integrate health care services into regional managed care environments across payer sources will provide further structure. The CCO contract requires the following:

Creation of a system of care by implementing a children's Wraparound Demonstration Project and by providing oversight and, in collaboration with OHA, evaluation. Contractor shall develop local and state level partnerships to collaborate with OHA on the implementation of ORS 418.975 to 418.985 in the development of the Statewide Children's Wraparound Initiative.

Preliminary collaboration efforts are beginning to emerge under the CCO structure.

All partner agencies will need to take major action to fully comply by 2015 with the requirements of ORS 418.975 to 418.985. This includes analysis and re-evaluation of the current spending levels and resources being dedicated to children who meet the law's

defined targets. These include youth who have emotional, behavioral or substance use-related needs, or are at high risk of developing them, and who are involved with two or more child-serving systems.

Partner agencies need to further analyze their mandates and missions for flexibility and fit so they can incorporate the law's principles and practices. The ability to integrate and blend funding with partner agencies would greatly propel this work forward. This work is critical to improving the outcomes for children and families while increasing effectiveness and efficiency.

# Wraparound & Systems of Care

## A Guide for Coordinated Care Organizations

### Wraparound

An intensive evidence-based planning process that is used to implement Systems of Care values & principles for children with special healthcare needs.

### Systems of Care (SOC)

A coordinated network to support children/youth with challenges and their families in order to help them function better at home, school and in life. It's a spectrum of effective, community-based services and supports that build meaningful partnerships. Benefits:



## Relevant for CCOs



The stated goals of CCOs – better health, better care and lower costs – are closely aligned with those of Wraparound and SOC. Oregon's Statewide Children's Wraparound Initiative serves as a useful and relevant guide for CCOs on cross-system workforce development, finance structures, policy development, data collection, referral process and multi-disciplinary collaboration.

To learn more about SOC/ Wraparound and the link to CCO's, contact Bill Baney, PSU System of Care Institute at 503.725.5914 or [baneyw@pdx.edu](mailto:baneyw@pdx.edu).

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