AGREEMENT FOR SERVICES #180-S0711

THIS AGREEMENT made and entered by and between the County of El Dorado, a political subdivision of the State of California (hereinafter referred to as "County") and New Morning Youth and Family Services, Inc., a California Corporation, duly qualified to conduct business in the State of California, whose principal place of business is 675 Green Valley Road, Placerville, CA 95667; (hereinafter referred to as "Contractor");

W I T N E S S E T H

WHEREAS, County has determined that it is necessary to obtain a Contractor to provide services necessary for a Mental Health Services Act (MHSA) Family-Centered Services Program on the South Lake Tahoe Region of El Dorado County for the Mental Health Department; and

WHEREAS, Contractor has represented to County that it is specially trained, experienced, expert and competent to perform the special services required hereunder and County has determined to rely upon such representations; and

WHEREAS, it is the intent of the parties hereto that such services be in conformity with all applicable federal, state and local laws; and

WHEREAS, County has determined that the provision of these services provided by Contractor is in the public's best interest, and that these services are more economically and feasibly performed by outside independent Contractors as well as authorized by El Dorado County Charter, Section 210 (b) (6) and/or Government Code 31000;

NOW, THEREFORE, County and Contractor mutually agree as follows:

ARTICLE I

Scope of Services: Contractor shall provide services necessary for a MHSA Family-Centered Services Program on the Western Slope of El Dorado County for the Mental Health Department. Contractor shall provide services using the Wraparound Model to uninsured and underinsured youth at risk of out-of-home placement who otherwise do not have access to a full-service partnership mental health program.

Contractor will:

1. Provide wraparound services in a collaborative, team-based, family-driven service delivery model which includes clinical case management, an individualized service plan, and flexible supports and services;
2. Provide services in a convenient and comfortable location for the family;
3. Collaborate with EDC Mental Health to deliver services; and
4. Provide quarterly service delivery reports and performance indicator reports to County.
5. Submit authorization, admission and discharge documentation to County for processing on a weekly basis.
6. Participate in quarterly client chart audits with County Utilization Review staff.
7. All services shall be in accordance with Exhibit "A", marked "Description of Services", incorporated herein and made by reference a part hereof.

Contractor shall provide these services in an atmosphere of cultural competency, offering services that will meet the needs of participants from different cultural backgrounds. Free interpretation services will be available for each client and can be accessed via the interpretation agreement maintained by County.

The MHSA principles, confidentiality regulations, and code of conduct as reflected in the attached documents are conditions of this Agreement, reference Exhibit "C", "D" "E", "F", "G", "H", and "I", incorporated herein and made by reference a part hereof. Timely and appropriate clinical documentation and billing practices must be followed. Contractor's staff will also compile relevant program data as requested for County and for the California State Department of Mental Health.

Contractor shall only begin mental health services for a specific client upon receipt of written authorization from the County Program Coordinator. Contractor shall secure prior approval from the Program Coordinator before making changes to the authorized treatment plan. The County will not pay for services that have not been pre-approved.

Contractor shall provide **Specialty Mental Health Services** as defined in California Code of Regulations, Title 9, Rehabilitative and Developmental Services, Section 1810.247. These services include Day Rehabilitation, Case Management, Crisis Intervention, Medication Services and Mental Health Services.

Contractor shall provide quality care in a manner consistent with efficient, cost effective delivery of covered services.

Contractor shall provide covered services to a Beneficiary in the same manner in which it provides said services to all other individuals receiving services from Contractor subject to any limitations contained in Beneficiaries' treatment plans.

Contractor agrees to provide documentation or reports to County when requested to assure CONTRACTOR'S compliance with contract terms.

Contractor will use Medi-Cal codes for services rendered as appropriate.

ARTICLE II

Term: This Agreement shall become effective when fully executed by both parties hereto and shall expire June 30, 2008.

ARTICLE III

Compensation for Services: For services provided herein, County agrees to pay Contractor monthly in arrears. Contractor shall submit monthly invoices no later than thirty (30) days following the end of a "service month." For billing purposes, a "service month" shall be defined as a calendar month during which Contractor provides services in accordance with "Scope of Services. For the purpose of this Agreement, payments shall be made in accordance with Exhibit "B", marked "Contract Rates", incorporated herein and made by reference a part hereof.

If it is determined that a program participant has private insurance which covers the services, Contractor shall bill the appropriate insurance carrier. If the participant's insurance covers the service at a rate less than the rate set forth in this Agreement, Contractor shall only bill the County for the difference. If the participant has no insurance for the service, Contractor shall bill the County at the rate set forth in this Agreement.

Contractor shall submit a single monthly invoice identifying charges as identified in Exhibit "B". For services provided, supporting documentation must include applicable timesheets. For reimbursement of other expenses, supporting documentation must include a copy of the receipt or invoice.

For mental health services provided by the Contractor, the Contractor will provide supporting documentation for each service provided identifying the name of the client, the date of service, the type of service and the number of service minutes.

Payment shall be made within thirty (30) days following the County's receipt of approved invoice(s). Contractor shall submit only original invoices. Photocopied or faxed invoices will not be accepted. Contractor shall ensure only billing information is included on the invoice.

County agrees to reimburse Contractor for transportation and travel expenses in accordance with Exhibit "B" and Exhibit "J", marked "Board of Supervisors Travel Policy D-1", incorporated herein and made by reference a part hereof.

County agrees to reimburse Contractor for any miscellaneous items used to perform the services of this Agreement, such as; activities, personal items, food, beverages, etc., in accordance with Exhibit "B", "Flex Funds".

County will provide relevant training for program staff employed by Contractor. Such training will be conducted at the sole expense of the County. This training will be mandatory.

The total amount of this Agreement shall not exceed $263,953, inclusive of all expenses.

ARTICLE IV

Cost Report: Contractor shall submit an Annual Cost Report to County on or before October 31 of each year. Contractor shall prepare the Cost Report in accordance with all Federal, State, and County requirements and generally accepted accounting principles. The Cost Report shall allocate direct and indirect cost of providing Specialty Mental Health Services by funding source (i.e., medical or non-medical) and service type in accordance with such requirements and consistent with prudent business practice. Such costs and allocations shall be supported by source documentation maintained by Contractor, and available at any time to Administrator upon reasonable notice.

Contractor shall document that costs are reasonable and allowable and directly or indirectly related to the services provided hereunder. The Cost Report shall be the final financial record of services rendered under this Agreement for subsequent audits, if any.

Any payment made by County to Contractor which is subsequently determined to have been for a non-reimbursable expenditure or service, shall be repaid by Contractor to County in cash within forty-five (45) days of submittal of the Cost Report or County may elect to reduce any amount owed Contractor by an amount not to exceed the reimbursement due County.

ARTICLE V

Limitation of County Liability for Disallowances: Notwithstanding any other provision of the Agreement, County shall be held harmless from any Federal or State audit disallowance resulting from payments made to Contractor pursuant to this Agreement, less the amounts already submitted to the State for the disallowed claim.

To the extent that a Federal or State audit disallowance results from a claim or claims for which Contractor has received reimbursement for services provided, County shall recoup within 30 days from Contractor through offsets to pending and future claims or by direct billing, amounts equal to the amount of the disallowance in that fiscal year, less the amounts already remitted to the State for the disallowed claim. All subsequent claims submitted to County applicable to any previously disallowed claim may be held in abeyance, with no payment made, until the federal or state disallowance issue is resolved.

Contractor shall reply in a timely manner to any request for information or to audit exceptions by County, State and Federal audit agencies that directly relate to the services to be performed under this Agreement.

ARTICLE VI

Certification of Program Integrity: Contractor shall with all State and Federal statutory and regulatory requirements for certification of claims including Title 42, Code of Federal Regulations (CFR) Part 438.

Contractor shall ensure that each Medi-Cal beneficiary for whom the Contractor is submitting a claim for reimbursement has met the following criteria:

An assessment of the Medi-Cal beneficiary was conducted in compliance with the requirements established in the Mental Health Plan (MHP) contract between El Dorado County and the State Department of Mental Health, a copy of which will be provided to Contractor by County under separate cover.

The Medi-Cal beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the beneficiary.

The services included in the claim were actually provided to the beneficiary.

Medical necessity was established for the beneficiary as defined in statute for the service or services provided, for the timeframe in which the services were provided.

A treatment plan was developed and maintained for the beneficiary that met all plan requirements established in the MHP contract between County and the State Department of Mental Health.

For each beneficiary with day rehabilitation, day treatment intensive, or EPSDT supplemental specialty mental health services included in the claim, all requirements for MHP payment authorization in the MHP contract for day rehabilitation, day treatment intensive, and EPSDT supplemental specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in the MHP contract between County and the State Department of Mental Health

NOTE: Authority: Sections 5775, 14043.75 and 14680 Welfare and Institutions Code.

ARTICLE VII

Standard of Performance: Contractor shall perform all services required pursuant to this Agreement in the manner and according to the standards observed by a competent practitioner of the profession in which Contractor is engaged in the geographical area in which Contractor practices its profession. All products of whatsoever nature which Contractor delivers to County pursuant to this Agreement shall be prepared in a substantial first class and workmanlike manner and conform to the standards or quality normally observed by a person practicing in Contractor's profession.

ARTICLE VIII

Business Interruption: In the event the operations of Contractor or substantial portion thereof are interrupted by war, fire, insurrection, bankruptcy, riots, the elements, earthquakes, acts of God, or, without limiting the foregoing, any other cause beyond Contractor's power, Contractor agrees to develop a plan with County which in good faith shall assure the safety and welfare of all County Beneficiaries until such time as usual services can be renewed or until all Beneficiaries can be released or transferred to appropriate settings.

Nothing contained herein shall be construed to limit or reduce County's obligation to pay Contractor for services rendered prior or subsequent to an event described herein.

ARTICLE IX

Licensure and Laws: Contractor shall, throughout the term of this Agreement, maintain all necessary licenses, permits, approvals, certificates, waivers and exemptions necessary for the provision of services hereunder and as required by federal, state and local laws or any other appropriate governmental agency. Contractor represents and warrants to County that Contractor shall, at its sole cost and expense, keep in effect or obtain at all times during the term of this Agreement, any licenses, permits, and approvals which are legally required for Contractor to practice its profession at the time the services are performed. Contractor is responsible to submit verification to County semi-annually that Licensed Mental Health professionals' licenses and registrations are current.

Contractor shall notify the County Contract Administrator, or Case Management Program Coordinator, immediately in writing, of its inability to obtain or maintain, irrespective of the pendency of an appeal, such permits, licenses, approvals, certificates, waivers and exemptions.

Contractor agrees to comply with all applicable provisions of the State of California Standard Agreement between County and the State Department of Mental Health (DMH) for Managed Mental Health Care including, but not limited to, payment authorizations, utilization review, beneficiary brochure and provider lists, service planning, cooperation with the State Mental Health Plan's Quality Improvement (QI) Program, and cost reporting.

Contractor shall possess and maintain Mental Health Organizational Provider certification, and comply with the DMH requirements thereof, including on-site reviews at least once every three years.

Contractor shall comply with all applicable laws, governmental regulations and requirements as they exist now or may hereafter be amended or changed. These regulations shall be deemed to include policies and procedures as set forth in State Department of Mental Health Letters.

ARTICLE X

Records: Contractor shall, subject to the provisions of applicable law, upon reasonable advance notice and during normal business hours or at such other times as may be agreed upon, make available accounting and administrative books and records, program procedures, as well as documentation relating to licensure and accreditation, as they pertain to this Agreement and/or care, and to allow interviews of any employees who might reasonably have information related to such records. The Contractor shall be subject to the examination and audit of the State Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7).

Contractor shall maintain adequate medical records of each individual beneficiary which shall include a record of services provided by the various professional personnel in sufficient detail to make possible an evaluation of services, and contain all data necessary as required by the California State Department of Mental Health and federal regulations, including records of beneficiary interviews, progress notes and treatment plans. The MHP and other relevant parties shall have access to relevant clinical records to the extent permitted by State and Federal laws.

Beneficiary records and notes shall be maintained by Contractor. Appropriate beneficiary information will be available to County upon client discharge. Such records and information shall be provided each party hereto pursuant to procedures designed to protect the confidentiality of beneficiary medical records applicable legal requirements and recognized standards of professional practice.

Upon termination of this Agreement, Contractor agrees to cooperate with beneficiaries and subsequent Contractors with respect to the orderly and prompt transfer of copies of medical records of beneficiaries. This Agreement does not preclude Contractor from assessing reasonable charges for the expense of transferring such records if appropriate.

All beneficiary records shall be retained by Contractor for seven (7) years or one (1) year beyond the beneficiaries reaching majority, whichever is greater. Majority is defined as eighteen (18) years of age.

Contractor shall maintain complete financial records which clearly reflect the actual cost and related fees received for each type of service for which payment is claimed. The beneficiary eligibility determination and fees charged to, and collected from, beneficiaries must also be reflected therein. Any apportionment of costs shall be made in accordance with generally accepted accounting principles.

ARTICLE XI

Confidentiality: The Contractor shall protect from unauthorized disclosure names and other identifying information concerning persons receiving services pursuant to this Agreement, except for statistical information not identifying any client. The contractor shall not use such information for any purpose other than carrying out the Contractor's obligations under this Agreement. The Contractor shall promptly transmit to the County all requests for disclosure of such information not originating from the client. The Contractor shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such information to anyone other than the County, except when subpoenaed by a court. For purposes of this paragraph, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finder or voice print or a photograph. If the Consultant receives any individually identifiable health information ("Protected Health Information" or "PHI") from County or creates or receives any PHI on behalf of County, the Consultant shall maintain the security and confidentiality of such PHI as required of County by applicable laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the regulations promulgated thereunder.

ARTICLE XII

Changes to Agreement: This Agreement may be amended by mutual consent of the parties hereto. Said amendments shall become effective only when in writing and fully executed by duly authorized officers of the parties hereto.

ARTICLE XIII

Contractor to County: It is understood that the services provided under this Agreement shall be prepared in and with cooperation from County and its staff. It is further agreed that in all matters pertaining to this Agreement, Contractor shall act as Contractor only to County and shall not act as Contractor to any other individual or entity affected by this Agreement nor provide information in any manner to any party outside of this Agreement that would conflict with Contractor's responsibilities to County during term hereof.

ARTICLE XIV

Assignment and Delegation: Contractor is engaged by County for its unique qualifications and skills as well as those of its personnel. Contractor shall not subcontract, delegate or assign services to be provided, in whole or in part, to any other person or entity without prior written consent of County.

ARTICLE XV

Independent Contractor/Liability: Contractor is, and shall be at all times, deemed independent and shall be wholly responsible for the manner in which it performs services required by terms of this Agreement. Contractor exclusively assumes responsibility for acts of its employees, associates, and subcontractors, if any are authorized herein, as they relate to services to be provided under this Agreement during the course and scope of their employment.

Contractor shall be responsible for performing the work under this Agreement in a safe, professional, skillful and workmanlike manner and shall be liable for its own negligence and negligent acts of its employees. County shall have no right of control over the manner in which work is to be done and shall, therefore, not be charged with responsibility of preventing risk to Contractor or its employees.

ARTICLE XVI

Fiscal Considerations: The parties to this Agreement recognize and acknowledge that County is a political subdivision of the State of California. As such, El Dorado County is subject to the provisions of Article XVI, Section 18 of the California Constitution and other similar fiscal and procurement laws and regulations and may not expend funds for products, equipment or services not budgeted in a given fiscal year. It is further understood that in the normal course of County business, County will adopt a proposed budget prior to a given fiscal year, but that the final adoption of a budget does not occur until after the beginning of the fiscal year.

Notwithstanding any other provision of this Agreement to the contrary, County shall give notice of cancellation of this Agreement in the event of adoption of a proposed budget that does not provide for funds for the services, products or equipment subject herein. Such notice shall become effective upon the adoption of a final budget which does not provide funding for this Agreement. Upon the effective date of such notice, this Agreement shall be automatically terminated and County released from any further liability hereunder.

In addition to the above, should the Board of Supervisors during the course of a given year for financial reasons reduce, or order a reduction, in the budget for any County department for which services were contracted to be performed, pursuant to this paragraph in the sole discretion of the County, this Agreement may be deemed to be canceled in its entirety subject to payment for services performed prior to cancellation.

ARTICLE XVII
Default, Termination, and Cancellation:

A. Default: Upon the occurrence of any default of the provisions of this Agreement, a party shall give written notice of said default to the party in default (notice). If the party in default does not cure the default within ten (10) days of the date of notice (time to cure), then such party shall be in default. The time to cure may be extended at the discretion of the party giving notice. Any extension of time to cure must be in writing, prepared by the party in default for signature by the party giving notice and must specify the reason(s) for the extension and the date on which the extension of time to cure expires.

Notice given under this section shall specify the alleged default and the applicable Agreement provision and shall demand that the party in default perform the provisions of this Agreement within the applicable period of time. No such notice shall be deemed a termination of this Agreement unless the party giving notice so elects in this notice, or the party giving notice so elects in a subsequent written notice after the time to cure has expired. . In the event of termination for default, County reserves the right to take over and complete the work by contract or by any other means.

B. Bankruptcy: This Agreement, at the option of the County, shall be terminable in the case of bankruptcy, voluntary or involuntary, or insolvency of Contractor.

C. Ceasing Performance: County may terminate this Agreement in the event Contractor ceases to operate as a business, or otherwise becomes unable to substantially perform any term or condition of this Agreement.

D. Termination or Cancellation without Cause: County may terminate this Agreement in whole or in part upon seven (7) calendar days written notice by County without cause. If such prior termination is effected, County will pay for satisfactory services rendered prior to the effective dates as set forth in the Notice of Termination provided to Contractor, and for such other services, which County may agree to in writing as necessary for contract resolution. In no event, however, shall County be obligated to pay more than the total amount of the contract. Upon receipt of a Notice of Termination, Contractor shall promptly discontinue all services affected, as of the effective date of termination set forth in such Notice of Termination, unless the notice directs otherwise

ARTICLE XVIII
Notice to Parties: All notices to be given by the parties hereto shall be in writing and served by depositing same in the United States Post Office, postage prepaid and return receipt requested.

Notices to County shall be addressed as follows:

COUNTY OF EL DORADO
DEPARTMENT OF MENTAL HEALTH
344 PLACERVILLE DRIVE, SUITE 20
PLACERVILLE, CA 95667
ATTN: TOM MICHAELSON, DEPARTMENT ANALYST

or to such other location as the County directs.

Notices to Contractor shall be addressed as follows:

NEW MORNING YOUTH & FAMILY SERVICES, INC.
6765 GREEN VALLEY ROAD
PLACERVILLE, CA 95667
ATTN: DAVID ASHBY, EXECUTIVE DIRECTOR

or to such other location as the Contractor directs.

ARTICLE XIX

Indemnity: The Contractor shall defend, indemnify, and hold the County harmless against and from any and all claims, suits, losses, damages and liability for damages of every name, kind and description, including attorneys fees and costs incurred, brought for, or on account of, injuries to or death of any person, including but not limited to workers, County employees, and the public, or damage to property, or any economic or consequential losses, which are claimed to or in any way arise out of or are connected with the Contractor's services, operations, or performance hereunder, regardless of the existence or degree of fault or negligence on the part of the County, the Contractor, subcontractor(s) and employee(s) of any of these, except for the sole, or active negligence of the County, its officers and employees, or as expressly prescribed by statute. This duty of Contractor to indemnify and save County harmless includes the duties to defend set forth in California Civil Code Section 2778.

ARTICLE XX

Insurance: Contractor shall provide proof of a policy of insurance satisfactory to the El Dorado County Risk Manager and documentation evidencing that Contractor maintains insurance that meets the following requirements:

A. Full Workers' Compensation and Employers' Liability Insurance covering all employees of Contractor as required by law in the State of California.

B. Commercial General Liability Insurance of not less than $1,000,000.00 combined single limit per occurrence for bodily injury and property damage.

C. Automobile Liability Insurance of not less than $1,000,000.00 is required in the event motor vehicles are used by the Contractor in the performance of the Agreement.

D. In the event Contractor is a licensed professional, and is performing professional services under this Agreement, professional liability (for example, malpractice insurance) is required with a limit of liability of not less than $1,000,000.00 per occurrence. For the purposes of this Agreement, professional liability is required.

E. Contractor shall furnish a certificate of insurance satisfactory to the El Dorado County Risk Manager as evidence that the insurance required above is being maintained.

F. The insurance will be issued by an insurance company acceptable to the Risk Management Division, or be provided through partial or total self-insurance likewise acceptable to the Risk Management Division.

G. Contractor agrees that the insurance required above shall be in effect at all times during the term of this Agreement. In the event said insurance coverage expires at any time or times during the term of this Agreement, Contractor agrees to provide at least thirty (30) days prior to said expiration date, a new certificate of insurance evidencing insurance coverage as provided for herein for not less than the remainder of the term of the Agreement, or for a period of not less than one (1) year. New certificates of insurance are subject to the approval of the Risk Management Division and Contractor agrees that no work or services shall be performed prior to the giving of such approval. In the event the Contractor fails to keep in effect at all times insurance coverage as herein provided, County may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

H. The certificate of insurance must include the following provisions stating that:

1. The insurer will not cancel the insured's coverage without thirty (30) days prior written notice to County, and;

2. The County of El Dorado, its officers, officials, employees, and volunteers are included as additional insured, but only insofar as the operations under this Agreement are concerned. This provision shall apply to the general liability policy.

I. The Contractor's insurance coverage shall be primary insurance as respects the County, its officers, officials, employees and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees or volunteers shall be excess of the Contractor's insurance and shall not contribute with it.

J. Any deductibles or self-insured retentions must be declared to and approved by the County, either: the insurer shall reduce or eliminate such deductibles or self-insured retentions as respects the County, its officers, officials, employees, and volunteers; or the Contractor shall procure a bond guaranteeing payment of losses and related investigations, claim administration and defense expenses.

K. Any failure to comply with the reporting provisions of the policies shall not affect coverage provided to the County, its officers, officials, employees or volunteers.

L. The insurance companies shall have no recourse against the County of El Dorado, its officers and employees or any of them for payment of any premiums or assessments under any policy issued by any insurance company.

M. Contractor's obligations shall not be limited by the foregoing insurance requirements and shall survive expiration of this Agreement.

N. In the event Contractor cannot provide an occurrence policy, Contractor shall provide insurance covering claims made as a result of performance of this Agreement for not less than three (3) years following completion of performance of this Agreement.

O. Certificate of insurance shall meet such additional standards as may be determined by the contracting County Department either independently or in consultation with the Risk Management Division, as essential for the protection of the County.

ARTICLE XXI

Interest of Public Official: No official or employee of County who exercises any functions or responsibilities in review or approval of services to be provided by Contractor under this Agreement shall participate in or attempt to influence any decision relating to this Agreement which affects personal interest or interest of any corporation, partnership, or association in which he/she is directly or indirectly interested; nor shall any such official or employee of County have any interest, direct or indirect, in this Agreement or the proceeds thereof.

ARTICLE XXII

Interest of Contractor: Contractor covenants that Contractor presently has no personal interest or financial interest, and shall not acquire same in any manner or degree in either: 1) any other contract connected with or directly affected by the services to be performed by this Agreement; or, 2) any other entities connected with or directly affected by the services to be performed by this Agreement. Contractor further covenants that in the performance of this Agreement no person having any such interest shall be employed by Contractor.

ARTICLE XXIII

California Residency (Form 590): All independent Contractors providing services to the County must file a State of California Form 590, certifying their California residency or, in the case of a corporation, certifying that they have a permanent place of business in California. The Contractor will be required to submit a Form 590 prior to execution of an Agreement or County shall withhold seven (7) percent of each payment made to the Contractor during term of the Agreement. This requirement applies to any agreement/contract exceeding $1,500.00.

ARTICLE XXIV

Taxpayer Identification Number (Form W-9): All independent Contractors or corporations providing services to the County must file a Department of the Treasury Internal Revenue Service Form W-9, certifying their Taxpayer Identification Number.

ARTICLE XXV

Administrator: The County Officer or employee with responsibility for administering this Agreement is Tom Michaelson, Department Analyst, Mental Health Department, or successor.

ARTICLE XXVI

Authorized Signatures: The parties to this Agreement represent that the undersigned individuals executing this Agreement on their respective behalf are fully authorized to do so by law or other appropriate instrument and to bind upon said parties to the obligations set forth herein.

ARTICLE XXVII

Partial Invalidity: If any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions will continue in full force and effect without being impaired or invalidated in any way.

ARTICLE XXVIII

Venue: Any dispute resolution action arising out of this Agreement, including, but not limited to, litigation, mediation, or arbitration, shall be brought in El Dorado County, California, and shall be resolved in accordance with the laws of the State of California.

ARTICLE XXIX

Entire Agreement: This document and the documents referred to herein or exhibits hereto are the entire Agreement between the parties and they incorporate or supersede all prior written or oral Agreements or understandings.

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REQUESTING CONTRACT ADMINISTRATOR CONCURRENCE:

By:_____ Dated: _____
Tom Michaelson, Department Analyst
Mental Health Department

REQUESTING DEPARTMENT HEAD CONCURRENCE:

By:_____ Dated: _____
John Bachman, Ph.D., Interim Director
Mental Health Department

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IN WITNESS WHEREOF, the parties hereto have executed this Agreement the day and year first below written.

--COUNTY OF EL DORADO--

Dated: _____

By: _____
Bonnie H. Rich, Purchasing Agent
Chief Administrative Office
"County"

--CONTRACTOR--

Dated: _____

NEW MORNING YOUTH & FAMILY SERVICES, INC.
A CALIFORNIA CORPORATION

By: _____
David Ashby
Executive Director
"Contractor"

EXHIBIT "A"

DESCRIPTION OF SERVICES

CONTRACTOR shall provide EPSDT Supplemental Specialty Mental Health Services as defined in California Code of Regulations, Title 9, Chapter 11, Section 1810.247. CONTRACTOR shall also provide mental health services to minors designated by the COUNTY as 26.5 and SB163.

I. EPSDT SUPPLEMENTAL MENTAL HEALTH SERVICE DEFINITIONS

A. MENTAL HEALTH SERVICES (MHS) are interventions designed to provide the maximum reduction of mental disability and restoration or maintenance of functioning consistent with the requirements for learning, development, independent living and enhanced self-sufficiency. [Title 9, Chapter 11, Section 1810.227 California Code of Regulations]

Service activities are directed toward achieving the individual's goals and include:

- **Assessment:** A service which may include a clinical analysis of the history and current status of an individual's mental, emotional, or behavioral disorder, and diagnosis. Assessment can also include an appraisal of the individual's community functioning in several areas which may include living situation, daily activities, social support systems, and health status. Relevant cultural issues are to be addressed in all assessment activities.
- **Collateral:** A service activity involving a significant support person in an individual's life with the intent of improving or maintaining the mental health status of the individual. The individual may or may not be present for this service activity. A "support person" is someone in a non-professional relationship with the individual. Collateral services may be delivered to an individual or group (e.g. parents of clients) of individuals.
- **Therapy:** A therapeutic intervention that focuses primarily on symptom reduction as a means to decrease functional impairments. Therapy may be delivered to an individual or group of individuals, and may include family therapy at which the individual is present.
- **Rehabilitation:** A service which may include assistance in improving, maintaining, or restoring an individual's, or group of individuals', functional skills. These include daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, relational skills, and/or medication education.
- **Plan Development:** A service activity that consists of working with the individual and their support people to develop the client's treatment plan. May also include the process of getting the treatment plan approved and services authorized.

B. CASE MANAGEMENT SERVICES (CM) are activities provided to assist individuals to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other needed community services for eligible individuals. These activities may include:

- **Consultation:** inter-agency and intra-agency **consultation** (or collaboration) regarding the individual's care. This activity involves people in professional relationships with the individual, e.g. CPS worker, probation officer, teacher, mental health staff, pediatrician.
- **Linkage:** locating and securing for the individual needed services and resources in the community. **Examples**: linking an individual with funding (SSI, Medi-Cal, etc.), medical/dental care, education, vocational training, parenting classes, etc.. This is normally a one-time activity, e.g. locating a low-cost dentist and linking an individual with the provider of dental care.
- **Access:** Activities related to assisting an individual to access mental health services. **Example**: phoning Dial-A-Ride (or a relative or a Group Home operator) on behalf of an individual unable to arrange transportation on their own due to mental illness and impairment in functioning. **Example**: providing interpretation and identification of cultural factors on behalf of an individual during a medication evaluation appointment. [Interpretation, in and of itself, is not a billable service.]
- **Placement:** locating and securing appropriate living environment for the individual (can include pre-placement visits, placement, and placement follow-up). Case management **placement** can also be billed while an individual is in an acute psychiatric hospital, when the individual is within 30-days of discharge, but only if the living environment at discharge from the hospital is in question or has yet to be determined.

C. CRISIS INTERVENTION (CI) is an emergency response service enabling the individual to cope with a crisis, while maintaining her/his status as a functioning community member to the greatest extent possible. A crisis is an unplanned event that results in the individual's need for immediate service intervention in order to avoid the need for a higher level of care. Crisis Intervention services are limited to stabilization of the presenting emergency. The emergency may or may not conclude with acute hospitalization.

D. DAY REHABILITATION means a structured program of rehabilitation with the goal of improving, maintaining, or restoring independence and functioning, consistent with requirements for learning and development. Day Rehabilitation provides services to a distinct group of beneficiaries and is available at least three hours (half-day) and less than twenty-four hours (full-day) each day the program is open.

E. THERAPEUTIC BEHAVIORAL SERVICES (TBS) provides short-term one-to-one assistance to children or youth under the age of 21 who have behaviors that put them at risk of losing their placement. It has been determined that it is highly likely that without TBS the minor may need a higher level of care, or that the minor may not successfully transition to a lower level of care. TBS can be provided at home, in a group

home, in the community, and during evening and weekend hours as needed. The minor must be receiving other specialty mental health services concurrent with TBS. Authorization of TBS services happens separately from authorization of other Specialty Mental Health services.

F. MEDICATION SUPPORT SERVICES (MS) are service activities that include prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. Activities may also include assessment/evaluation, med injections, collateral, and case management as these activities relate to Medication Support Services. These services can only be provided and billed by medical doctors, family nurse practitioners, physician assistants, nurses, and psychiatric technicians.

II. ADDITIONAL DEFINITIONS

A. Beneficiary as defined in California Code of Regulation Title 9, Chapter 11, Section 1810.205 means any person who is certified as eligible under the Medi-Cal Program according to Title 22, Section51001.

B. EPSDT refers to Early and Periodic Screening, Diagnosis and Treatment of eligible Medi-Cal beneficiaries as funded, administered and regulated by the Federal and State governments, with specific reference to Short/Doyle Medi-Cal services provided to any beneficiary under the age of 21 with non-restricted Medi-Cal eligibility.

C. Medi-Cal Statewide Maximum Allowance (SMA) means the maximum reimbursement rate set by the State for Medi-Cal funded mental health services in the State of California.

D. Provisional Rate means the projected cost of services less the projected revenues. This rate shall be based upon historical cost and actual cost data provided by the CONTRACTOR to the COUNTY in the cost report. Provisional rates shall approximate the actual costs. Costs of services shall not exceed the Statewide Maximum Allowance (SMA). If at any time during the term of the contract the SMA rate is lowered to an amount below the provisional rate, the provisional rate must immediately be reduced to the new SMA rate.

III. SCOPE AND QUALITY OF SERVICES TO BE PROVIDED BY CONTRACTOR

A. Values and Vision: The CONTRACTOR shall abide by the El Dorado Mental Health Plan's goal of creating a "best practice" service delivery model for Mental Health, within available budget resources that will meet the critical mental health needs of El Dorado County residents. Central to this goal is a commitment to collaborative planning among the Mental Health Providers, consumers, their families, and the Mental Health Plan. Principles guiding this effort include:

- Cultural competence throughout the system
- Age appropriate services for children, young adults, adults, and seniors
- A single point of coordinated care for each client

- Client and family involvement in service planning
- Geographically accessible, community-based services
- Patients' Rights advocacy and protection

B. **Medical Necessity** for EPSDT Specialty Mental Health Services is to be met continuously by the beneficiary for the duration of provision of services. Eligibility for EPSDT Specialty Mental health Services is established by completion of an assessment with the beneficiary and their family. The assessment must establish **Medical Necessity** defined as follows by the State Department of Mental Health:

Medical Necessity is the principal criteria by which the Mental Health Plan decides authorization and/or reauthorization for covered services. Medical Necessity must exist in order to determine when mental health treatment is eligible for reimbursement under Plan benefits.

Eligibility For Mental Health Treatment (A, B and C must be present)

A. Diagnostic Criteria

Must have one of the following DSM IV diagnoses, which will be the focus of the intervention being provided.

Included Diagnoses:

- Pervasive Developmental Disorder, except Autistic Disorder which is excluded.
- Attention Deficit and Disruptive Behavior Disorders
- Feeding and Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impluse-Control Disorders Not Otherwise Specified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders

Excluded Diagnoses:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders

- Autistic Disorders (Other Pervasive Developmental Disorders are included)
- Tic Disorders
- Delirium, Dementia, and Amnesic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other conditions that may be a focus of clinical attention, except medication induced movement disorders which are included

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

B. Impairment Criteria

Must have 1,2, or 3 (at least one) of the following as a result of the mental disorder(s) identified in the diagnostic ("A") criteria:

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of life functioning, or
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. (Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated, current DHS EPSDT regulations also apply).

C. Intervention Related Criteria

Must have all: 1,2, and 3 below:

1. The focus of proposed interventions is to address the condition identified in impairment criteria "B" above, and
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), and
3. The condition would not be responsive to physical healthcare based treatment.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty mental health treatment goals.

IV. GENERAL PROGRAM AND SERVICE REQUIREMENTS

A. CONTRACTOR shall provide comprehensive specialized mental health services, as defined in the California Code of Regulations Title 9, Chapter 11, to children and youth who meet the criteria established in, and in accordance with, the El Dorado County Mental Health Plan (MHP).

B. CONTRACTOR shall obtain written pre-authorization for all mental health services from the El Dorado County Quality Improvement Unit. Services rendered by CONTRACTOR without pre-authorization shall not be reimbursed.

C. CONTRACTOR shall adhere to guidelines in accordance with Policy and Procedures issued by the El Dorado County Quality Improvement Unit.

D. CONTRACTOR shall not accept a referral for a child/youth if s/he cannot be offered an appointment to be seen within ten (10) business days.

E. CONTRACTOR shall screen 100% of referred children/youth for Medi-Cal eligibility monthly for all children/youth receiving services. The eligibility screening shall include verifying El Dorado County as the responsible County, and assessing for valid full scope aid codes.

1. If the child/youth becomes ineligible for Medi-Cal, CONTRACTOR shall take the necessary steps to ensure the timely re-instatement of Medi-Cal eligibility.

2. If the child/youth is not Medi-Cal eligible, CONTRACTOR shall screen the child for Healthy Families eligibility and assist the child and family with the Healthy Families application and eligibility process.

F. CONTRACTOR shall screen 100% of referred Healthy Families beneficiaries for Healthy Families eligibility upon receipt of referral and monthly thereafter.

G. CONTRACTOR shall use the Uniform Method of Determining Ability to Pay (UMDAP), also referred to as "Client Registration", established by the State Department of Mental Health to determine the personal financial liability of all children/youth.

1. CONTRACTOR shall explain the financial obligations to the family/care-provider and child/youth at the time of the first visit.

2. CONTRACTOR shall, if the family requests, complete a Request for UMDAP Fee Reduction/Waiver and submit to the COUNTY, for families with significant financial issues. CONTRACTOR shall notify the financially responsible party that they remain financially responsible until otherwise stated in writing from the COUNTY. Screening for Healthy Families eligibility and enrollment is required before an UMDAP Fee Reduction/Waiver would be considered.

H. CONTRACTOR shall provide Chapter 26.5 (Government Code) services in accordance with Government Code Sections 7572.5, 7576, 7582, 7585, and 7586.

1. CONTRACTOR shall coordinate with El Dorado County Quality Improvement Unit to include tracking Chapter 26.5 status and notification of all changes to the level of services for all Chapter 26.5 eligible children and youth.

2. CONTRACTOR shall attend Individualized Education Program (IEP) Team Meetings.

I. CONTRACTOR shall collaborate with all parties involved with the child and family including but not limited to parents, schools, doctors, social services, Alta Regional, Alcohol and Drug Division, and Probation. CONTRACTOR shall provide referral and linkages as appropriate.

J. CONTRACTOR shall involve child/parents/caregivers/guardian in all treatment planning and decision-making regarding the child's services as documented in the child/youth's Treatment Plan.

K. CONTRACTOR shall provide clinical supervision to all treatment staff in accordance with the State Board of Behavioral Sciences and State Board of Psychology.

L. CONTRACTOR shall attend COUNTY sponsored Provider Meetings and other work groups as requested.

M. CONTRACTOR shall provide clients with a copy of the El Dorado County Mental Health Plan Grievance and Appeal brochures and "Guide to Medi-Cal Mental Health Services". If requested, CONTRACTOR shall assist clients/families in the Grievance or Appeal process outlined in the above referenced documents.

N. CONTRACTOR shall complete all Performance Outcomes requirements in accordance with the State Department of Mental Health, and El Dorado County Mental Health Department.

O. CONTRACTOR shall adhere to the guidelines in accordance with policies and procedures issued by COUNTY Quality Improvement Unit including but not limited to:

1. CONTRACTOR shall complete all chart documentation as defined in the Quality Improvement Unit.

2. CONTRACTOR shall participate in all COUNTY required Utilization Reviews.

3. CONTRACTOR shall conduct their own internal Utilization Review.

4. CONTRACTOR shall comply with audit requests by the COUNTY.

P. CONTRACTOR is prohibited from using any unconventional mental health treatments on children. Such unconventional treatments include, but are not limited to, any treatments that violate the children's personal rights as provided in Title 22, Division 6, Chapter 1, Section 80072(3) of the California Code of Regulations. Use of any such treatments by CONTRACTOR or any therapist providing services for

CONTRACTOR shall constitute a material breach of this Agreement and may be cause for termination of this Agreement.

V. SERVICE REQUIREMENTS FOR OUTPATIENT

A. CONTRACTOR shall provide a full range of quality mental health outpatient services to the child/youth and families/care providers individually, and in various combinations, as indicated by clinical need and reflected in the Treatment Plan. Services shall be provided in accordance with the El Dorado County Mental Health Plan.

1. Mental health services shall be provided to the individual child or youth, and may include family or significant support persons.

2. Services shall be provided anywhere in the community including home, school, office or other sites. Place of service shall enhance delivery and access to service. CONTRACTOR hours shall be flexible to include weekends and evenings to accommodate the family/care provider.

3. The length, type and duration of mental health services shall be defined in the Treatment Plan. Length of service will be based on clinical need as determined by the case carrying Clinician/Therapist/Service Coordinator in collaboration with the child/youth/family, but will not exceed the time authorized by El Dorado County Quality Improvement Unit on the Treatment Plan.

4. The client shall be defined as the authorized child/youth that is receiving mental health services from the CONTRACTOR. In cases where there is more than one (1) child/youth in the same family receiving mental health services, each child/youth is considered to be a separate client.

B. CONTRACTOR shall provide referrals and/or facilitate linkage to community social services for needs such as housing, food, clothing and transportation.

VI. SERVICE REQUIREMENTS FOR SB 163 WRAPAROUND

A. CONTRACTOR shall provide a full range of quality mental health services to the child/youth and families/care providers individually, and in various combinations, as indicated by clinical need and reflected in the Treatment Plan. Services shall be provided in accordance with the El Dorado County Mental Health Plan.

1. Mental health services shall include, but are not limited to therapy (individual and group), rehabilitation, collateral, plan development, case management, and crisis intervention services.

2. Mental health services shall be provided to the individual child or youth, and are to include family and significant support persons.

3. Services are to be provided anywhere in the community including home, school, office or other sites. Place of service shall enhance delivery and access to service. CONTRACTOR hours shall be flexible to include weekends and evenings to accommodate the family/care provider.

4. CONTRACTOR shall develop Treatment Plans to address the target behaviors causing impairment in functioning.

5. The length, type and duration of mental health services shall be defined in the Treatment Plan or Reauthorization Assessment. Length of service will be based on clinical need as determined by the case carrying Clinician/Therapist/Service coordinator in collaboration with the child/youth/family, but will not exceed the length authorized.

B. CONTRACTOR shall provide a comprehensive array of specialized mental health services, including flexible wraparound services, to eligible children and youth in accordance with the Department of Social Services All County Information Notice Number I-28-99.

C. CONTRACTOR shall provide Wraparound services to children and youth who are eligible for Medi-Cal, Title IV-E Waiver dollars, SB 1667 funds, or Chapter 26.5 services, and who meet the El Dorado County Mental Health Department target population criteria and would benefit from intensive Wraparound services.

D. Target population to be served is children and youth at risk of RCL 10/14 out of home care, or currently placed in RCL 10/14 care.

E. CONTRACTOR shall provide referrals and/or facilitate linkage to community social services for needs such as housing, food, clothing, and transportation

F. CONTRACTOR shall develop a Family Team that is comprised of family, friends, agency staff and people who are involved with the child and family to support the family. The Family Team shall determine service needs. The Family Team is to complete a strength-based assessment, along with a Family Team Plan that included a crisis plan, within 15 days of the referral.

G. CONTRACTOR shall be available 24 hours per day 7 days per week including holidays to provide: 1) Immediate face to face response to a crisis call, 2) Immediate support services to all family members, 3) Emergency Family Team meeting to revise safety plans as needed.

H. CONTRACTOR shall have a Policy and Procedure to address after-hours work and supervisor availability.

I. CONTRACTOR shall incorporate all goals and objectives on the Individual Education Plan (IEP) related to the child/youth's mental health needs into the child/youth's Treatment Plan.

VII. SERVICE REQUIREMENTS FOR THERAPUETIC BEHAVIORAL SERVICES (TBS)

A. CONTRACTOR shall provide Therapeutic Behavioral Service (TBS) in accordance with the State Department of Mental Health guidelines, and as outlined in the El Dorado County Mental Health Plan.

B. CONTRACTOR shall develop the TBS Client Plan in order to provide an array of individualized, one-to-one services that target behaviors or symptoms which jeopardize existing placements, or which are barriers to transitioning to a lower level of residential placement.

C. CONTRACTOR shall ensure that services are available at times and locations that are convenient for parents/care providers and acceptable to the child/youth.

D. CONTRACTOR shall develop a Transition Plan at the inception of TBS.

1. The Transition Plan shall outline the decrease and/or discontinuance of TBS when they are no longer needed, or appear to have reached a plateau in effectiveness.

2. When applicable, CONTRACTOR shall include a plan for transition to adult services when the child/youth turns twenty-one (21) years old, and is no longer eligible for TBS.

E. CONTRACTOR shall provide services at any community location not otherwise prohibited by regulations. These may include homes, foster homes, group homes, after school programs, and other community settings.

F. CONTRACTOR shall incorporate all goals and objectives on the IEP related to the child/youth's mental health needs into the child/youth's TBS client plan when appropriate.

G. CONTRACTOR shall provide the number of service hours to the child/youth as indicated on the TBS client plan. Service hours shall not exceed twenty four (24) hours on any given day.

H. CONTRACTOR shall comply with all TBS policies and procedures developed by the El Dorado Mental Health Department.

I. CONTRACTOR shall comply with all State Department of Mental Health (DMH) letters related to TBS readily available on the DMH website.

VIII. Service Requirements for Day Treatment Intensive and Day Rehabilitation

In addition to meeting the requirements of Title 9, California Code or Regulations (CCR), Sections 1840.318, 1840.328, 1840.330, 1840.350, and 1840.352, and State Department of Mental Health Notification Letter No. 02-06, providers of day treatment intensive and day rehabilitation shall include the following minimum service components in day treatment intensive or day rehabilitation:

a. Community meetings, which mean meetings that occur at a minimum once a day, but may occur more frequently as necessary, to address issues pertinent to the continuity and effectiveness of the therapeutic milieu that may, but are not required to be part of the continuous therapeutic milieu; actively involve staff and clients; for day treatment intensive, include a staff person whose scope of practice includes psychotherapy; for day rehabilitation, include a staff person who is a physician; a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; a registered nurse, a psychiatric technician, a licensed vocational nurse, or a mental health rehabilitation specialist; address relevant items including, but not limited to what the schedule for the day will be, any current event, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning for the day, the week, or for special events, old business from previous meetings or from previous day treatment experiences, and debriefing or wrap-up.

b. A therapeutic milieu, which means a therapeutic program that is structured by the service components described in subsections a. and b. below with specific activities being performed by identified staff; takes place for the continuous scheduled hours of operation for the program (more than four hours for a full-day program and a minimum of three hours for a half-day program); includes staff and activities that teach, model and reinforce constructive interactions; includes peer and staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress; involves clients in the overall program, for example, by providing opportunities to lead community meetings and to provide feedback to peers; includes behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

The therapeutic milieu service components described in subsections 1) and 2) below shall be made available during the course of the therapeutic milieu for at least a weekly average of three hours per day for full-day programs and an average of two hours per day for half-day programs. (For example, a full-day program that operates five days per week would need to provide a total of 15 hours for the week; a full-day program that operates for seven days a week would need to provide a total of 21 hours for the week.)

1) Day Rehabilitation shall include:

a) Process groups, which are groups facilitated by staff to help clients develop the skills necessary to deal with their individual problems and issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems. Day rehabilitation may include psychotherapy instead of process groups or in addition to process groups.

b) Skill building groups, which are groups in which staff help clients to identify barriers related to their psychiatric and psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.

c) Adjunctive therapies, which are non-traditional therapies in which both staff and clients participate that utilize self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.

c. An established protocol for responding to clients experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition (crisis services). If clients will be referred to crisis services outside the day treatment intensive or day rehabilitation program, the day treatment intensive or day rehabilitation staff shall have the capacity to handle the crisis until the client is linked to the outside crisis services.

d. A detailed weekly schedule that is available to clients and, as appropriate, to their families, caregivers or significant support persons. The detailed schedule will be a written weekly schedule that identifies when and where the service components of program will be provided and by whom. The written weekly schedule shall specify the program staff, their qualifications, and the scope of their responsibilities.

e. Staffing ratios that are consistent with the requirements in Title 9, CCR, Sections 1840.350 and 1840.352, and, for day treatment intensive, that include at least one staff person whose scope of practice includes psychotherapy.

Program staff may be required to spend time on Day Treatment Intensive and Day Rehabilitation activities outside the hours of operation and therapeutic milieu, e.g., time for travel, documentation, and caregiver contacts. These Day Treatment Intensive and Day Rehabilitation activities are included in the day rate and are not to be billed separately from, or in addition to the day rate.

The Contractor shall require that at least one staff person is present and available to the group in the therapeutic milieu for all scheduled hours of operation.

The Contractor shall require that if Day Treatment Intensive or Day Rehabilitation staff are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), a clear audit trail is documented by the provider. The Contractor shall require that there be documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.

f. An expectation that the beneficiary will be present for all scheduled hours of operation for each day. When a beneficiary is unavoidably absent for some part of the hours of operation, the Contractor shall ensure that the provider receives Medi-Cal reimbursement for Day Treatment Intensive and Day Rehabilitation for an individual beneficiary only if the beneficiary is present for at least 50 percent of the scheduled hours of operation for that day.

h. At least one contact, face-to-face or by an alternative method (e.g., e-mail, telephone, etc.) per month with a family member, caregiver or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. Adult clients may choose whether or not this service component is done for them. The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration. It is expected that this contact will occur outside hours of operation and the therapeutic milieu for Day Treatment Intensive and Day Rehabilitation, and not be billed for separately, or in addition to the day rate.

EXHIBIT B

CONTRACT RATES

FY 06/07

Facillitator	$33.55 per hour
Parent Partner	$25.75 per hour
WRAP Worker	$24.30 per hour
Therapist	$33.55 per hour

Not to exceed amount for FY 06/07 is $119,219.00

FY 07/08

Facillitator	$35.53 per hour
Parent Partner	$27.27 per hour
WRAP Worker	$25.73 per hour
Therapist	$35.53 per hour

Not to exceed amount for FY 06/07 is $144,734.00

REIMBURSABLE EXPENSES

Transportation Expenses	Paid at County mileage rate not to exceed $9,182 in FY 06/07 not to exceed $12,243 in FY 07/08
Flex Funds	not to exceed $16,464 in FY 06/07 not to exceed $23,087 in FY 07/08

EXHIBIT "C"

EL DORADO COUNTY
MENTAL HEALTH DEPARTMENT

POLICY/PROCEDURE

SUBJECT: Adherence to the Mental Health Services Act (MHSA) Guiding Principles	**POLICY NUMBER:**
APPROVED BY: Barry Wasserman, LCSW, Interim Director	**DATE:** _____

Background:
In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA), to expand funding for a comprehensive, community-based mental health system for seriously emotionally disturbed youth and seriously mentally ill adults. A key intent was to "transform" the existing public mental health delivery system on a number of levels. This document specifies how the El Dorado County Mental Health system and its contract providers will embrace the vision and put into practice the guiding principles for the MHSA identified by California stakeholders and the State Department of Mental Health (see California Department of Mental Health Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act, February 16, 2005, Attachment A).

Policy:
The El Dorado County Mental Health Department supports the vision, guiding principles, and essential elements for use of the Mental Health Services Act (MHSA) funding put forward by the State Department of Mental Health as a result of the state-level stakeholder process—including the requirement that services are voluntary in nature (see Attachment A and A Readers Guide to MHSA CSS Three-Year Program and Expenditure Plan Requirements, Attachment B). These parameters will be applied in the planning, program implementation and evaluation process of MHSA service delivery, and apply to community providers who are awarded MHSA service contracts.

Vision
El Dorado County Mental Health joins with state stakeholders and county community members in striving "to create a state-of-the art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families." Along with DMH, EDCMH commits to looking "beyond business as usual to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists (see Attachment A).

Guiding Principles

The El Dorado County Mental Health Department will utilize the following guiding principles as a means to work toward the above vision (paraphrased from Attachment A):

In order to look beyond "business as usual", we will:

1. Increase participation of clients and families in all aspects of the mental health service delivery system;
2. Increase consumer-operated services;
3. Adopt an approach to services in which clients and families participate in the development of their individualized plan of service that is client and family-driven, strengths-based and culturally competent;
4. Explore the needed changes in service location to ensure increased access in a timely fashion;
5. Eliminate ineffective policies, practices, and services in favor of values-driven, evidenced-based approaches that are responsive to clients and produce positive outcomes;
6. Increase treatment options and ensure informed choice for our clients improving the attainment of our clients' goals;
7. Create integrated screening, assessment, and unified treatment plans at all points of entry into the service delivery system for persons with both mental illness and substance abuse problems;
8. For youth, ensure meaningful collaboration with child welfare, juvenile justice, education and primary healthcare, in order to provide comprehensive services and attain positive outcomes;
9. For transitional age youth, ensure a point of contact for youth transitioning from the youth to adult system and unique programming to address their developmental needs;
10. For adults, ensure meaningful collaboration with local resources in order to provide integrated services with the goals of adequate healthcare, independent living, and self-sufficiency;
11. For older adults, implement strategies for community-based care that is integrated with physical healthcare, with the ability to reside in their community of choice as a fundamental objective;
12. Reduce the negative effects of untreated mental illness, such as institutionalization, homelessness, incarceration, suicide and unemployment;
13. Increase collaborative and integrated opportunities for clients in education, employment, housing, social relationships, and meaningful contribution to community life through community partnerships;
14. Reduce disparities in service access and utilization;
15. Implement culturally competent assessments and services;
16. Routinely employment outcome monitoring and use of data at the consumer, system, and community level to assist in program planning;
17. Create a structure and process whereby changes in service array result from intended outcomes—including the necessary training and support for the mental health staff to make this process effective; and,
18. Adopt effective service delivery approaches, use of standard performance indicators, data measurement and reporting strategies to ensure the achievement of MHSA accountability goals.

Five Essential Elements

The El Dorado County Mental Health Department will apply the five essential elements of the MHSA in all MHSA program planning, implementation and evaluation processes.

These elements are:

- Community collaboration
- Cultural competency
- Client/family-driven services
- Wellness focus
- Integrated services.

Procedure:

- This policy will be reviewed in the All Staff meetings upon publication.
- Supervisors will review this policy with all new employees as part of their orientation process to the Department.
- MHSA contract providers will be trained in the content of this policy and their contract will require compliance with and support of this policy.
- These important elements, the Vision, Guiding Principles, and Essential Elements, will be incorporated in new program development training as the MHSA CSS programs are implemented.
- The content of this policy will serve as a benchmark for all MHSA programs. Annual reports and contract reviews must address these elements to demonstrate compliance and progress in these areas.
- All EDCMH employees and contract providers are expected to comply with this policy.
- The MHSA Project Management Team, EDCMH Contracts Officer, the EDCMH Program Managers, and the Department Director are responsible for ensuring compliance with this policy.

ATTACHMENT A

California Department of Mental Health (DMH)
Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act
February 16, 2005

Introduction

The Mental Health Services Act (MHSA) includes a clear set of challenging goals for all stakeholders to hold in common as the MHSA becomes reality.[1] Within the context of those common goals, the California Department of Mental Health (DMH) developed, in partnership with stakeholders, a ***Vision Statement*** and ***Guiding Principles*** to use as it implements the Community Services and Supports component of the MHSA.[2]

Most of the language and concepts included in the Vision Statement and Guiding Principles document were originally presented to MHSA stakeholders on the DMH website and at a public meeting in Sacramento in December 2004. At that time it was entitled "DMH Vision Statement". Since then, in response to stakeholder comments and DMH policy clarification, this document has become a Vision Statement and Guiding Principles for DMH to hold for itself and stakeholders as it implements the Community Services and Supports component of the MHSA.

VISION STATEMENT

TO GUIDE DMH IN THE IMPLEMENTATION OF COMMUNITY SERVICES AND SUPPORTS

As a designated partner in this critical and historic undertaking, the California Department of Mental Health (DMH) will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists.

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[1] Mental Health Services Act, "Section 3. Purpose and Intent."

[2] "Community Services and Supports " means the same as "System of Care" in the MHSA, Welfare and Institutions Code Sections 5878.1-.3 and 5813.5

GUIDING PRINCIPLES

TO GUIDE DMH IN THE IMPLEMENTATION OF COMMUNITY SERVICES AND SUPPORTS

Beyond the goals in statute for the MHSA as a whole, DMH has developed, with stakeholder input, a set of Guiding Principles. These Guiding Principles will be the benchmark for DMH in its implementation of the MHSA Community Services and Supports component. DMH will work toward significant changes in the existing public mental health system in the following areas:

Consumer and Family Participation and Involvement

1. Significant increases in the level of participation and involvement of clients and families in all aspects of the public mental health system including but not limited to: planning, policy development, service delivery, and evaluation.

2. Increases in consumer-operated services such as drop-in centers, peer support programs, warm lines, crisis services, case management programs, self-help groups, family partnerships, parent/family education, and consumer provided training and advocacy services.

3. Full implementation of an approach to services through which each client and her/his family, as appropriate, participates in the development of an individualized plan of services determined by the individual's goals, strengths, needs, race, culture, concerns and motivations.

Programs and Services

4. Changes in access and increased geographic proximity of services so that clients will be able to receive individualized, personalized responses to their needs within a reasonable period of time and to the extent needed to enable them to live successfully in the community.

5. Elimination of service policies and practices that are not effective in helping clients achieve their goals. Ineffective treatment methods will be replaced by the development and expansion of new values-driven, evidence-based and promising practices, policies, approaches, processes and treatments which are sensitive and responsive to clients' cultures and produce more favorable outcomes.

6. Increases in the array and types of available services so children, transition age youth, adult and older adults clients and their families will be able to choose, in consultation with mental health professionals, the kinds of services and the intensity of services that will assist them in attaining the goals in their individualized plans.

7. Integrated treatment for persons with dual diagnoses, particularly serious mental illness and serious substance use disorders, through a single individualized plan, and integrated screening and assessment at all points of entry into the service system.

Age–Specific Needs

8. For children, youth and their families, implementation of specific strategies to achieve more meaningful collaboration with child welfare, juvenile justice, education and primary healthcare, in order to provide comprehensive services designed to enable youth to be safe, to live at home, to attend and succeed in school, abide by the law, be healthy and have meaningful relationships with their peers.

9. For transition-age youth[3], programming to address the unique issues of this population who must manage their mental health issues while moving toward independence. This should include a person as a point of contact who would follow youth as they transition from the youth systems into the adult system or move out of the mental health system. To meet the needs of these youth, programming needs to include specific strategies for collaboration between the youth and adult systems of care, education, employment and training agencies, alternative living situations and housing and redevelopment departments.

10. For adults, implementation of specific strategies to achieve more meaningful collaboration with local resources such as physical health, housing, employment, education, law enforcement and criminal justice systems in order to promote creative and innovative ways to provide integrated services with the goals of adequate health care, independent living and self-sufficiency.

11. For older adults, implementation of specific strategies to increase access to services such as transportation, mobile and home-based services, comprehensive psychiatric assessments which include a physical and psychosocial evaluation, service coordination with medical and social service providers and integration of mental health with primary care. The ability to reside in their community of choice is a fundamental objective.

[3] The MHSA defines transition age as youth ages 16 to 25 in Welfare and Institutions Code (WIC) 5847.

12. For all ages, reductions in the negative effects of untreated mental illness including reductions in institutionalization, homelessness, incarceration, suicide, and unemployment.

Community Partnerships

13. Significant increases in the numbers of agencies, employers, community based organizations and schools that recognize and participate in the creation of opportunities for education, jobs, housing, social relationships and meaningful contributions to community life for all, including persons with mental illness. Care must be collaborative and integrated, not fragmented.

Cultural Competence

14. Outreach to and expansion of services to client populations to more adequately reflect the prevalence estimates and the race and ethnic diversity within counties and to eliminate disparities in accessibility and availability of mental health services.

15. Implementation of more culturally and linguistically competent assessments and services that are responsive to a client's and family's culture, race, ethnicity, age, gender, sexual orientation and religious/spiritual beliefs.

Outcomes and Accountability

16. Expanded commitment to outcome monitoring including developing/refining strategies for evaluation of consumer outcomes, and system and community indicators, using standardized measurement approaches whenever possible. Data needs to be readily accessible and viewed as an essential part of program planning.

17. Development and implementation of policy and procedures to ensure that changes in service array in the future are based on intended outcomes. This may necessitate increased training and support for the mental health workforce.

18. Achievement of the MHSA accountability goals necessitates statewide adoption of consistent, effective service delivery approaches as well as standard performance indicators, data measurement and reporting strategies.

Taking a Comprehensive Viewpoint

19. Beyond the MHSA goals, and the DMH Vision Statement and Guiding Principles for implementation of Community Services and Supports, DMH will rely on the principles, goals, strategies, data and other information from the following nationally recognized documents and sources:

    - Principles articulated in the *President's New Freedom Commission Report* on Mental Health report.

    - Accountability based on the spirit of the Institute of Medicine's *Crossing the Quality Chasm* report.

    - Accountability based on the findings of Mental Health: Culture, Race and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 2001.

    - The vision, mission and values of the public mental health system as articulated in the California Mental Health Planning Council's *Master Plan*.

    - DMH will also consider previous reviews of the public mental health system such as the Little Hoover Commission reports and the reports of the Select Committee of the California Legislature.

Summary of Stakeholder Input

DMH and all stakeholders owe a debt of gratitude to those individuals who attended the December 17, 2004 initial MHSA stakeholders meeting in Sacramento. The comments and input provided on that occasion have proven to be invaluable guidance for DMH in the implementation of Community Services and Supports.

Pacific Health Consulting Groups noted the following as key stakeholder concerns about the original Vision Statement in the summary of the December 17, 2004 meeting:

"Participants provided both written and verbal comments about the vision statement. About 260 people provided about 380 written comments, many making more than one comment. The major themes were, in order of the numbers of comments per theme:

- Populations/Consumers and Family
- Children
- Alternative Treatments/Support Services
- Integration with Primary Care
- Workforce and Training
- Cultural Competence
- Outcomes/Quality of Life
- Prevention and Early Intervention
- Best Practices/Seamlessness/Transformation
- Stakeholders/Collaboration/Criminal Justice
- Substance Abuse/Co-occurring Disorders"

DMH concurred with stakeholder comment that the Vision Statement as initially written was too long and yet didn't address all the various components of the MHSA. It was also clear that the goals written in the MHSA itself provide the best over-all picture of what the MHSA should achieve.

DMH adapted the language of the Vision Statement so that it became both a Vision Statement and Guiding Principles. These are intended to refer *only* to DMH's implementation of the MHSA Community Services and Support Component within the context of the goals of the MHSA. DMH realizes it may be necessary to develop similar implementation visions and principles as it proceeds with implementation of other components. In addition, many stakeholder concerns expressed about the initial draft have been clarified and moved to DMH Letter 05-01 which was issued in January, 2005. Remaining concerns are included in the "Draft Community Services and Supports Plan Requirements" that is presently under review by stakeholders.

EXHIBIT "D"

EL DORADO COUNTY
MENTAL HEALTH DEPARTMENT

POLICY/PROCEDURE

SUBJECT: Adherence to the Mental Health Services Act (MHSA) Cultural Competency Requirements	**POLICY NUMBER:**
APPROVED BY: Barry Wasserman, LCSW, Interim Director	**DATE:** _____

Background:
The following factors highlight the critical role that culture, ethnicity, and language differences play in the field of public mental health service delivery (from the Technical Assistance Document 5, Considerations for Embedding Cultural Competency, DMH draft, May 23, 2005):

- The non-Hispanic white population represents 47% of the California population and therefore ethnic, racial, linguistic and multiracial groups represent the majority of the State's population.
- Racial and ethnic populations are a growing segment of the US population and in California, the data from the County Mental Health Plans indicates that disparities exist among ethnic and racial groups.
- Collectively, ethically, racially and linguistically diverse populations experience greater disability from emotional and behavioral disorders relative to Caucasian populations:
    - partially due to decreased access and poorer quality of care
    - partially due to inadequate funding of the public mental health system and its inability to address the unique needs of diverse groups
    - the result is misdiagnoses, mistrust, and poor utilization of services
- Furthermore, ethnically, racially, and linguistically diverse populations experience more stressful environments due to poverty, violence, discrimination and racism.
- Ethnic and racial groups are over-represented in vulnerable populations, such as the homeless, foster care, and incarcerated youth;
- Public mental health systems must comply with federal and state legislation regarding services for limited English-proficient individuals, such as mandates for meaningful and equal access to health and social services.
- The only threshold language (language spoken by at least 5% of the county population thereby requiring increased levels of available resources, i.e., translated written materials) in El Dorado County at this time is Spanish.
- Culturally competent services and systems are fiscally prudent—it is estimated that the general cost of untreated or poor treatment of mental illness is $113 billion a year.

"Cultural competence is defined as a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family members, and professionals that enables that system, agency, or those professionals and consumers, and family member providers to work effectively in cross-cultural situations" (DMH Information Notice. : 02-03).

A culturally competent service delivery system provides the following efficiencies:

- Improved service access, including early intervention;
- Accuracy of diagnosis;
- Appropriate and individualized service planning and efficiency;
- Effective integration of the client's family (including extended family);
- Use of relevant community resources;
- Use of external resources in client services; and,
- Financial efficiencies—cost-avoidance and cost-effectiveness.

A culturally competent service delivery system will look very different from the traditional approach:

- Planning will involve the community in setting goals and outcomes—including new and different partners for a mental health department.
- Different help-seeking behavior, communication and parenting styles, culturally-based treatments and healers will be recognized.
- Operating procedures will be adapted to meet community needs as opposed to expecting that various diverse communities will adapt to the existing system.
- There is recognition that studies generally do NOT include the perspective of ethnic communities.
- There is an awareness and understanding that the standard categories, such as breakdown by age groups, is not necessarily compatible with how ethic communities operate—for example, ethnic/racial/linguistic populations operate as an integrated system, often living in multi-generational households. Therefore, a transformed system would provide services within a community setting, not to individuals by age.

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA), to expand funding for a comprehensive, community-based mental health system for seriously emotionally disturbed youth and seriously mentally ill adults. A central feature to the "transformation" of the public mental health service delivery system is the ability to decrease ethnic disparities in access to and benefits from services. The State Department of Mental Health (DMH) developed Technical Assistance Document 5 which offers "Consideration for Embedding Cultural Competency" (Attachment A) within MHSA program planning. Further, the requirements of the Community Services and Supports (CSS) MHSA three-year plan required data analysis and program planning which specifically addressed the identification of local ethnic disparities in service access and in the community issues which result from unmet mental health needs and subsequent program planning.

This policy and procedure is intended to outline the approach and expectations that the El Dorado County Mental Health Department has identified for the MHSA programs.

Policy:

The El Dorado County Mental Health Department has established the following basic elements for all MHSA programs to facilitate culturally competent practices, to increase access and improved outcomes, and to thereby decrease ethnic disparities in mental healthcare.

These standards apply to community providers who are awarded MHSA service contracts.

- Free interpretation services must be offered and effectively accessed for any client with limited English proficiency (LEP).
- Forms, documents and signage must be translated in all threshold languages.
- Bilingual/bicultural staff for threshold languages will be actively recruited for all positions.
- Annual training to increase culturally competency skills will be provided and all Department and contractor provider staff must attend.
- Culturally competent service delivery will include assessments at all entry points which explore issues of ethnicity, language, culture, gender, sexual orientation, and religious/spiritual practices that may be relevant treatment issues. This information will be documented and tracked for program development purposes.

The following documents will be used to provide a framework and standards of practice that will be developed for all MHSA programs:

- Framework for Eliminating Cultural, Linguistic, Racial and Ethic Behavioral Health Disparities, adopted by the California Mental Health Directors Association (CMHDA) on March 10, 2005 and prepared by Ethnic Services Managers from the Bay Area, Central, Southern, and Superior Regions.
- Cultural competence Standards in Managed Mental Health Care Services: Four Underserved/Underrepresented Racial/Ethnic Groups, Final Report from Working Groups on Cultural Competence in Managed Mental Health Care Services, Center for Mental Health Services, SAMHSA, US DHHS.

Procedures

<u>Provision of free-interpretation services/non-requirement of client-provided interpretation</u>
El Dorado County Mental Health and any service contract providers must proactively offer free interpretation services to clients. Clients may not be required to provide their own interpreters. If a client prefers to provide their own interpreter, staff must ensure that the interpreter is not a minor. Further, the client must sign a release form to indicate their consent and to waive privilege of confidentiality with the interpreter.

Signage explaining this policy should be visibly displayed in public service areas in all threshold languages. Further, the AT & T language line can be used as a resource in any language—including to convey to the client that free interpretation services are available and to identify the language that the client prefers if it is not clear to the staff member.
The offer of interpretation services, how this offer was conveyed, and how the client responded should be documented in the client record. Further, use of an interpreter should also be documented in the client record time it occurs.

Finally, service sites should establish effective procedures for all staff to follow to ensure that interpretation services are quickly obtained so that clients are not discouraged in their attempt to access mental health services—this includes procedures and training for support staff and other non-clinical staff who may come in contact with the public and may often be the first point of contact for the public.

Provision of program documents, forms, and signage in threshold languages
All MHSA program marketing materials, client forms, and signage must be translated in all threshold languages (Spanish). The Department's Ethnic Services Coordinator has responsibility for identifying an effective translator and for maintaining an original copy of all MHSA forms in English and Spanish. Any requests of changes to MHSA forms therefore must be coordinated with the Ethnic Services Coordinator.

Active recruitment of bilingual/bicultural employees for threshold languages
Recruitment of bilingual/bicultural staff in threshold languages will be a routine practice. Resources include ethnically-oriented professional organizations, graduate schools, employment websites, ethnic media, and the local ethnic service providers.

Annual training:
Training to increase skills in cultural competency will be provided by the Department to all staff and MHSA contract providers and are considered mandatory. Topics will range and may include training in sensitivity to difference, assessment skills, and culture-specific training. Evidence-based practices that have demonstrated positive outcomes for ethnic groups will be pursued as part of ongoing system improvement (e.g., Multidimensional Family Therapy, and use of the Promotora model). Training to be an effective interpreter will be provided for bilingual Spanish-speaking staff and training in the effective use of interpreters will be provided for direct service clinical staff.

Service provision
- All MHSA assessments and data collection will include inquiry regarding the ethnicity and preferred language of all clients served.
- Service plans must address issues of culture, language, and various areas of difference, as appropriate.
- Chart audits to ensure compliance will be conducted by EDCMH.
- Partnership and collaboration with ethic-service agencies will be pursued for the Latino and Native American populations, specifically exploring collaborative outreach and case management.
- Chart audits and monitoring protocols will be applied to both the Department and contract providers to ensure compliance with these standards via the Clinical Review Subcommittee and the Cultural Competency Subcommittee.
- The Ethnic Services Coordinator and the Cultural Competency Subcommittee shall provide leadership in applying the framework and standards in the CMHDA and SAMHSA documents.

EXHIBIT "E"

El Dorado County Mental Health Department

CONFIDENTIALITY STATEMENT

There are some important legal restrictions on the release of patient information and records. These restrictions are for the protection of the psychiatric patient and cover mental health service programs. Confidentiality covers all information on both inpatients and outpatients, including information on whether or not a person is a patient.

Access to records for El Dorado County Mental Health staff, interns, volunteers, etc., is limited to information necessary to perform specific clinical treatment or Utilization Review and Quality Assurance functions on a professional "need to know" basis.

The Lanterman-Petris Short Act contained in the Welfare and Institutions Code states in part:

Section 5328:
"All information and records obtained in the course of providing services ... to either voluntary or involuntary recipients of services shall be confidential...".

The specific circumstances under which information and records may be released are spelled out in the sub-sections.

Section 5530 speaks to the enforcement of this law as follows:
"Any person may bring an action against an individual who has willfully and knowingly released confidential information or records concerning him in violation of the provision of this chapter, for the greater of the following amounts:

(1) Ten Thousand ($10,000) Dollars or:

(2) Three (3) times the amount of actual damages, if any, sustained by the plaintiff... It is not a prerequisite to an action under this section that the plaintiff suffer or be threatened with actual damages."

In addition to the LPS law, a breach of confidentiality is a serious infraction of the County of El Dorado policy and may result in dismissal.

Pledge of Confidentiality: I certify by my signature that I will not give information about patients to unauthorized persons and to do so would be a serious violation of my responsibility.

Signature: _____

Position: _____

Date: _____

EXHIBIT "F"

EL DORADO COUNTY
MENTAL HEALTH DEPARTMENT

POLICY/PROCEDURE

SUBJECT: Code of Conduct	**POLICY NUMBER:** II-A-0-004
APPROVED BY: Barry Wasserman, LCSW, Interim Director	**DATE:**

El Dorado County Department of Mental Health ("EDCDMH") maintains high ethical standards and is committed to complying with all applicable statutes, regulations, and guidelines. EDCDMH and each of its employees and contractors shall follow this Code of Conduct.

PURPOSE

The purpose of the EDCDMH Code of Conduct is to ensure that all EDCDMH employees and contractors are committed to conducting their activities ethically and in compliance with all applicable state and federal statutes, regulations, and guidelines applicable to Federal Health Care programs, and with all EDCDMH Policies and procedures. This Code of Conduct also serves to demonstrate EDCDMH's dedications to providing quality care to its patients, and to submitting accurate claims for reimbursement to all payers.

CODE OF CONDUCT – GENERAL STATEMENT

- The Code of Conduct is intended to provide EDCDMH employees and contractors with general guidelines to enable them to conduct the business of EDCDMH in an ethical and legal manner;

- Every EDCDMH employee and contractor is expected to uphold the Code of Conduct;

- Failure to comply with the Code of Conduct, or failure to report reasonable suspected issues of non-compliance, may subject the EDCDMH employee or contractor to disciplinary action, up to or including termination of employment or contracted status. In addition, such conduct may place the individual, or EDCDMH, at substantial risk in terms of its relationship with various payers. In extreme cases, there is also the risk of action by a governmental entity up to and including an investigation, criminal prosecution, and/or exclusion form participation in the Federal Health Care Programs.

CODE OF CONDUCT

All EDCDMH employees and contractors:

- Shall perform their duties in good faith and to the best of their ability;
- Shall comply with all statutes, regulations, and guidelines applicable to Federal Health Care program, and with EDCDMH's own Policies and Procedures;
- Shall refrain from any illegal conduct. When an employee or contractor is uncertain of the meaning or application of a statute, regulation, or policy, or the legality of a certain practice or activity, he or she shall seek guidance from his or her immediate supervisor or the designated Compliance Officer;
- Shall not obtain any improper personal benefit by virtue of their employment or contractual relationship with EDCDMH;
- Shall notify the Compliance Officer immediately upon the receipt (at work or at home) of any inquiry, subpoena, or other agency or government request for information regarding EDCDMH;
- Shall not destroy or alter EDCDMH information or documents in anticipation of, or in response to, a request for documents by any applicable government agency or from a court of competent jurisdictions;
- Shall not engage in any practice intended to unlawfully obtain favorable treatment or business from any entity, physician, patient, resident, vendor, or any other person or entity in a position to provide such treatment or business;
- Shall not accept any gift of more than nominal value or any hospitality or entertainment, which because of its source or value, might influence the employee's or contractor's independent judgment in transactions involving EDCDMH;
- Shall disclose to the Compliance Officer any financial interest, official position, ownership interest, or any other relationship that they (or a member of their immediate family) has with EDCDMH's vendors or contractors;
- Shall not participate in any false billing of patients, government entities, or any other party;
- Shall not participate in preparation of any false cost report or other type of report submitted to the government;
- Shall not pay or arrange for EDCDMH to pay any person or entity for the referral of patients to EDCDMH, and shall not accept any payment or arrange for EDCDMH to accept any payment for referrals from EDCDMH;

- Shall not use confidential EDCDMH information for their own personal benefit or for the benefit of any other person or entity, while employed at or under contract to EDCDMH, or at any time thereafter;

- Shall not disclose confidential medical information pertaining to EDCDMH's patients without the express written consent of the patient or pursuant to court order and in accordance with the applicable law and EDCDMH applicable Policies and Procedures;

- Shall promptly report to the Compliance Officer any and all violations or reasonably suspected violations of the Code of conduct by other employees or contractors;

- Shall promptly report to the Compliance Officer any and all violations or reasonably suspected violations of any statute, regulations, or guideline applicable to Federal Health Care programs or violations of EDCDMH's own Policies and Procedures by other employees or contractors;

- Shall have the right to use the Confidential Disclosure Program without fear of retaliation with respect to disclosures; and with EDCDMH commitment to maintain confidentiality, as appropriate; and

- Shall not engage in or tolerate retaliation against any employee(s) or contractor(s) who report suspected wrongdoing.

CERTIFICATION

I, _____ by signing this Certification acknowledge that:

1. I have received a copy of the attached Code of Conduct Policy.
2. I have read the attached copy of the Code of Conduct Policy.
3. I agree to comply with the attached copy of the Code of Conduct Policy.

Signed _____

Date _____

Please return this signed-off original Certification to the El Dorado County Mental Health Compliance Officer.

Thank you.

EXHIBIT "G"

El Dorado County Mental Health Department
Mental Health Services Act (MHSA) Family-Centered Services Program
Contract Provider Assurance

In order to comply with Federal, State and MHSA program requirements, upon award of the MHSA contract, the Proposer agrees to the following requirements:

- Clients served must meet the MHSA criteria of seriously emotionally disturbed and the locally determined criteria of uninsured or under-insured (unable to receive this service through other financial means) and at risk of out-of-home placement due to unmet mental health needs.
- Clients served must be El Dorado County residents.
- Proposals must be realistic in scope and staffing and within available funding.
- Proposals must ensure that the Wraparound model will be applied consistently with fidelity to the model.
- Proposers must employ the use of all Wraparound Team member roles—the facilitator, the Wrap worker, and the Parent Partner.
- Proposals must support in spirit and practice the five essential elements of the Mental Health Services Act (MHSA).
- Proposers must adhere to the EDC MHSA policies regarding the MHSA principles and culturally competent practice expectations and requirements.
- Proposers must provide forms and program documentation in Spanish and must have access to bilingual Spanish-speaking interpreters for this program.
- Proposers must utilize MHSA program documentation forms, including the full-service partnership outcome forms which are submitted to the State Department of Mental Health.
- Proposers must participate in performance indicator measures and community satisfaction surveys that reflect outcomes and responses to the Family-Centered Services Program.
- Proposers must submit quarterly service delivery reports, performance indicator reports, and budget reports.
- Proposers must have the capacity to transmit data electronically.
- Proposers must have their administrator and Family-Centered Services Team members sign the El Dorado County Mental Health Confidentiality Statement and Code of Conduct agreements.
- Family-Centered Services Team members must participate in annual cultural competency and compliance training.
- Proposers must engage in active outreach, engagement and culturally competent practices to assist in decreasing the ethnic disparity in mental health service delivery to the Latino and Native American populations. Collaborative outreach and case management with ethnic-specific organizations for these target populations will be required.
- Proposers must provide 24/7 urgent response for families served.
- Contracts will include a flex fund that will be administered by the contract provider. Administrative oversight and sign off is required for each expenditure. Expenditures must be central to the family WRAP plan having ruled out other alternatives. Monthly invoices for these expenditures must itemize each expense and justification for the expense.

Proposer Signature _____ Date _____

Agency Name and Address _____

EXHIBIT "H"

Full Service Partnership/System Development

Family-Centered Services Program - Wraparound Program for uninsured and under-insured youth at risk of out-of-home placement

Part II, Section VI, Summary information on Programs to be Developed or Expanded

Part II, Section VI, I-1

- Please see Exhibit 2 for information regarding funds requested for each program
- Please see Exhibit 3 for information regarding populations to be served each year, by age, race, and gender
- Please see Exhibit 4 for information regarding strategies to be used by funding category and age

Part II, Section VI, I-2

66% of the El Dorado County 3-year MHSA allocation will be spent as Full Service Partnership funds. In addition, in the Family-Centered Services Program 100% of the System Development and Outreach and Engagement funds are for Full Service Partnership participants.

Part II, Section VI, I-3

- The estimated number of youth to receive services funded by System Development funds in Year 1 is 2 and those expected to have Full Service Partnerships is 2.
- The estimated number of youth to receive services funded by System Development funds in Year 2 is 12 and those expected to have Full Service Partnerships is 12.
- The estimated number of youth to receive services funded by System Development funds in Year 3 is 18 and those expected to have Full Service Partnerships is 18.

Part II, Section VI, I-4

Outreach and Engagement strategies are not specifically funded for this program. It is anticipated that referrals will readily be available through the access and placement process already in place for the existing Wraparound Program and the existing networks between mental health, human services, probation and education. In addition, a newly formed Child Assessment Team (CAT), facilitated by CPS and including mental health staff membership, currently identifies children at risk of out-of-home placement and will be used as a referral source.

Part II, Section VI, I-5

El Dorado County has an existing Wraparound program for youth and families that essentially serves one region, the Western Slope. As an effective model that embraces the MHSA elements of community collaboration, cultural competence, client/family-driven and integrated services within a wellness focus, the community has selected to expand this program to serve a broader population—uninsured and underinsured youth at risk of out-of-home placement.

Part II, Section VI, II-1a (please see Exhibit 4 on pages 127-128)

Program Summary

The Family-Centered Services Program will employ the Wraparound Model for use with uninsured and under-insured youth at risk of out-of-home placement who otherwise do not have access to this type of full-service partnership program. The Wraparound Model is a collaborative, team-based, family-driven service delivery model which includes clinical case management, an individualized service plan, and flexible supports and services. Case management and service delivery are implemented in a convenient and comfortable location for the family who also directs the use of family, community and system supports. This program is a full service participation program as defined by the Mental Health Services Act.

In the West Slope region this program will build upon El Dorado County's existing Wraparound Services Program by extending services to the uninsured or under-insured population of youth at risk of out-of-home placement. This focus on youth still at home is different than the existing Wraparound Program which serves youth already placed, or at risk of placement in high level group homes. However, the treatment model is the same.

In South Lake Tahoe there are no existing resources for Wraparound Services upon which to build. Therefore, funding will be made available to hire and train staff to operate a Family-Centered Services Program based on the Wraparound model. The goal for the South Lake Tahoe Team is to first serve the MHSA target population and, once the Family-Centered Services Program is established, to leverage resources to serve the Medi-Cal population of children within the child welfare and probation systems who cannot be served by the MHSA Wraparound Program.

Funding will be awarded on a competitive basis to community providers. The County Mental Health Department will serve as an active partner by providing programmatic coordination, clinical oversight, and evaluation support.

Training in the Wraparound Model, and evidence-based practices such as the Incredible Years Parenting Program, Aggression Replacement Training (ART), and Functional Family Therapy will be provided for relevant clinical staff.

Part II, Section VI, II-1b

Age and situation characteristics of the priority population

Children (and their families), 0-17, at risk of out of home placement, with no insurance or under-insured for the needed mental health services.

Criteria:

1. SED (Serious Emotional Disturbance or 0-3 Crosswalk Tool) **AND**
2. Uninsured or NO MH coverage **AND**
3. At risk of out of home placement due to at least one of the following:
   a) Abandonment by or incarceration of parents/caretakers
   b) Domestic Violence
   c) Death of parent
   d) Mental Illness (child or caretaker)
   e) Abuse/neglect as defined in WIC
   f) Disability (child or caretaker)
   g) Substance abuse (child or caretaker)
   h) Drug exposed infants
   i) Physical Illness (child or caretaker)
   j) Homelessness/Inadequate housing
   k) Relinquishment or termination of parental rights
   l) Infant of young child of teen in placement
   m) Beyond control of parents
   n) Delinquency (adjudicated)
   o) Danger to self, others, or community
   p) Child/youth returning home from placement or moving to less restrictive level of care

4. **OR** Underinsured (has some insurance but insurance does not cover the depth, breadth of services required to prevent out of home placement)

There is an estimated 500 youth who are at risk of out-of-home placement in the county.

Part II, Section VI, II-1c

Strategies

- Youth involvement in planning and service development
- Services and supports provided at school, in the community, and in the home.
- Infrastructure for the Children's System of Care
- Family preservation services
- Crisis response 24/7
- Education for children/youth/families re: mental illness and medications.
- Values-driven, evidence-based practices integrated with overall service planning and which support youth/family selected goals.

- Childcare
- Transportation
- Use of evidence-based practices, such as the Incredible Years Parenting Program, Aggression Replacement Therapy (ART), and Functional Family Therapy and referral for Parent-Child Interactive Therapy (PCIT) and Dialectical Behavior Therapy (DBT).

Part II, Section VI, II-1d

Funding types and age group
MHSA Full Service Partnership funds (22.5% of the allocation was earmarked for youth ages 0-17) and System Development Funds (Peer and Family Education and Support funds to hire Parent Partners) will be used to serve eligible youth (0-17) and their families. In addition, Medi-Cal funding will be accessed, to leverage the investment of MHSA funds in creating a new Wraparound Services team in South Lake Tahoe, thereby allowing the team to serve Medi-Cal beneficiaries, as well.

Part II, Section VI, II-2

Program Description and Advancement of the MHSA Goals
Use of the Wraparound services program model ensures the delivery of services within a system-of-care with philosophies, values and standards consistent with the MHSA mission. Individualized plans are client and family-driven and strengths-based. Use of the Wraparound Team model supports community collaboration and integrated service delivery. Cultural competence is a critical goal addressed individually with each family to ensure respectful, ethnic-specific, and age/gender-appropriate services.

This vision of this program is to support children, their caretakers, and the community by keeping children healthy and safe at home, in school and out of trouble. Program characteristics will include flexible hours and community-based services. Each regional MHSA Wraparound Program, once fully established, will serve six MHSA children at a time (these will be full service partnership enrollments) for a county-wide total of twelve. In addition, the South Lake Tahoe Wraparound Program will have the capacity to enroll six Medi-Cal children once fully operational. It is anticipated that once established and at full capacity, the South Lake Tahoe Wraparound Team will be able to serve an average of 24 clients per year with a caseload of 12 families at any given time (6 MHSA and 6 Medi-Cal) and the expanded capacity in the Western Slope will serve 6 MHSA clients at an given time for an average of 12 clients per year. There is an estimated annual pool of 500 youth who are at risk of out-of-home placement.

El Dorado County Mental Health will provide clinical oversight of both teams and evaluation support. Funds will be contracted out on a competitive basis for the following South Lake Tahoe Team positions and the Western Slope Team expansion positions. Based on FY 06-07 funding levels (the first full year of operation), MHSA funds for this project will be applied as follows:

South Lake Tahoe Wraparound Team: $175,665

WS Wraparound Team Expansion: $125,192

Clinical Oversight and Evaluation: $60,403

Total Wraparound budget: $361,260

These programs will follow the 10 principles of the wraparound process and the practices outlined by the National Wraparound Initiative Advisory Group (October 1, 2004). Services and supports will be delivered in a fashion that is strengths-based andfamily-driven within a single individualized services and supports plan and with the support of a Wrap Coordinator. As a full-service partnership program, support will be available on a 24/7 basis and a flex fund will be used to access resources needed by the family to successfully fulfill their individualized plan and keep the family intact.

The EDCMH Department will serve as the lead public agency and will provide clinical oversight through the Children's Services Clinical Coordinators. EDCMH will contract with community agencies to staff the MHSA Wrap team positions, to administer the flex funds, and to provide the 24/7 response. The program will be implemented collaboratively.

An existing Interagency Advisory Council is in place and is comprised of the Directors of Social Services, Mental Health, Public Health, Probation, and the Department of Education. This group will also serve as an oversight body for this MHSA project. The existing Wraparound Program MOU will be expanded to include this program. The existing Cross-System Operations Team (CSOT) will provide programmatic oversight and includes the EDCMH Children's Services Program Manager, Clinical Coordinators, Family Coordinators and Parent Partners. An evaluator will be funded at .5 FTE to support this program and will provide regular reports to both of these interagency teams, as will the EDCMH fiscal team. Finally, in the Western Slope, a Placement Committee for the existing WRAP teams will expand to serve as an authorizing body for the MHSA WRAP enrollments. SLT will create an ACCESS team to serve a similar function.

Each Wraparound Team will be staffed by a Facilitator (introduces the family to the model, sets up, coordinates, and facilitates meetings), Parent Partner (advocates, educates, and develops community resources), and Family Coordinator or WRAP worker (therapeutic behavioral aide providing family support activities, mentoring and coaching, and assisting with community resource access), in addition to the family and other members selected by the family.

Training on the model, principles, phases of service, and roles and responsibilities will be provided prior to program implementation. Family orientation is provided to each family on an individual basis upon beginning the program.

EDCMH will conduct the evaluation activities. Each family will be assisted in identifying their measurable treatment goals. The following State-recommended tools may be used to capture the data, pending further planning. The Parent Partners will be used to collect the data to ensure family-focused input. Data will be collected when the family enters the program and each six months thereafter. The Evaluator will report the findings to the CSOT, Advisory Committee and to the Wraparound Teams every 6 months.

Evaluation data may be captured using the following tools:

- Child Behavior Checklist (CBCL) – (Achenbach, 1991)
- Parent Satisfaction Survey – (Attkinson & Larsen, 1989, 1990)
- Family-Centered Behavior Scale – (Petr & Allen, 1995)
- Social Skills Rating System (SSRS) – (Gresham & Elliot, 1990)
- Walter Problem Behavior Identification Checklist – (Walker, 1970)
- Child and Adolescent Functional Assessment Scale (CAFAS) – Hodges, Bickman & Kirtz, 1991)
- Youth Self Report (YSR) – (Achenbach, 1991)
- Client Satisfaction Quest (CSQ-8) – (Attkinson & Larsen, 1990)
- Short Form – 36 Health Survey (SF-36) – (Medical Outcome Trust,. 1993)

Program effectiveness will be examined in the following functional areas:

- Days of psychiatric hospitalization
- Days in shelters
- Days of arrests
- Type of school placement
- School attendance
- Academic performance
- Days in out of home placement
- Child care stability

Referrals may come from families themselves, schools, the emergency youth shelter, youth serving agencies, mental health, including inpatient hospital and crisis services, human services (CPS), Child Assessment Team (CAT), medical care settings, , and probation. Furthermore, collaborative outreach with the MHSA Latino Outreach and Engagement Initiative and the Shingle Springs Tribal Health Program will be used to ensure access for the Latino and Native American populations.

Part II, Section VI, II-3

Housing and/or employment services--NA
Referrals to appropriate agencies will be made for families in need of these resources. In case of family emergencies, the Flex Funds account may be used to temporarily provide housing stability or support to a family in crisis.

Part II, Section VI, II-4

Average cost for each Full Service Partnership participant
The average cost for each full-service partnership participant will be $15,805 based on FY 07-08 funding levels (the first full year of operation).

Part II, Section VI, II-5

Recovery and Resilience
Wellness concepts for family and youth are embedded in the Wraparound program. Client and family strengths are defined from the initial conversation with the family and drive the determination of intervention strategies. Adults are encouraged to establish goals consistent with ensuring meaningful roles for themselves in addition to their role as parent. With the Team, youth and families are continuously encouraged to identify, reflect on and acknowledge each step of growth, effective coping strategies, and success which demonstrates youth resiliency. The family is also encouraged to draw on natural supports and community supports in their individual plan which serves as a Wellness Recovery Action Plan (WRAP) for the family unit.

Part II, Section VI, II-6

Program Expansion
The Western Slope of El Dorado County began providing SB 163 Wraparound services in 2002. With that funding (six SB 163 slots) 20 SB163 children and their families were served over a 3 year period. However, in FY 03-04, a total of 32 children were served by this team as Medi-Cal funds were leveraged. Based on this past experience, we have projected the capacity for our MHSA Wraparound extension in Western Slope and South Lake Tahoe. Use of the existing organizational structure and design will provide an efficient means of supporting this expansion. Expansion of these services by use of our community-based organizations in partnership with the county will enrich this component of the service delivery system. We do not anticipate that this expanded component will interfere in any way with the existing services being provided to families involved in Wraparound services.

Part II, Section VI, II-7

Services and supports to be provided by clients and/or family members
The Parent Partner will serve as support and advocate for each WRAP family. Family members will not run the service but as part of the service team, their role will be to:

- Participate on all family treatment teams,
- Provide mentoring/support for parents and consumer,
- Assist facilitator in finding appropriate community resources,
- Plan celebrations,
- Advocate for family by teaching parents how to navigate the various systems
- Orient parent to Wraparound model.
- Co-facilitate Incredible Years model parenting class
- Increase families' knowledge re: services and supports available

Part II, Section VI, II-8

Collaboration strategies:
The Wraparound program on the Western Slope currently has partnerships in place with Human Services, Sierra Family Services, Summitview Child Treatment Center, County Office of Education, and Probation Department. Additional partners will include Family Connections, New Morning Youth and Family Services, Early Childhood Counseling Center, the Family Resource Center, and the Shingle Springs Tribal Health Program. These partners will be used to refer families for Wraparound services, to participate on individualized teams, and to provide a range of services and supports as directed by the individualized family plans. Community mental health agencies serve as resources for evidence-based practices such as the Parent-Child Interactive Therapy (PCIT) model and Dialectical Behavior Therapy (DBT).

The Cross-Systems Operation Team meets quarterly and includes program managers from the Office of Education and Departments of Probation, Human Services, Mental Health, and Public Health. The team also includes a Parent Partner. The team assists in applying best practices, developing interagency procedures, and addressing family complaints and grievances. The team is responsible for collecting data and overseeing performance outcomes.

Partnerships with ethnic and faith-based community organizations, such as the Family Resource Center (Latino community) and Shingle Springs Tribal Health Program will need to be established to ensure access to the Wraparound Team and culturally competent practice.

All of these partnerships serve to ensure strengths-based, client-centered practice, cultural competence, service access, and integrated service delivery all of which improve the service delivery system and client outcomes.

Part II, Section VI, II-9

Cultural Competence and Ethnic Disparities
This comprehensive model is designed to improve access to mental health services, improve accuracy of diagnosis, improve use of appropriate and individualized service planning and delivery, use of effective integration of client

families into services, and use of community and external resources—all goals of culturally competent service delivery.

The Wraparound program will provide culturally competent services tailored to family culture, values, norms, strengths, and preferences. The Wraparound team will consist of the appropriate membership per the request of the family. Families will be encouraged to communicate and share their cultural perspective and needs. During each of the phases, the role of culture and belief systems will be raised for family input. The team will also seek to find ways to celebrate successes within the cultural framework of the family.

Further, these specific practices will be incorporated to provide culturally competent services to youth and families:

1) The Wraparound Team will collaborate with the MHSA Latino Outreach Program to inform the community of their services and to get referrals. The bilingual/bicultural peer outreach worker will be available to program participants and staff for interpretation assistance.
2) Collaborative outreach and case management will occur with the Shingle Springs Tribal Health Program to effectively serve the Native American population.
3) All team members will also participate in the intensive training that will be created for all MHSA program staff regarding cultural competent practice skills.
4) The Wraparound staff will establish a policy outlining the values, principles and practices addressing culturally competent practice that this program will adopt.
5) An assessment of cultural issues and language needs will be included in the individual planning process.
6) Data regarding client culture and language will be collected and evaluated.
7) Interpretation services are available and all program literature will be available in both English and Spanish.
8) Forms and brochures will be available in English and Spanish.
9) Every effort will be made to have a bilingual/bicultural Spanish–speaking staff member on the Wraparound Team.

The high rate of poverty and lack of insurance in the Latino family community and poverty among local Native American families suggests that outreach and engagement to these groups is critical. Use of the Promotora model and bilingual/bicultural services in the home will be needed to identify and engage Latino families in need. Collaboration with the local ethnic-services agency for Native American families will be the first step to better address the needs of this population. Risk factors reported among LGBT youth and the stigma barrier will be addressed as part of the anti-stigma campaign to improve community education, service access, and timely identification of youth in need.

Part II, Section VI, II-10

<u>Sexual orientation, gender and the different psychologies of men, women, boys and girls</u>

Training regarding service delivery that is sensitive to issues surrounding sexual orientation, gender differences, and the varying psychologies based on gender, developmental stages, and generational issues will be provided for all team members. The assessment and treatment phases of the program will explore issues of sexuality and gender-related issues. Ensuring an awareness of the mental health stressors associated with sexual orientation issues, the increased barriers associated with gender differences, and the varying manifestations of issues of gender and sexuality at different developmental stages are critical to the delivery of culturally competent and client-centered service delivery that celebrates individual strengths and diversity. The complexity of these issues increases when dealing with the family unit—family members themselves will have varying perspectives and different issues along the lines of sexuality and gender—including generational differences.

Part II, Section VI, II-11

Out of county residents
This program will serve only clients who reside in the county.

Part II, Section VI, II-12

Strategies not listed in Section IV
All of the strategies are consistent with those listed in Section IV and the MHSA goals.

Part II, Section VI, II-13

Timeline and Critical Implementation Dates

Critical Implementation Date: January 2006-March 2006
Milestones:

- Finalization of program design
- Host a community meeting to discuss final draft
- Create training modules (MHSA overview and requirements, cultural competency, Wraparound model, and basic information on the evidence-based practices that will be accessed by the teams).

Critical Implementation Date: April 2006-June 2006
Milestones:

- Pending approval of MHSA application, let RFP and establish contracts with winning bidders and hire MHSA staff.
- Creation of draft MOU's for Wraparound Team
- Hold a team retreat that will include orientation to MHSA, the Treatment Model, and issues around cultural competency.
- Program outreach
- Begin accepting client referrals

Critical Implementation Date: July 2006-September 2006
Milestones:

- Creation of policies and procedures for WRAP Team
- Create data collection tools, reports and databases.
- Create collaborative outreach processes, including the Latino Outreach and Engagement Program, the Family Resource Center, and Shingle Springs Tribal Health Program.

Critical Implementation Date: October 2006-December 2006
Milestones:

- Attend Incredible Years Training.

Critical Implementation Date: April 2007-June 2007
Milestones:

- Attend Aggression Replacement Therapy Training.

Critical Implementation Date: July 2007-September 2007
Milestones:

- Complete and present year end report to the Advisory Committee.
- Present findings in a community meeting.
- Modify and submit MHSA three year plan update.
- SLT will begin to serve Medi-Cal clients.

Critical Implementation Date: October 2007-December 2007
Milestones:

- Begin Functional Family Therapy training process

Critical Implementation Date: January 2008-March 2008

- Review and revise policies and procedures, as appropriate.

Milestones:

- Annual cultural competency training.

EXHIBIT "I"

Implementing the wraparound process: What the *National Wraparound Initiative* can offer communities

Collaborative consumer-provider teams have become an increasingly popular mechanism for creating and implementing individualized care plans for adults, children, and families with complex needs. Within children's mental health, a team-based approach known as *wraparound* has become one of the primary strategies for providing community-based care for children experiencing emotional and behavioral problems. It is estimated that over 200,000 young people nationally receive services via some type of wraparound process.

Wraparound's popularity and visibility stems from its philosophy for service delivery, which is appealing to a broad range of stakeholders. In addition, wraparound is viewed as a means for accomplishing several goals for well-functioning systems of care as presented in the President's *New Freedom Commission Report* on Mental Health:

- Creating an individualized plan of care for every child or youth;
- Administering a culturally competent, family-driven care process based on the perspectives of the family;
- Bringing flexible resources and natural supports to bear on behalf of the youth and family, through use of a child and family team; and
- Creatively mobilizing all resources necessary to keep the child in the community.

These features of the wraparound process have led most SAMHSA-funded *Children's Mental Health Initiative* systems-of-care communities to use the wraparound process to plan and manage care for youth with the most serious needs and their families. In fact, the most recent SAMHSA Request for Applications for the Children's Mental Health Initiative (RFA number SM-05-010; found at http://www.samhsa.gov/grants/2005/grants.aspx) requires that an applicant community describe how they will develop the capacity to administer the wraparound process, and support its high-quality implementation.

Unfortunately, though there is general agreement about the philosophy that should guide wraparound, the children's services field has historically been hindered by the lack of a standard model for wraparound practice and a dearth of well-articulated descriptions of what is needed to support wraparound. As a collaborative effort seeking to overcome these longstanding gaps in understanding (and thus promote the implementation of high quality wraparound), the ***National Wraparound Initiative*** is poised to help prepare communities to meet these challenges. For communities who are interested in implementing the wraparound process, we have prepared this brief introduction to how the materials on the National Wraparound Initiative website may help your efforts.

Q: What is wraparound?

Wraparound has traditionally been defined by a set of principles about how family members, people in their support system, and service providers should work together to support the family or individual who needs help. The National Wraparound Initiative and its collaborating partners have undertaken a research project that included a consensus building process to refine and crystallize these principles at a child and family level. Enacting these principles should be considered the foundation of high quality wraparound practice. To view information about the consensus-building process, and the resulting document, click here: 10 Principles of the Wraparound Process

In addition, in 2003, some members of the National Initiative contributed several articles to a special issue of Focal Point on "Quality and Fidelity in Wraparound," including a **history of wraparound** by John VanDenBerg, Eric Bruns, and John Burchard.

Finally, Eric Bruns, a researcher from the University of Washington, has written a newsletter article about wraparound's -status as an empirically supported approach for child and family services. This piece can be found here:
http://www.wraparoundsolutions.com/newscontent.asp?pg=2

Q: What happens during the wraparound process?

During the Wraparound process, a team, guided by a facilitator, creates an individualized plan of care to improve the life of a child or youth and his or her family. Wraparound team members—the identified child/youth, parents/caregivers and other family and community members, mental health professionals, educators, and others—meet regularly to design, implement, and monitor a plan to meet the unique needs of the child and family. Though this may sound relatively simple, actually implementing this process is challenging. Through an interactive process employing many advisors, the National Wraparound Initiative has described a model of procedures that typically occur within a high-quality wraparound process. This document can be found here: **Phases and Activities of the Wraparound Process.**

Q: What kinds of administrative and system supports does wraparound require?

Clearly, the model described in the "Phases and Activities of the Wraparound Process" is a complex one that will require significant supports to be implemented. Researchers at Portland State's Research and Training Center conducted a series of studies intended to determine what kinds of supports are necessary for a community to administer a wraparound process. These supports, which can be described at the wraparound, team, organizational, and system levels, are described in a **full monograph**, as well as an abbreviated **primer** created for the National Wraparound Initiative, and in a **Focal Point article** from 2003.

Q: How does a community measure implementation of wraparound and conduct quality assurance around the process?

Collaborators participating in the National Wraparound Initiative have developed several methods for measuring wraparound implementation. Researchers at the Portland State RTC have developed methods for communities to assess the adequacy of organizational and system supports, which can be found in the **monograph** described above. In addition, there are several methods for assessing adherence to wraparound principles in as administered to individual families. These include the Wraparound Observation Form[1] (which measures wraparound as administered in a team meeting) and the **Wraparound Fidelity Index**, originally developed by John Burchard at the University of Vermont, which measures wraparound implementation via interviews with the youth, caregiver, and resource facilitator.

Q. Where can I review more information?

The above resources represent only a small cross-section of the information available through the National Wraparound Initiative. As you consider the requirements for implementing a high-quality wraparound process in your community, we invite you to review the full sample of materials we have compiled on the **website**. Please let us know what you have found to be most helpful – or areas in which you require more information – by emailing the coordinators of the project, Eric Bruns (ebruns@u.washington.edu) and Janet Walker (janetw@pdx.edu).

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[1] Epstein, M.H., et al. (2003). Assessing the Wraparound Process During Family Planning Meetings *Journal of Behavioral Health Services & Research, 30,* 352-362.

Ten Principles of the Wraparound Process

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October 1, 2004

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Introduction

The philosophical principles of wraparound have long provided the basis for understanding this innovative and widely-practiced service delivery model. This value base for working in collaboration and partnership with families extends from wraparound's roots in programs such as *Kaleidoscope* in Chicago, the *Alaska Youth Initiative*, and *Project Wraparound* in Vermont. In 1999, a monograph on wraparound was published that presented 10 core elements of wraparound, as well as 10 practice principles, from the perspective of wraparound innovators.[1] These elements and practice principles spanned activity at the team, organization, and system levels; in other words, some elements were intended to guide direct work that happens with the youth, family and hands-on support people (team level); some referred to work by the agency or organization housing the wraparound initiative (program level); and some guided the funding and community context around the wraparound activities (system level). For many, these original elements and principles became the best means available for understanding the wraparound process. They also provided an important basis for initial efforts at measuring wraparound fidelity.

Many have expressed a need to move beyond a value base for wraparound in order to facilitate program development and replicate positive outcomes. However, wraparound's philosophical principles will always remain the starting point for understanding the model. The current document attempts to make the wraparound principles even more useful as a framework and guide for high-quality practice for youth and families. It describes wraparound's principles exclusively at the youth/family/team level. In doing so, we hope the organizational and system supports necessary to achieve high-quality wraparound practice[2] will always be grounded in the fundamental need to *achieve the wraparound principles for families and their teams.* By revisiting the original elements of wraparound, we also capitalized on an opportunity to break complex principles (e.g., "individualized and strengths-based") into independent ones, and make sure the principles aligned with other aspects of the effort to operationalize the wraparound process.

The current document is the result of a small team of wraparound innovators, family advocates, and researchers working together over several months. This team revised the original elements and practice principles and provided them to a much larger national group of family members, program administrators, trainers, and researchers familiar with wraparound. Through several stages of work, these individuals voted on the principles presented, provided feedback on phraseology, and participated in a consensus-building process.[3]

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[1] Goldman, S.K. (1999). The Conceptual Framework for Wraparound. In Burns, B. J. & Goldman, K. (Eds.), *Systems of care: Promising practices in children's mental health, 1998 series, Vol. IV: Promising practices in wraparound for children with severe emotional disorders and their families.* Washington DC: Center for Effective Collaboration and Practice.

[2] Another component of the *National Wraparound initiative*, originally described in detail in Walker, J.S., Koroloff, N., & Schutte, K. (2003). *Implementing high-quality collaborative individualized service/support planning: Necessary conditions.* Portland, OR: Research and Training Center on Family Support and Children's Mental Health

[3] Description of the *Delphi* process used can be found on the National Wraparound Initiative's web page at www.rtc.pdx.edu/nwi/NWIMethod.htm.

Though far from complete, consensus on the principles as presented here was strong. Nonetheless, you will see as you read descriptions of these 10 principles that there are several key areas where the complexity of wraparound itself hindered realization of a clear consensus among our advisory group. Commentary provided with each principle highlights such tensions and goes into much greater depth about the intentions and implications of each principle.

Considered along with its accompanying materials, we hope that this document helps achieve the main goal expressed by members of the *National Wraparound Initiative* at its outset: To provide clarity on the specific characteristics of the wraparound process model for the sake of communities, programs, and families. Just as important, we hope that this document is viewed as a work in progress, and that it remains a living document that can be updated as needed based on feedback from an even broader audience of reviewers.

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Ten Principles of the Wraparound Process

1. **Family voice and choice.** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

The wraparound process recognizes the importance of long-term connections between people, particularly the bonds between family members. The principle of family voice and choice in wraparound stems from this recognition and acknowledges that the people who have a long-term, ongoing relationship with a child or youth have a unique stake in and commitment to the wraparound process and its outcomes. This principle further recognizes that a young person who is receiving wraparound also has a unique stake in the process and its outcomes. The principle of family voice and choice affirms that these are the people who should have the greatest influence over the wraparound process as it unfolds.

This principle also recognizes that the likelihood of successful outcomes and youth/child and family ownership of the wraparound plan are increased when the wraparound process reflects family members' priorities and perspectives. The principle thus explicitly calls for family voice—the provision of opportunities for family members to fully explore and express their perspectives during wraparound activities—and family choice—the structuring of decision making such that family members can select, from among various options, the one(s) that are most consistent with their own perceptions of how things are, how things should be, and what needs to happen to help the family achieve its vision of well-being. Wraparound is a collaborative process (principle 3); however within that collaboration, family members' perspectives must be the most influential.

The principle of voice and choice explicitly recognizes that the perspectives of family members are not likely to have sufficient impact during wraparound unless *intentional* activity occurs to ensure their voice and choice drives the process. Families of children with emotional and behavioral disorders are often stigmatized and blamed for their children's difficulties. This and other factors—including possible differences in social and educational status between family members and professionals, and the idea of professionals as experts whose role is to "fix" the family—can lead teams to discount, rather than prioritize, family members' perspectives during group discussions and decision making. These same factors also decrease the probability that youth perspectives will have impact in groups when adults and professionals are present. Furthermore, prior experiences of stigma and shame can leave family members reluctant to express their perspectives at all. Putting the principle of youth and family voice and choice into action thus requires intentional activity that supports family members as they explore their perspectives and as they express their perspectives during the various activities of wraparound. Further intentional activity must take place to ensure that this perspective has sufficient impact within the collaborative process, so

that it exerts primary influence during decision making. Team procedures, interactions, and products—including the wraparound plan—should provide evidence that the team is indeed engaging in intentional activity to prioritize the family perspectives.

While the principle speaks of *family* voice and choice, the wraparound process recognizes that the families who participate in wraparound, like American families generally, come in many forms. In many families, it is the biological parents who are the primary caregivers and who have the deepest and most enduring commitment to a youth or child. In other families, this role is filled by adoptive parents, step-parents, extended family members, or even non-family caregivers. In many cases, there will not be a single, unified "family" perspective expressed during the various activities of the wraparound process. Disagreements can occur between adult family members/ caregivers or between parents/caregivers and extended family. What is more, as a young person matures and becomes more independent, it becomes necessary to balance the collaboration in ways that allow the youth to have growing influence within the wraparound process. Wraparound is intended to be inclusive and to manage disagreement by facilitating collaboration and creativity; however, throughout the process, the goal is always to prioritize the influence of the people who have the deepest and most persistent connection to the young person and commitment to his or her well-being.

Special attention to the balancing of influence and perspectives within wraparound is also necessary when legal considerations restrict the extent to which family members are free to make choices. This is the case, for example, when a youth is on probation, or when a child is in protective custody. In these instances, an adult acting for the agency may take on caregiving and/or decision making responsibilities vis-à-vis the child, and may exercise considerable influence within wraparound. In conducting our review of opinions of wraparound experts about the principles, this has been one of several points of contention; specifically, how best to balance the priorities of youth and family against those of these individuals. Regardless, there is strong consensus in the field that the principle of family voice and choice is a constant reminder that the wraparound process must place special emphasis on the perspectives of the people who will still be connected to the young person after agency involvement has ended.

2. **Team based.** The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.

Wraparound is a collaborative process (see principle 3), undertaken by a team. The wraparound team should be composed of people who have a strong commitment to the family's well-being. In accordance with principle 1, choices about who is invited to join the team should be driven by family members' perspectives.

At times, family members' choices about team membership may be shaped or limited by practical or legal considerations. For example, one or more family members may be reluctant to invite a particular person— e.g., a teacher, a therapist, a probation officer, or a non-custodial ex-spouse—to join the team. At the same time, not inviting that person may mean that the team will not have access to resources and/or

interpersonal support that would otherwise be available. Not inviting a particular person to join the team can also mean that the activities or support that he or she offers will not be coordinated with the team's efforts. It can also mean that the family loses the opportunity to have the team influence that person so that he or she becomes better able to act supportively. If that person is a professional, the team may also lose the opportunity to access services or funds that are available through that person's organization or agency. Not inviting a particular professional to join the team may also bring undesired consequences, for example, if participation of the probation officer on the wraparound team is required as a condition of probation. Family members should be provided with support for making informed decisions about whom they invite to join the team, as well as support for dealing with any conflicts or negative emotions that may arise from working with such team members. Or, when relevant and possible, the family should be supported to explore options such as inviting a different representative from an agency or organization. Ultimately, the family may also choose not to participate in wraparound.

When a state agency has legal custody of a child or youth, the caregiver in the permanency setting and/or another person designated by that agency may have a great deal of influence over who should be on the team; however, in accordance with principle 1, efforts should be made to include participation of family members and others who have a long-term commitment to the young person and who will remain connected to him or her after formal agency involvement has ended.

3. **Natural supports.** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

This principle recognizes the central importance of the support that a youth/child, parents/caregivers, and other family members receive "naturally," i.e., from the individuals and organizations whose connection to the family is independent of the formal service system and its resources. These sources of natural support are sustainable and thus most likely to be available for the youth/child and family after wraparound and other formal services have ended. People who represent sources of natural support often have a high degree of importance and influence within family members' lives. These relationships bring value to the wraparound process by broadening the diversity of support, knowledge, skills, perspectives, and strategies available to the team. Such individuals and organizations also may be able to provide certain types of support that more formal or professional providers find hard to provide.

The primary source of natural support is the family's network of interpersonal relationships, which includes friends, extended family, neighbors, co-workers, church members, and so on. Natural support is also available to the family through community institutions, organizations, and associations such as churches, clubs, libraries, or sports leagues. Professionals and paraprofessionals who interact with the family primarily offer paid support; however, they can also be connected to family members through caring

relationships that exceed the boundaries and expectations of their formal roles. When they act in this way, professionals and paraprofessionals too can become sources of natural support.

Practical experience with wraparound has shown that formal service providers often have great difficulty accessing or engaging potential team members from the family's community and informal support networks. Thus, there is a tendency that these important relationships will be underrepresented on wraparound teams. This principle emphasizes the need for the team to act intentionally to encourage the full participation of team members representing sources of natural support.

4. **Collaboration.** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

Wraparound is a collaborative activity—team members must reach collective agreement on numerous decisions throughout the wraparound process. For example, the team must reach decisions about what goals to pursue, what sorts of strategies to use to reach the goals, and how to evaluate whether or not progress is actually being made in reaching the goals. The principle of collaboration recognizes that the team is more likely to accomplish its work when team members approach decisions in an open-minded manner, prepared to listen to and be influenced by other team members' ideas and opinions. Team members must also be willing to provide their own perspectives, and the whole team will need to work to ensure that each member has opportunities to provide input and feels safe in doing so. As they work to reach agreement, team members will need to remain focused on the team's overarching goals and how best to achieve these goals in a manner that reflects all of the principles of wraparound.

The principle of collaboration emphasizes that each team member must be committed to the team, the team's goals, and the wraparound plan. For professional team members, this means that the work they do with family members is governed by the goals in the plan and the decisions reached by the team. Similarly, the use of resources available to the team—including those controlled by individual professionals on the team—should be governed by team decisions and team goals.

This principle recognizes that there are certain constraints that operate on team decision making, and that collaboration must operate within these boundaries. In particular, legal mandates or other requirements often constrain decisions. Team members must be willing to work creatively and flexibly to find ways to satisfy these mandates and requirements while also working towards team goals.

Finally, it should be noted that, as for principles 1 (family voice and choice) and 2 (team-based), defining wraparound's principle of collaboration raises legitimate concern about how best to strike a balance between wraparound being youth- and family-driven as well as team-driven. This issue is difficult to resolve completely, because it is clear

that wraparound's strengths as a planning and implementation process derive from being team-based and collaborative while also prioritizing the perspectives of family members and natural supports who will provide support to the youth and family over the long run. Such tension can only be resolved on an individual family and team basis, and is best accomplished when team members, providers, and community members are well supported to fully implement wraparound in keeping with all its principles.

5. **Community-based.** The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

This principle recognizes that families and young people who receive wraparound, like all people, should have the opportunity to participate fully in family and community life. This implies that the team will strive to implement service and support strategies that are accessible to the family and that are located within the community where the family chooses to live. Teams will also work to ensure that family members receiving wraparound have greatest possible access to the range of activities and environments that are available to other families, children, and youth within their communities, and that support positive functioning and development.

6. **Culturally competent.** The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

The perspectives people express in wraparound—as well as the manner in which they express their perspectives—are importantly shaped by their culture and identity. In order to collaborate successfully, team members must be able to interact in ways that demonstrate respect for diversity in expression, opinion, and preference, even as they work to come together to reach decisions. This principle emphasizes that respect toward the family in this regard is particularly crucial, so that the principle of family voice and choice can be realized in the wraparound process.

This principle also recognizes that a family's traditions, values, and heritage are sources of great strength. Family relationships with people and organizations with whom they share a cultural identity can be essential sources of support and resources; what is more, these connections are often "natural" in that they are likely to endure as sources of strength and support after formal services have ended. Such individuals and organizations also may be better able to provide types of support difficult to provide through more formal or professional relationships. Thus, this principle also emphasizes the importance of embracing these individuals and organizations, and nurturing and strengthening these connections and resources so as to help the team achieve its

goals, and help the family sustain positive momentum after formal wraparound has ended.

This principle further implies that the team will strive to ensure that the service and support strategies that are included in the wraparound plan also build on and demonstrate respect for family members' beliefs, values, culture, and identity. The principle requires that team members are vigilant about ensuring that culturally competent services and supports extend beyond wraparound team meetings.

7. **Individualized.** To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

This principle emphasizes that, when wraparound is undertaken in a manner consistent with all of the principles, the resulting plan will be uniquely tailored to fit the family. The principle of family voice and choice lays the foundation for individualization. That principle requires that wraparound must be based in the family's perspective about how things are for them, how things should be, and what needs to happen to achieve the latter. Practical experience with wraparound has shown that when families are able to fully express their perspectives, it quickly becomes clear that only a portion of the help and support required is available through existing formal services. Wraparound teams are thus challenged to create strategies for providing help and support that can be delivered outside the boundaries of the traditional service environment. Moreover, the wraparound plan must be designed to build on the particular strengths of family members, and on the assets and resources of their community and culture. Individualization necessarily results as team members collaboratively craft a plan that capitalizes on their collective strengths, creativity, and knowledge of possible strategies and available resources.

8. **Strengths based.** The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

The wraparound process is strengths based in that the team takes time to recognize and validate the skills, knowledge, insight, and strategies that each team member has used to meet the challenges they have encountered in life. The wraparound plan is constructed in such a way that the strategies included in the plan capitalize on and enhance the strengths of the people who participate in carrying out the plan. This principle also implies that interactions between team members will demonstrate mutual respect and appreciation for the value each person brings to the team.

The commitment to a strengths orientation is particularly pronounced with regard to the child or youth and family. Wraparound is intended to achieve outcomes not through a focus on eliminating family members' deficits but rather through efforts to utilize and

increase their assets. Wraparound thus seeks to validate, build on, and expand family members' psychological assets (such as positive self-regard, self-efficacy, hope, optimism, and clarity of values, purpose, and identity), their interpersonal assets (such as social competence and social connectedness), and their expertise, skill, and knowledge.

9. **Persistence.** Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer required.

This principle emphasizes that the team's commitment to achieving its goals persists regardless of the child's behavior or placement setting, the family's circumstances, or the availability of services in the community. This principle includes the idea that undesired behavior, events, or outcomes are not seen as evidence of child or family "failure" and are not seen as a reason to eject the family from wraparound. Instead, adverse events or outcomes are interpreted as indicating a need to revise the wraparound plan so that it more successfully promotes the positive outcomes associated with the goals. This principle also includes the idea that the team is committed to providing the supports and services that are necessary for success, and will not terminate wraparound because available services are deemed insufficient. Instead, the team is committed to creating and implementing a plan that reflects the wraparound principles, even in the face of limited system capacity.

It is worth noting that the principle of "persistence" is a notable revision from "unconditional" care. This revision reflects feedback from wraparound experts, including family members and advocates, that for communities using the wraparound process, describing care as "unconditional" may be unrealistic and possibly yield disappointment on the part of youth and family members when a service system or community can not meet their own definition of unconditionality. Resolving the semantic issues around "unconditional care" has been one of the challenges of defining the philosophical base of wraparound. Nonetheless, it should be stressed that the principle of "persistence" continues to emphasize the notion that teams work until a formal wraparound process is no longer needed, and that wraparound programs adopt and embrace "no eject, no reject" policies for their work with families.

10. **Outcome based.** The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

This principle emphasizes that the wraparound team is accountable—to the family and to all team members; to the individuals, organizations and agencies that participate in wraparound; and, ultimately, to the public—for achieving the goals laid out in the plan. Determining outcomes and tracking progress toward outcomes should be an active part

of wraparound team functioning. Outcomes monitoring allows the team to regularly assess the effectiveness of plan as a whole, as well as the strategies included within the plan, and to determine when the plan needs revision. Tracking progress also helps the team maintain hope, cohesiveness, and efficacy. Tracking progress and outcomes also helps the family know that things are changing. Finally, team-level outcome monitoring aids the program and community to demonstrate success as part of their overall evaluation plan, which may be important to gaining support and resources for wraparound teams throughout the community.

Phases and Activities of the Wraparound Process

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Phases and Activities of the Wraparound Process

The table presented here represents the results of a research project intended to clarify the types of activities that must be included in a full wraparound process. It is one component among a set of materials produced by the *National Wraparound Initiative*, a project with a goal to clearly operationalize and define this important and innovative model for working with families. The *National Wraparound Initiative* materials also include a description of the principles of wraparound, a description of the organizational and system conditions needed to support a high-quality wraparound process, and a glossary of terms. Some of the documents still being completed include youth, family, and team member handbooks, fidelity measures, and a compilation of tools and procedures to support the process described here. This multi-dimensional description of the wraparound process is the result of an extended process of compiling materials, synthesizing them, and getting quantitative and qualitative feedback from the initiative's Advisory Group.

To create the current document on the activities of the wraparound process, descriptions of wraparound models were compiled from training manuals, monographs, operating procedures of successful wraparound programs, and interviews with wraparound trainers, family members, and family advocates. We created an initial description of the phases and activities and received in-depth feedback from 10 wraparound innovators and prominent family advocates . A revision was then presented to approximately 45 Advisory Group members nationally. Their quantitative feedback was obtained using a *Delphi* process that asked (1) whether the activities presented were "essential," "optional," or "inadvisable;" and (2) whether the wording of the activities was "fine," "so-so," or "unacceptable." Their qualitative feedback included specific suggestions for revising content and wording. An extensive revision based on the quantitative and qualitative feedback was then undertaken.

The resulting "Phases and Activities of the Wraparound Process" focuses on *what* needs to happen in wraparound; however, *how* the work is accomplished is equally important. Merely accomplishing the tasks is insufficient unless this work is done in a manner consistent with the 10 principles of wraparound. In addition, future work from the National Wraparound Initiative will provide more detailed information about team member skills that are necessary for the wraparound process, as well as descriptions of specific procedures, templates, and other tools that can be used to complete the activities described here. Finally, it should be stressed that even the basic description presented here remains a "living document" that will be updated based on pilot testing and feedback from an even broader audience of reviewers than has participated thus far.

Phases and Activities of the Wraparound Process

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Phases and Activities of the Wraparound Process: Phase 1

MAJOR TASKS/Goals	ACTIVITIES	NOTES
PHASE 1: Engagement and team preparation During this phase, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborate. During this phase, the tone is set for teamwork and team interactions that are consistent with the wraparound principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.		
1.1. Orient the family and youth GOAL: To orient the family and youth to the wraparound process.	**1.1 a. Orient the family and youth to wraparound** In face-to-face conversations, the facilitator explains the wraparound philosophy and process to family members and describes who will be involved and the nature of family and youth/child participation. Facilitator answers questions and addresses concerns. Facilitator describes alternatives to wraparound and asks family and youth if they choose to participate in wraparound. Facilitator describes types of supports available to family and youth as they participate on teams (e.g., family/youth may want coaching so they can feel more comfortable and/or effective in partnering with other team members).	This orientation to wraparound should be brief and clear, and should avoid the use of jargon, so as not to overwhelm family members. At this stage, the focus is on providing enough information so that the family and youth can make an informed choice regarding participation in the wraparound process. For some families, alternatives to wraparound may be very limited and/or non-participation in wraparound may bring negative consequences (as when wraparound is court ordered); however, this does not prevent families/youth from making an informed choice to participate based on knowledge of the alternatives and/or the consequences of non-participation.
	1.1 b. Address legal and ethical issues Facilitator reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences. Facilitator discusses relevant legal and ethical issues (e.g., mandatory reporting), informs family of their rights, and obtains necessary consents and release forms before the first team meeting.	Ethical and legal considerations will also need to be reviewed with the entire team as described in phase 2.

MAJOR TASKS/Goals	ACTIVITIES	NOTES
1.2. Stabilize crises GOAL: To address pressing needs and concerns so that family and team can give their attention to the wraparound process.	**1.2 a. Ask family and youth about immediate crisis concerns** Facilitator elicits information from the family and youth about immediate safety issues, current crises, or crises that they anticipate might happen in the very near future. These may include crises stemming from a lack of basic needs (e.g., food, shelter, utilities such as heat or electricity).	The goal of this activity is to quickly address the most pressing concerns. The whole team engages in proactive and future-oriented crisis/safety planning during phase 2. As with other activities in this phase, the goal is to do no more than necessary prior to convening the team, so that the facilitator does not come to be viewed as the primary service provider and so that team as a whole can feel ownership for the plan and the process.
	1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises Facilitator elicits information from the referring source and other knowledgeable people about pressing crisis and safety concerns.	Information about previous crises and their resolution can be useful in planning a response in 1.2.c.
	1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization Facilitator and family reach agreement about whether concerns require immediate attention and, if so, work to formulate a response that will provide immediate relief while also allowing the process of team building to move ahead.	This response should describe clear, specific steps to accomplish stabilization.
1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.	**1.3 a. Explore strengths, needs, culture, and vision with child/youth and family.** Facilitator meets with the youth/child and family to hear about their experiences; gather their perspective on their individual and collective strengths, needs, elements of culture, and long-term goals or vision; and learn about natural and formal supports. Facilitator helps family identify potential team members and asks family to talk about needs and preferences for meeting arrangements (location, time, supports needed such as child care, translation).	This activity is used to develop information that will be presented to and augmented by the team in phase 2. Family members should be encouraged to consider these topics broadly.

MAJOR TASKS/Goals	ACTIVITIES	NOTES
	1.3 b. Facilitator prepares a summary document Using the information from the initial conversations with family members, the facilitator prepares a strengths-based document that summarizes key information about individual family member strengths and strengths of the family unit, as well as needs, culture, and vision. The family then reviews and approves the summary.	
1.4. Engage other team members GOAL: To gain the participation of team members who care about and can aid the youth/child and family, and to set the stage for their active and collaborative participation on the team in a manner consistent with the wraparound principles	**1.4 a. Solicit participation/orient team members** Facilitator, together with family members if they so choose, approaches potential team members identified by the youth and family. Facilitator describes the wraparound process and clarifies the potential role and responsibilities of this person on the team. Facilitator asks the potential team members if they will participate. If so, facilitator talks with them briefly to learn their perspectives on the family's strengths and needs, and to learn about their needs and preferences for meeting.	The youth and/or family may choose to invite potential team members themselves and/or to participate in this activity alongside the facilitator. It is important, however, not to burden family members by establishing (even inadvertently) the expectation that they will be primarily responsible for recruiting and orienting team members.
1.5. Make necessary meeting arrangements GOAL: To ensure that the necessary procedures are undertaken for the team is prepared to begin an effective wraparound process.	**1.5 a. Arrange meeting logistics** Facilitator integrates information gathered from all sources to arrange meeting time and location and to assure the availability of necessary supports or adaptations such as translators or child care. Meeting time and location should be accessible and comfortable, especially for the family but also for other team members. Facilitator prepares materials—including the document summarizing family members' individual and collective strengths, and their needs, culture, and vision—to be distributed to team members.	

Phases and Activities of the Wraparound Process: Phase 2

MAJOR TASKS/Goals	ACTIVITIES	NOTES
PHASE 2: Initial plan development During this phase, team trust and mutual respect are built while the team creates an initial plan of care using a high-quality planning process that reflects the wraparound principles. In particular, youth and family should feel, during this phase, that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should be completed during one or two meetings that take place within 1-2 weeks, a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's *mission* or overarching goal.		
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles	**2.1 a. Determine ground rules** Facilitator guides team in a discussion of basic ground rules, elicits additional ground rules important to team members, and facilitates discussion of how these will operate during team meetings. At a minimum, this discussion should address legal and ethical issues—including confidentiality, mandatory reporting, and other legal requirements—and how to create a safe and blame-free environment for youth/family and all team members. Ground rules are recorded in team documentation and distributed to members.	In this activity, the team members define their collective expectations for team interaction and collaboration. These expectations, as written into the ground rules, should reflect the principles of wraparound. For example, the principles stress that interactions should promote family and youth voice and choice and should reflect a strengths orientation. The principles also stress that important decisions are made within the team.
	2.1 b. Describe and document strengths Facilitator presents strengths from the summary document prepared during phase 1, and elicits feedback and additional strengths, including strengths of team members and community.	While strengths are highlighted during this activity, the wraparound process features a strengths orientation throughout.
	2.1 c. Create team mission Facilitator reviews youth and family's vision and leads team in setting a *team mission*, introducing idea that this is the overarching goal that will guide the team through phases and, ultimately, through transition from formal wraparound.	The team mission is the collaboratively set, long-term goal that provides a one or two sentence summary of what the team is working towards.

MAJOR TASKS/Goals	ACTIVITIES	NOTES
	2.1 d. Describe and prioritize needs/goals Facilitator guides the team in reviewing needs and adding to list. The facilitator then guides the team in prioritizing a small number of needs that the youth, family, and team want to work on first, and that they feel will help the team achieve the mission.	The elicitation and prioritization of needs is often viewed as one of the most crucial and difficult activities of the wraparound process. The team must ensure that needs are considered broadly, and that the prioritization of needs reflects youth and family views about what is most important. Needs are not services but rather broader statements related to the underlying conditions that, if addressed, will lead to the accomplishment of the mission.
	2.1 e. Determine goals and associated outcomes and indicators for each goal Facilitator guides team in discussing a specific goal or outcome that will represent success in meeting each need that the team has chosen to work on. Facilitator guides the team in deciding how the outcome will be assessed, including specific indicators and how frequently they will be measured.	Depending on the need being considered, multiple goals or outcomes may be determined. Similarly, for each goal or outcome determined by the team for measurement, multiple indicators may be chosen to be tracked by the team. However, the plan should not include so many goals, outcomes, or indicators that team members become overwhelmed or tracking of progress becomes difficult.
	2.1 f. Select strategies Facilitator guides the team in a process to think in a creative and open-ended manner about strategies for meeting needs and achieving outcomes. The facilitator 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/incorporate strengths; and the extent to which they are consistent with family culture and values. When evaluating more formal service and support options, facilitator aids team in acquiring information about and /or considering the evidence base for relevant options.	This activity emphasizes creative problem solving, usually through brainstorming or other techniques, with the team considering the full range of available resources as they come up with strategies to meet needs and achieve outcomes. Importantly, this includes generating strategy options that extend beyond formal services and reach families through other avenues and time frames. These are frequently brainstormed by the team, with the youth and family and people representing their interpersonal and community connections being primary nominators of such supports. Finally, in order to best consider the evidence base for potential strategies or supports, it may be useful for a wraparound team or program to have access to and gain counsel from a point person who is well-informed on the evidence base.

MAJOR TASKS/Goals	ACTIVITIES	NOTES
	2.1 g. Assign action steps Team assigns responsibility for undertaking action steps associated with each strategy to specific individuals and within a particular time frame.	Action steps are the separate small activities that are needed to put a strategy into place, for example, making a phone call, transporting a child, working with a family member, finding out more information, attending a support meeting, arranging an appointment. While all team members will not necessarily participate at the same level, all team members should be responsible for carrying out action steps. Care should be taken to ensure that individual team members, particularly the youth and family, are not overtaxed by the number of action steps they are assigned.
2.2. Develop crisis/safety plan GOAL: To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified *crisis prevention and response* plan that is consistent with the wraparound principles. A more proactive *safety plan* may also be created.	**2.2 a. Determine potential serious risks** Facilitator guides the team in a discussion of how to maintain the safety of all family members and things that could potentially go wrong, followed by a process of prioritization based on seriousness and likelihood of occurrence.	Past crises, and the outcomes of strategies used to manage them, are often an important source of information in current crisis/safety planning.
	2.2 b. Create crisis/safety plan In order of priority, the facilitator guides team in discussion of each serious risk identified. The discussion includes safety needs or concerns and potential crisis situations, including antecedents and associated strategies for preventing each potential type of crisis, as well as potential responses for each type of crisis. Specific roles and responsibilities are created for team members. This information is documented in a written *crisis plan*. Some teams may also undertake steps to create a separate *safety plan*, which specifies all the ways in which the wraparound plan addresses potential safety issues.	One potential difficulty with this activity is the identification of a large number of crises or safety issues can mean that the crisis/safety plan "takes over" from the wraparound plan. The team thus needs to balance the need to address all risks that are deemed serious with the need to maintain focus on the larger wraparound plan as well as youth, family, and team strengths.
2.3. Complete necessary documentation and logistics	**2.3 a. Complete documentation and logistics** Facilitator guides team in setting meeting schedule and determining means of contacting team members and distributing documentation to team members	

Phases and Activities of the Wraparound Process: Phase 3

MAJOR TASKS/Goals	ACTIVITIES	NOTES
PHASE 3: Implementation During this phase, the initial wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal wraparound is no longer needed.		
3.1. Implement the wraparound plan GOAL: To implement the initial plan of care, monitoring completion of action steps and strategies and their success in meeting need and achieving outcomes in a manner consistent with the wraparound principles.	**3.1 a. Implement action steps for each strategy** For each strategy in the wraparound plan, team members undertake action steps for which they are responsible. Facilitator aids completion of action steps by checking in and following up with team members; educating providers and other system and community representatives about wraparound as needed; and identifying and obtaining necessary resources.	The level of need for educating providers and other system and community representatives about wraparound varies considerably from one community to another. Where communities are new to the type of collaboration required by wraparound, getting provider "buy in" can be very difficult and time consuming for facilitators. Agencies implementing wraparound should be aware of these demands and be prepared to devote sufficient time, resources, and support to this need.
	3.1 b. Track progress on action steps Team monitors progress on the action steps for each strategy in the plan, tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the plan, and the completion of the requirements of any particular intervention.	Using the timelines associated with the action steps, the team tracks progress. When steps do not occur, teams can profit from examining the reasons why not. For example, teams may find that the person responsible needs additional support or resources to carry out the action step, or, alternatively, that different actions are necessary.
	3.1 c. Evaluate success of strategies Using the outcomes/indicators associated with each need, the facilitator guides the team in evaluating whether selected strategies are helping team meet the youth and family's needs.	Evaluation should happen at regular intervals. Exactly how frequently may be determined by program policies and/or the nature of the needs/goals. The process of evaluation should also help the team maintain focus on the "big picture" defined by the team's mission: Are these strategies, by meeting needs, helping achieve the mission?

MAJOR TASKS/Goals	ACTIVITIES	NOTES
	3.1. d. Celebrate successes The facilitator encourages the team to acknowledge and celebrate successes, such as when progress has been made on action steps, when outcomes or indicators of success have been achieved, or when positive events or achievements occur.	Acknowledging success is one way of maintaining a focus on the strengths and capacity of the team and its members. Successes do not have to be "big", nor do they necessarily have to result directly from the team plan. Some teams make recognition of "what's gone right" a part of each meeting.
3.2. Revisit and update the plan GOAL: To use a high quality team process to ensure that the wraparound plan is continually revisited and updated to respond to the successes of initial strategies and the need for new strategies.	**3.2. a. Consider new strategies as necessary** When the team determines that strategies for meeting needs are not working, or when new needs are prioritized, the facilitator guides the team in a process of considering new strategies and action steps using the process described in activities 2.1.f and 2.1.g.	Revising of the plan takes place in the context of the needs identified in 2.1.d. Since the needs are in turn connected to the mission, the mission helps to guide evaluation and plan revisions.
3.3. Maintain/build team cohesiveness and trust GOAL: To maintain awareness of team members' satisfaction with and "buy-in" to the process, and take steps to maintain or build team cohesiveness and trust.	**3.3 a. Maintain awareness of team members' satisfaction and "buy-in"** Facilitator makes use of available information (e.g., informal chats, team feedback, surveys—if available) to assess team members' satisfaction with and commitment to the team process and plan, and shares this information with the team as appropriate. Facilitator welcomes and orients new team members who may be added to the team as the process unfolds.	Many teams maintain formal or informal processes for addressing team member engagement or "buy in", e.g. periodic surveys or an end-of-meeting wrap-up activity. In addition, youth and family members should be frequently consulted about their satisfaction with the team's work and whether they believe it is achieving progress toward their long-term vision, especially after major strategizing sessions. In general, however, this focus on assessing the process of teamwork should not eclipse the overall evaluation that is keyed to meeting identified needs and achieving the team mission.
	3.3 b. Address issues of team cohesiveness and trust Making use of available information, facilitator helps team maintain cohesiveness and satisfaction (e.g., by continually educating team members—including new team members—about wraparound principles and activities, and/or by guiding team in procedures to understand and manage disagreement, conflict, or dissatisfaction).	Teams will vary in the extent to which issues of cohesiveness and trust arise. Often, difficulties in this area arise from one or more team members' perceptions that the team's work—and/or the overall mission or needs being currently addressed—is not addressing the youth and family's "real" needs. This points to the importance of careful work in deriving the needs and mission in the first place, since shared goals are essential to maintaining team cohesiveness over time.

MAJOR TASKS/Goals	ACTIVITIES	NOTES
3.4. Complete necessary documentation and logistics	**3.4 a. Complete documentation and logistics** Facilitator maintains/updates the plan and maintains and distributes meeting minutes. Team documentation should record completion of action steps, team attendance, use of formal and informal services and supports, and expenditures. Facilitator documents results of reviews of progress, successes, and changes to the team and plan. Facilitator guides team in revising meeting logistics as necessary and distributes documentation to team members.	Team documentation should be kept current and updated, and should be distributed to and/or available to all team members in a timely fashion.

MAJOR TASKS/Goals	ACTIVITIES	NOTES
4.2. Create a "commencement" GOAL: To ensure that the cessation of formal wraparound is conducted in a way that celebrates successes and frames transition proactively and positively.	**4.2 a. Document the team's work** Facilitator guides team in creating a document that describes the strengths of the youth/child, family, and team members, and lessons learned about strategies that worked well and those that did not work so well. Team participates in preparing/reviewing necessary final reports (e.g., to court or participating providers, where necessary)	This creates a package of information that can be useful in the future.
	4.2 b. Celebrate success Facilitator encourages team to create and/or participate in a culturally appropriate "commencement" celebration that is meaningful to the youth/child, family, and team, and that recognizes their accomplishments.	This activity may be considered optional. Youth/child and family should feel that they are ready to transition from formal wraparound, and it is important that "graduation" is not constructed by systems primarily as a way to get families out of services.
4.3. Follow-up with the family GOAL: To ensure that the family is continuing to experience success after wraparound and to provide support if necessary.	**4.3 a. Check in with family** Facilitator leads team in creating a procedure for checking in with the youth and family periodically after commencement. If new needs have emerged that require a formal response, facilitator and/or other team members may aid the family in accessing appropriate services, possibly including a reconvening of the wraparound team.	The check-in procedure can be done impersonally (e.g., through questionnaires) or through contact initiated at agreed-upon intervals either by the youth or family, or by another team member.

Phases and Activities of the Wraparound Process: Phase 4

MAJOR TASKS/Goals	ACTIVITIES	NOTES
PHASE 4: Transition During this phase, plans are made for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities.		
4.1. Plan for cessation of formal wraparound GOAL: To plan a purposeful transition out of formal wraparound in a way that is consistent with the wraparound principles, and that supports the youth and family in maintaining the positive outcomes achieved in the wraparound process.	**4.1 a. Create a transition plan** Facilitator guides the team in focusing on the transition from wraparound, reviewing strengths and needs and identifying services and supports to meet needs that will persist past formal wraparound.	Preparation for transition begins early in the wraparound process, but intensifies as team meets needs and moves towards achieving the mission. While formal supports and services may be needed post-transition, the team is attentive to the need for developing a sustainable system of supports that is not dependent on formal wraparound. Teams may decide to continue wraparound—or a variation of wraparound—even after it is no longer being provided as a formal service.
	4.1 b. Create a post-transition crisis management plan Facilitator guides the team in creating post-wraparound crisis management plan that includes action steps, specific responsibilities, and communication protocols. Planning may include rehearsing responses to crises and creating linkage to post-wraparound crisis resources.	At this point in transition, youth and family members, together with their continuing supports, should have acquired skills and knowledge in how to manage crises. Post-transition crisis management planning should acknowledge and capitalize on this increased knowledge and strengthened support system. This activity will likely include identification of access points and entitlements for formal services that may be used following formal wraparound.
	4.1 c. Modify wraparound process to reflect transition New members may be added to the team to reflect identified post-transition strategies, services, and supports. The team discusses responses to potential future situations, including crises, and negotiates the nature of each team member's post-wraparound participation with the team/family. Formal wraparound team meetings reduce frequency and ultimately cease.	Teams may continue to meet using a wraparound process (or other process or format) even after formal wraparound has ended. Should teamwork continue, family members and youth, or other supports, will likely take on some or all of the facilitation and coordination activities.