

MONROE COUNTY ACCESS

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ABSTRACT

The Monroe County Office of Mental Health, in partnership with families and youth, child serving systems and grassroots community organizations, proposes to transform all aspects of mental health care for children and youth having serious emotional disturbances (SED), and their families, throughout Monroe County, New York. This transformation will address disparities in services to children and families who have been traditionally underserved, integrate services for children having multi-system involvement, and foster independence, self-management, and smooth transitions to and from care for older youth.

The proposed project, Monroe County ACCESS (Achieving Culturally Competent Effective Services and Supports), creates the infrastructure, service delivery, and financing reforms necessary to sustain a system of care that is family driven, youth-guided, culturally relevant, and based upon sound scientific evidence. At the systems level, families and youth will serve on the Governing Board and its four Councils: Family, Youth, Cultural Competence, Research to Practice. Recruiting significant numbers of families and youth from diverse racial and ethnic backgrounds to serve in these roles will be a priority, and the project co-director will be a family member. At the service delivery level, children and families will partner with care coordinators in building upon strengths and selecting the services and supports appropriate to their needs. At the program evaluation level, youth and families will work with the evaluation team to assure that all tools, methods, and analyses are family-friendly and appropriately reflect core values.

Through social marketing, it is anticipated that children and families will access services earlier, and through the implementation of evidenced-based practices, develop the skills and supports needed to maintain wellness. Care coordinators will engage children and families in a Child and Family Team process, using a wraparound approach, to build upon strengths and create an individualized plan of care, using flexible funds to support their unique service and support needs. The outcomes of system transformation include, but are not limited to: earlier access to mental health treatment, especially for children and families of color; an expanded array of community supports; reduced costs for intensive mental health services and out of home placements; improved linkages; and greater independence and functioning among young adults.

The key to enduring transformation is the ability to sustain the vision, values and philosophy as well as continue critical service expansions. ACCESS includes community-wide and targeted training to transform the value base of all systems. This extensive training, coupled with social marketing and ongoing sustainability planning, will ensure that ACCESS and its reforms to thrive well after graduation from the grant.

PROJECT NARRATIVE:

SECTION A: UNDERSTANDING OF THE PROJECT

Overview

The overall goal of Monroe County ACCESS (Achieving Culturally Competent and Effective Services and Supports) is to transform all aspects of mental health services delivery so that the infrastructure, values, oversight, and financing mechanisms support and sustain a culturally relevant system of care that is family-driven, youth-guided, and includes promising and evidenced-based practices. ACCESS is based upon the premise that effective transformation can only be realized and sustained by using a structured and methodical process whereby all involved must constantly ask themselves – “Are we doing it right?” Are the right voices included and heard? Are the right structures and mechanisms in place? Are the right partnerships in place? Are we using the right care delivery approaches and the right evidence-based interventions? Are we reaching the right people? Are we producing the right results? These questions must be asked at every step along the way, at every level of the system, with each strategy developed and implemented; additionally, mechanisms must be in place to make adjustments in those areas deemed to not be on the right track.

Literature Review

Communities seeking a better way to meet the needs of children with emotional and behavioral needs are beneficiaries of a twenty year long national conversation and the trustees of continued reform. In 1984, responding to a plea for attention to a fragmented and inadequate service system that relied heavily on placement (Knitzer, 1982), the Child and Adolescent Service System Program (CASSP) began supporting states to develop coordinated ‘systems of care’ (Stroul & Friedman, 1986; 1996) for youth with serious emotional disturbances (SED). The planning focus of CASSP was followed by various CMHS initiatives to assist communities to translate those plans into action and evaluate the results (National Resource Network, 1991). The Surgeon General’s Report, Call to Action (US Public Health Service 1999, 2000) and later the Blueprint for Change (US Public Health Service, 2003) summarized progress and set an agenda for continued reform with an emphasis on expanding the evidence base (Hoagwood, et al., 2001; Burns & Hoagwood, 2003; Weisz & Jensen, 1999; NYS OMH, 2005). Communities are also striving to refine the translation of system of care values (e.g., that services be non-categorical, strengths-based, culturally competent, family driven, comprehensive, individualized, and unconditional) into effective practice and policy. For example, what began as a desire to simply enable families to have input in their child’s services has evolved to a more powerful concept of family and youth driven care (Freisen & Koroloff, 1990; Heflinger & Nixon, 1996; Osher, et al., 1999). The idea that each child would benefit from individualized services has evolved to include mechanisms such as wraparound care, purchase of service with flexible funds, child and family team meetings and efforts to enhance the consistency and quality of these innovations (Bruns et al., 2004).

In Monroe County the Coordinated Children’s Services Initiative (Greene, et al, 1998; Pryor, 2002), and Youth and Family Partnership (Coordinated Care Services, Inc., 2004, 2005; Levison-Johnson, 2005) demonstrate the power of improving outcomes for children with multi-system needs (Burns et al., 1995; Quinn & Epstein, 1998; Cocozza & Skowrya, 2000; Lyons et al., 2001) by dismantling archaic barriers and unifying intake, assessment, planning, treatment, evaluation, financing and staff training across systems. Utilization data indicate that there remains a persistent gap between need (20% of youth), and utilization (5-7%) of mental health services (Friedman, et al., 1996; OTA, 1986; Burns, et al., 1995; Surgeon General, 1999). Improved outreach (Saunders, 1996), timely access and retention (Kazdin, 1997) are critical. Minority children (Hernandez et al., 1998; Surgeon General, 2001) and older adolescents (Trupin, et al., 1991; Delman and Jones, 2002; NIMH, 2001) are the least likely to receive

appropriate care and have poorer outcomes. Cultural Brokers (Goode, 2004; Heifetz & Laurie, 1997; Phillips & Crowell, 1994) and research-informed frameworks for assessing the cultural competence strengths and gaps in the system can guide reform (NCCC, 2004; US Public Health Service, 2001). In a similar way, cross system principles and specific interventions can be applied to meet the needs of older adolescents/young adults (Clark & Davis, 2000).

Thorough organizational culture change and consistent training in the techniques of wraparound care planning and team facilitation (across systems) increases the odds of making best-practices standard practice (Bruns and Walker, 2003; Koroloff, et al., 2003). Extensive training, over several years, will increase the likelihood that staff fully understand new culture concepts and gain the skills to operationalize the concepts to achieve improved outcomes (Schein, 2004). Monroe County has been proactive through the evolution of system reform and is poised to continue to challenge assumptions, redirect resources, connect with the evidence base, modify for special populations, and use results to continue to improve the system to support recovery and positive outcomes for all children, and their families.

Target Population

The target population for the ACCESS Initiative will be: all children, youth, and emerging adults (hereafter often referred to as children), **ages 0 - 21**, having SED, and their families, residing in Monroe County, New York. These children will have a diagnosable disorder according to DSM IV-TR criteria (APA, 2000), with at least moderate functional impairment in two life areas. While it is expected that all children and their families will benefit from the planned infrastructure, service delivery and financing reforms emphasis will be given to subpopulations that have been underserved or not served in a comprehensive manner in any of the child serving systems. Targeted subpopulations of SED children and their families include:

- Children, ages 0 – 21, who are of African American or Latino descent;
- Children, ages 0 -18, who are involved in multiple child and family serving systems;
- Youth and emerging adults, ages 14 - 21, who are transitioning to or from care.

Prevalence: In developing estimates regarding the prevalence of children with SED within New York State, the NYS Office of Mental Health uses prevalence rates as reported by SAMHSA's National Mental Health Information Center, Center for Mental Health Services (CMHS, Federal Register, Vol. 63, No.137). These data suggest that 12% of children between the ages of 9 and 17 have a serious emotional disturbance. If this rate is applied to 2000 census data for Monroe County, which shows a total of 96,960 children within this age range, it suggests that there are approximately **11,635** children ages 9-17 with SED. NYS OMH uses the adult prevalence as reported in the Surgeon General's Report (US Public Health Service, 1999) to estimate prevalence among those ages 18-21. These data suggest that 2.6% of the adult population have a serious and persistent mental illness. If this rate is applied to the 2000 census data for Monroe County, which shows a total of 42,543 young adults within this age range, it suggests there are approximately **1,106** young adults ages 18-21 with a serious mental illness.

Racial/Ethnic: Monroe County is an urban county located in upstate New York. The County's population totals 735,343 residents, of which 79.1% are white, 13.7% African American, 2.4% Asian and 6% other or multi-racial, with 5.3% of the population being Hispanic or Latino. The main urban center, the City of Rochester has a population of 219,773, which in contrast is 48.3% white, 38.5% African American, 2.2% Asian and 10.9% other or multi-racial, with 12.8% of the population being Hispanic or Latino. The Hispanic population in the County has grown 145% between 1990 and 2000. Over 70% of the Hispanic population is of Puerto Rican descent. (US Census, 2000). There are 182,256 children under the age of 18 and 42,543 young adults ages 18 to 21 residing in Monroe County, closely split by **gender**.

Language/Immigration: Close to 49,000 residents of Monroe County were born outside of the United States, with 42% born in Europe, 31% in Asia and 16% in Latin America. Close to half (46%) of the Asian born and over one third (37%) of Latin American born entered the country between 1990 and 2000. Nearly 20% of the City's children and families speak a language other than English at home, with Spanish being the most frequent, followed by Asian and Eastern European/Slavic dialects. Although by numbers, those who speak Spanish comprise the largest group of linguistically isolated households, 37% of Asian speaking households and 30% of households speaking other languages are linguistically isolated. (US Census, 2000)

Demographics/Disability: The median **income** in 2000 for families in the County (\$44,891) is 1.7 times higher than that of families in the City (\$27,123). According to a recent report for the American City Business Journals, the Rochester metropolitan area ranks 5th in the country among 47 metropolitan areas for **income disparity** between whites and African Americans. The Children's Defense Fund ranks Rochester 11th in the nation for child poverty; with nearly 23,000 children living below the poverty level. Sixty-three percent of children under the age of 18 in the City live in single parent households, the overwhelming majority of which are headed by a female; over half of these households are below the poverty level. In 2001, 85% of City School district children were eligible for the free or reduced price lunch program. The rate of child abuse reports of 28.0 per 1,000 children in the County exceeds that of comparison counties in New York State, with a 6% increase in Child Protective Services (CPS) Reports from 2003-2004. The rate of indicated CPS reports has increased as well and 13.2% of children who were victims of child abuse and/or neglect in the first 6 months of 2002 had another substantiated or indicated report within 6 months. There are 19 school districts in Monroe County, with a total of 1,593 students classified as emotionally disturbed in the 2002/03 school year. The majority of these students were from the Rochester City School District. In 2004, 342 youth with a serious emotional disturbance were enrolled in mental health day treatment programs. In the 2002/03 school year only **18% of City School District students met the 8th grade English language standards**, as opposed to 58% in other County school districts. (Child & Family Services Plan, 2004; Monroe County BHCD, 2004; US Census, 2000).

Out-of-Home/Service Disparities: There were 1,659 children placed in foster care in 2003, with the county having one of the highest in-care rates among comparable counties in New York State (3.9/1,000). One-third of these placements were to congregate care. Of the children placed, 45% were African American and 8.4% Hispanic. Children in foster care tend to be older, with 36% ages 14-17 and 20% ages 10-13. In the juvenile justice system, 127 youth were placed out-of-home as juvenile delinquents (2002) and 119 as PINS (2003). Minority youth were disproportionately represented among those placed, with 72% of juvenile delinquent and 65% of PINS placements being African American. Mental health was indicated as a presenting need for close to one-third of juvenile delinquent placements, with substance abuse indicated for over half. This population tends to be male (81%), ages 15 and over. The Children's Detention Center, a secure detention facility, served 702 children in 2003. Those served were predominantly male (77%), African American (75%) and ages 14 and 15 (67%). (MCDHS, 2005; MCDHS ICP, 2004). School districts placed 60 youth in out-of-home settings in school year 2002-03, with 5 being placed out of state. As of May 2005, there were 35 children residing in mental health residential treatment facilities, with 4 residing in facilities outside of the county (NYS ED, NYS OMH).

Referrals: It is anticipated that referrals to ACCESS will come from a broad range of sources. ACCESS will be structured with community-based access sites, coupled with aggressive social marketing and outreach to reach families, neighborhood, religious and community-based organizations, pediatricians, schools and others who come into contact with young people. It is expected that by the end of the grant period 1,000 children will be served annually. Of the 1000

referrals projected annually, 10% will be directly from families, 30% will be from child welfare, 15% from juvenile justice, 10% from schools, 10% from community providers and 25% from mental health providers.

Current Capacity

Table A: Mental Health Services Participant Characteristics, January- December 2004

Service Type	Age	Total # Served	*W %	*AA %	*H %	SED # Served	W %	AA %	H %
Crisis/Emergency (ER, Crisis residence, mobile crisis, HBCI)	0-17	1,745	58%	28%	10%	602	57%	29%	9%
	18-21	759	63%	24%	10%	217	57%	30%	9%
Inpatient (Acute, intermediate)	0-17	394	65%	24%	7%	256	63%	25%	7%
	18-21	236	55%	30%	11%	149	54%	30%	10%
Residential (RTF, Family-based treatment, community residence, family care)	0-17	68	66%	25%	3%	68	66%	25%	3%
	18-21	38	61%	24%	11%	37	62%	22%	11%
Outpatient (Clinic, day treatment, partial, psych rehab.)	0-17	5,628	53%	31%	11%	1,129	55%	30%	10%
	18-21	1,381	61%	22%	12%	430	57%	25%	13%
Community Support (Family support, respite, advocacy, vocational)	0-17	290	57%	28%	9%	134	55%	25%	12%
	18-21	89	45%	42%	8%	54	44%	43%	9%
Case Management (intensive, supportive, waiver, ACT, other)	0-17	294	54%	28%	11%	284	55%	27%	11%
	18-21	133	46%	38%	12%	115	50%	36%	10%
Unduplicated Total	0-17	6,451	54%	30%	11%	1,313	56%	30%	10%
	18-21	1,799	61%	23%	11%	485	57%	26%	12%

*W = White, AA = African American, H = Hispanic (any race) Source: MCBHCD, 2004

Table A provides information on Monroe County children, ages 0-21, who received any service in the public mental health system during 2004. A total of 6,451 children ages 0-17 and 1,799 ages 18-21 (unduplicated) were served in 2004. An algorithm was created to estimate those served who may meet SED criteria, based on intensity of service utilization, diagnosis and duration of service utilization, yielding 1,798 children ages 0-21 who may be considered to be SED. Numbers served within each program are unduplicated although children may have received services within multiple service categories.

Significance

The key gaps, inadequacies and barriers are a summary obtained through an extensive planning process undertaken by the Monroe County Office of Mental Health (MCOMH). This process involved families and a wide array of community constituencies to plan for a system of care. A broad-based System of Care Task Force and related work groups (Family, Youth, Older Adolescents) were convened in 2004 to identify barriers to meeting the needs of children with SED and recommend strategies for creating a system of care. The Report issued by the Task Force (FLHSA, 2004) has been used to dialogue with community stakeholders in designing ACCESS. Ongoing planning has included work with community groups and collaboratives, analysis of data from performance management/monitoring activities, and targeted focus groups. Many of the items below are the barrier statements as expressed by families and community members during this process. Table B is a summary of gaps, barriers and inadequacies organized by their relationship to the RFA and New Freedom Commission Goals and serves as the basis for the areas necessary to be addressed by ACCESS to realize system transformation.

Table B: Gaps, Inadequacies and Barriers that Justify the Need for the Project

<p><i>New Freedom Goal (NFG): Americans Understand that Mental Health is Essential to Overall Health</i></p> <p><i>Monroe County Barriers:</i> Many families and communities do not understand mental illness; limited prevention, education and outreach; label or diagnosis required for system entry may result in reluctance to use services due to stigma; stigma limits ability to integrate children into normalized settings.</p>
<p><i>NFG: Mental Health Care is Consumer and Family Driven</i></p> <p><i>RFA: Create a care management team with an individualized service plan for each child; Promote full participation of families and youth in service planning and development of local services and supports</i></p> <p><i>Monroe County Barriers:</i> Limited family involvement at systems level; focus on “identified” child not the family; limited focus on empowerment, natural supports; few family advocates; youth not adequately prepared for adult life and/or smoothly linked to adult services; multiple entry points to services; families constantly re-tell their story; systems not designed for convenience of families; no consistent person to remain with the family over time; each system has its own mandates, eligibility criteria, reimbursement</p>
<p><i>NFG: Disparities in Mental Health Care are Eliminated</i></p> <p><i>RFA: Incorporate culturally and linguistically competent practices; eliminate disparities</i></p> <p><i>Monroe County Barriers:</i> Services not fully culturally or linguistically competent; assessment tools and services planning may not take cultural framework into account; limited number of minority providers or professional staff ; lack of culturally relevant outreach and use of non-traditional alternatives; access not culturally defined, families must get to traditional treatment sites; “family” is often narrowly defined by systems; child must fit services available rather than services being fit to the needs of child/family.</p>
<p><i>NFG: Early Mental Health Screening, Assessment and Referral to Services are Common Practice</i></p> <p><i>RFA: Expand community capacity to serve children with SED and their families</i></p> <p><i>Monroe County Barriers:</i> Systems focused on providing treatment not early identification/intervention; focus on preventing out of home placement rather than promotion of mental health; often can’t access services until child in crisis; early identification/intervention of mental illness not routinely incorporated into systems serving young children (primary care, early childhood education, child care, schools)..</p>
<p><i>NFG: Excellent Mental Health Care is Delivered and Research is Accelerated</i></p> <p><i>RFA: Provide a broad array of effective services, treatments and supports</i></p> <p><i>Monroe County Barriers:</i> Gaps in services - respite, in-home supports, youth empowerment, skillbuilding, integrated MICA treatment, care management, family advocacy, child psychiatrists, transition services for 18-21; limited use of evidence-based practices; lack of evidence based practices for minority populations; lack of funding and training to implement evidence-based practices with fidelity</p>
<p><i>NFG: Technology is Used to Access Mental Health Care and information</i></p> <p><i>Monroe County Barriers:</i> Lack of comprehensive data regarding systems effectiveness; data not integrated across systems; each has its own measures and outcomes; families & youth not routinely involved in evaluation activities; they are just evaluated, families and the community lack ready access to information; families and youth lack access to training or to develop skills to participate at all levels</p>

Collaboration with Reform Initiatives

The core elements of ACCESS will be built upon existing reform efforts and structured to be consistent with the goals of the President's New Freedom Commission and other Federal Initiatives such as Safe Schools/Healthy Students, Safe Start and Drug Free Communities. ACCESS will be linked to the New York State Office of Mental Health (NYSOMH) Coordinated Children's Services Initiative (CCSI), Single Point of Access (SPOA), "Winds of Change" and Multicultural reform initiatives. At the local level, ACCESS incorporates the Youth and Family Partnership (YFP), a multi-system wraparound service delivery initiative. In 2003, Monroe County fundamentally transformed the structure and delivery of human services. The Department of Social Services was revamped creating a new Department of Human Services which includes the Office of Mental Health, the Divisions of Child and Family Services, Financial Assistance (Medicaid and other entitlements), Special Children's Services, Adult Services and the Youth Bureau. The resulting operational efficiencies and collaboration present additional opportunities for reinvestment of much needed financial resources for improved and expanded services.

SECTION B – IMPLEMENTATION PLAN: INFRASTRUCTURE DEVELOPMENT

How Infrastructure Will be Developed

The ACCESS infrastructure will be built upon existing structures and initiatives: the Coordinated Children's Services Initiative (CCSI), the Youth and Family Partnership (YFP), the Single Point of Access (SPOA) for mental health services for high need children with SED, the Monroe County Cultural Competence Initiative and an active family support organization. These structures will be enhanced and united to form the infrastructure for ACCESS.

CCSI will serve as the foundation for systems integration and interagency collaboration. CCSI is a statewide initiative supported by an interagency collaborative body (Tier III) at the state level. The county level Tier II interagency team will be expanded to incorporate additional family members, youths, representatives from racial/ethnic minority communities and a wider array of systems and will serve as the Governing Body for ACCESS. YFP will serve as the foundation for transforming service delivery to a Child and Family Team approach. YFP was begun in 2002 under CCSI direction as a local interagency-funded wraparound initiative for youth receiving services from mental health, child welfare and juvenile justice. YFP has an extensive training component and integrated operating protocols. ACCESS will expand this wraparound model to serve all children with SED.

In Monroe County, leadership for family involvement comes from Better Days Ahead (BDA), a family support organization. BDA partners with other local family support programs and family advocates for individual and systems advocacy activities. ACCESS will fund BDA to further develop their capacity to act as the catalyst for increased family and youth involvement and to employ the ACCESS Key Family Contact/Project Co-Director and Youth Coordinators. The purpose of the MCOMH Cultural Competence Initiative is to improve the cultural competence of the behavioral health system. The initiative provides training and technical assistance to contract providers to assist them in meeting the CMHS Cultural Competency Standards (CMHS, 2001). Through ACCESS, this will be extended to all child-serving systems and the current Advisory Committee will serve as the Cultural Competence Council.

Governing Body

The Governing Body will have decision-making authority and be responsible for policy and oversight of ACCESS. The expanded CCSI Tier II will serve as the Governing Body. Membership will include: family members, Director of Better Days Ahead, youths, representatives from cultural/ethnic communities, Chair of the Monroe County Cultural Competence Advisory Committee, leadership from Monroe County Departments (OMH, Child

and Family Services, Youth Bureau, Probation, Health, Office of Faith-Based Initiatives, Special Children's Services), NYS Offices (Mental Health, Substance Abuse and Developmental Disabilities), educational representatives (Rochester City Schools, BOCES/suburban districts) and providers from the children's systems and adult mental health. There will be a minimum of three seats each for family members, youths and racial/ethnic community representatives. The Governing Body will include four standing Councils – Family, Youth, Cultural Competence, and Research to Practice. These Councils will be responsible for ensuring that the Strategic Plan and all policies, procedures, and structures are culturally competent and reflective of the principles of family-driven and youth-guided care. Training and mentoring will be offered to ensure that families, youth and community participants feel adequately prepared. Translation for meetings, minutes and materials will be available. Family and community members will receive stipends and be reimbursed for childcare and/or transportation. The Governing Body and its Councils will meet at times and locations that accommodate family, youth and community participants' needs.

Procedures

The Governing Body, guided by a shared vision, operating procedures and by-laws, will direct *systems integration and interagency collaboration* across ACCESS. Each agency will enter into an MOU specifying responsibilities, expectations and resource commitments. Through the strategic planning process, agencies will work to further integrate systems at all levels building from the systems integration processes established for YFP. Collaboration will be enhanced through linkages with existing cross-systems efforts in Monroe County (e.g., Monroe County Interagency Council, Behavioral Health Systems Integration Committee, School-Community Partnership Council).

Services integration will occur at the Child and Family Team (CFT) level, with the development of an individualized service plan (ISP). Interagency commitments will support the use of a wide array of services and supports in the ISP. ACCESS will provide training on the CFT process and ISP development for care coordinators in all child-serving systems and mental health and non-mental health providers to ensure integration at the practice level. A strengths-based *wraparound process* will be used for individualized care planning. *Flexible funding* will be available to support the ISP, to purchase goods and services that build on family strengths and culture (e.g., services of a faith healer) or address family needs. Flexible funding available through existing services (CCSI, waiver, YFP, case management) will be incorporated into ACCESS. Grant funding will initially supplement these funds and financing strategies for blended flexible funding will be developed over time. Protocols for use and accounting of funds will be based on existing protocols.

The Clinical Director will work with a *Care Review* Team, co-chaired by a parent and professional, to oversee ACCESS care review. This Team will implement procedures to conduct a quarterly review of a random sample of enrollees, to include: individualization of service plan, appropriateness of services and supports when compared to needs, family satisfaction and functional outcomes. Fidelity measures will be incorporated into this process. *Access* to the initiative will be through a Single Point of Access (SPOA) process. SPOA serves as the entry point to high intensity mental health services and will be expanded to serve additional families. This entry point will utilize assessment tools that are culturally appropriate, will accommodate those whose primary language is other than English through bilingual staff and/or translation and will provide materials at the client's reading level and in their preferred language and format.

Financing procedures will involve the use of funding from multiple systems to support operations and service delivery. ACCESS will be financed through a combination of grant funding and non-federal match support from the mental health and child welfare systems, along with in-kind support from substance abuse, other county departments and the community. Available funds from existing systems will be maximized for service delivery options. Existing

required and optional mental health services are financed through though a combination of Medicaid reimbursement, and state and local funds. YFP is financed through child welfare preventive funds. Flexible funds will be available to support the CFT process. The sustainability plan at the end of Section B further addresses financing strategies.

Workforce Development will include both extensive training and strategies to increase the minority professionals in the mental health field. Standards for workforce competencies will be developed by the Governing Body based upon the principles of cultural competence, family-driven/youth guided care, and individualized care planning. Training will be structured to develop these competencies in the workforce. A partnership with the University of Rochester School of Nursing has been established to develop a Child Psychiatric Nurse Practitioner program to addresses the lack of child psychiatrists in the community. Staff recruitment will focus on identifying minority candidates for key staff positions, including working with minority community organizations. MCOMH has obtained the support of **Community Leaders** from government (County Executive, County department leadership, NY State offices representatives), the private sector (United Way, behavioral health providers, child serving providers), minority community organizations (Urban League of Rochester, Puerto Rican Youth Development) and education. See Appendix 1, MOU's for the extent and diversity of community leader commitment.

Plan for Replication

Monroe County has a strong tradition of participating in dialogue at the state and national level on human services reform affording opportunities for replication. The MCOMH is a member of the NYS Conference of Local Mental Hygiene Directors, a forum for statewide dissemination. The MCOMH has already begun networking with other SOC funded communities in NYS including Erie, Albany and Westchester counties. Regional and statewide family advocacy networks will be another avenue for dissemination. The MCOMH is a participating county in the Western New York Care Coordination Project, an adult mental health systems reform initiative which has recently been awarded funding from the NYSOMH for statewide replication. Lessons learned from this hands-on replication effort will be invaluable to ACCESS replication efforts.

The NYSOMH has incorporated the system of care philosophy, values, and principles into its most recent comprehensive plan: *The 2004-2008 New York State Office of Mental Health Comprehensive Plan for Mental Health Services*. Mental health services are fiscally integrated into the statewide plan through the use of Community Mental Health Block Grant and State purposes funding to support children's mental health services. ACCESS will relate to other federal and state initiatives through cross-representation on governance structures and/or MOUs for related services including Safe Start, Safe Schools/Healthy Students, Drug Free Community Support Grants and specific SAMHSA service grants (Young Adult Offender Re-entry, Behavioral Health in Primary Care Grant). MOU's are included in Appendix 1.

Strategies for Developing Structures

The Governing Body will guide the development of structures to support ACCESS. Key staff of the *Administrative Team* will work with a cadre of expert consultants and the Governing Body to develop the structures, convening task-oriented work groups as necessary. The Administrative Team will be responsible for project development and implementation and management of day-to-day operations. The Team will be comprised of the Principal Investigator, Project Director, Key Family Contact/Project Co-Director, Parent Partner, Youth Coordinator, Clinical Director, Technical Assistance/Social Marketing Manager, Cultural Competence Coordinator, Lead Cultural Broker, State and Local Agency Liaison and Lead Evaluator. Recruitment efforts will focus on identifying racial/ethnic minority candidates and family members for key ACCESS positions.

The current *clinical network* is comprised of an array of public mental health providers that utilize some evidence-based interventions (e.g., Functional Family Therapy, Dialectical Behavior Therapy). ACCESS will expand the use of such practices, particularly those with proven effectiveness with minority children and emerging adults. A Research-to-Practice Council will be established to identify interventions for implementation. Funds for training and support will be available to ensure practices are implemented with fidelity. Cultural competence and system of care training/technical assistance will be provided to transform the value base of the clinical network making clinical services easy to access, respectful to families, family driven, culturally responsive and part of a holistic individualized care plan. A *training capacity* is required to effect such change. The Technical Assistance/Social Marketing Manager will work with other key staff and expert consultants to assess community needs and develop training strategies. ACCESS will draw upon available resources and local training capacity in the areas of cultural competence, parent-professional partnerships, youth and family leadership and empowerment. Community Care Systems, Inc. will support the CFT facilitation training.

Performance Standards will be developed by the Project Director and Lead Evaluator, working with in-kind local experts, families, youth and community representatives. Particular attention will be paid to developing standards that are relevant to families, youth and ethnic/racial communities and measures that are sensitive to identifying racial/ethnic differential outcomes and disparities. Standards and measures will be incorporated into the local evaluation and the management information system. A *management information system* will be developed to support ACCESS administrative and service delivery functions. The Project Director will convene an MIS technical advisory group to direct this work. The group will assess the feasibility of building the MIS off existing platforms. The MIS will minimally have the capability to integrate data across systems for ACCESS enrollees and the feasibility of linking and/or integrating data across child serving systems will be explored. Attention will be paid to incorporating additional cultural indicators such as level of acculturation, recency of immigration, religion, language and other measures deemed relevant by families, youth and cultural groups. ACCESS will establish an *office in the community*, with the administrative site to be located in the City of Rochester with easy access via public transportation. Work with families will take primarily take place at other community sites. The décor and ambiance will be family friendly and culturally welcoming to reflect the ACCESS core values.

Collaboration with Other Child Serving Systems

The Governing Body, which will include participants from all relevant child-serving systems, will be the primary mechanism for collaboration. MOU's have been obtained from organizations/agencies that have agreed to be part of the Governing Body and its councils, to provide in-kind expert consultation, offer services to enrollees and/or to participate in training and evaluation. MOU's specify each organization's level of commitment to the initiative, resources available to support ACCESS including cash and/or in-kind contributions, agreement

to fully participate in evaluation activities and commitment to ensuring sustainability. MOU's will be updated annually to reflect expanded commitments.

The following MOU's and letters of agreement are included in Appendix 1: Monroe County Departments (Department of Human Services – Office of Mental Health, Youth Bureau, Child and Family Services, Financial Assistance, Early Intervention; Probation; Public Health; Office of Faith-Based Initiatives), New York State Offices (Mental Health, Mental Retardation Developmental Disabilities), School Districts (Rochester City Schools, BOCES I and II, Greece Central); NYS CCSI Tier III, Families Together in NYS, Community Providers (multiple provider agencies), Children's Institute (Evaluation), Better Days Ahead (Family Support), United Way, and multiple MOU's from expert consultants and related initiatives.

Training, Technical Assistance and Social Marketing Strategies

ACCESS will develop comprehensive technical assistance/training and social marketing plans aimed at reaching multiple stakeholders with broad-based and targeted strategies. **Training** teams will include family members, youth and racial/ethnic minorities, along with "professional" trainers. Community-wide training on ACCESS and system of care and cultural competence values and principles will be the first step. Practice level training in wraparound and the CFT process will be provided. Clinical training on implementing evidence-based practices with fidelity will be offered. Ongoing assessment of training needs through performance management and evaluation measures will determine follow-up training needs. Training will be on-going and strategies include expanding the base of training as additional constituencies and needs are identified through outreach. Train the trainer approaches will be used to perpetuate training. The TA/Social Marketing Manager will coordinate with SAMHSA and take full advantage of their technical assistance offerings.

Social marketing strategies will target multiple constituencies for the purposes of outreach, information, education, stigma reduction and soliciting support to sustain transformation. Local strategies will be coordinated with the SAMHSA National Campaign's technical assistance and other resources. The AdCouncil Rochester has donated its services to work with ACCESS to develop social marketing strategies to educate and inform the general public, including development of messages and materials that are linguistically/culturally appropriate. Indigenous community organizations and media will be used to deliver messages, such as churches, social organizations and Spanish radio. An assessment of the information needs of diverse communities will be conducted to assure integration into social marketing strategies. Targeted outreach to identified racial/ethnic communities will be conducted by family support organizations in collaboration with indigenous community organizations. Strategies will also include marketing at the policy level to legislators and policymakers to garner resources to sustain the initiative. ACCESS will make strategic use of evaluation outcome data to highlight improved child and family outcomes, cost-savings and family testimonials.

Increase Capacity and Quality of Services

ACCESS will increase the availability of key services and utilize quality improvement processes to ensure that outcomes are realized. A priority is to ensure that an array of effective services are in place to meet the needs of diverse communities. It is expected that improved utilization management and individualized care planning will result in decreased length of stay in current case management services resulting in additional children and families being served. The ISP will focus on developing a natural support network and decreasing reliance on the formal systems over time. Capacity building strategies will be employed to increase the ability of communities to support children with SED in natural environments (i.e., community recreation centers, church youth groups, scout troops). Grant funding will be used to increase capacity of certain services, with ongoing sustainability planning to incorporate these expansions into alternate funding streams.

The number of children currently served in existing key services is as follows: Case Management (ICM, SCM, Waiver): 466; Home-Based Crisis Intervention: 104; Crisis Intervention (residential and mobile): 558; Day Treatment: 359; Family Support/Respite/Advocacy: 318. Children also receive services in a number of programs not noted as key services by the RFA (see Section A, Table A for breakdown of children served by key service category). ACCESS will increase service capacity in the key areas below. (Note that the capacity growth rate decreases in Years 5 and 6 based on sustainability projections outlined later Section B.)

Care Coordination and Family Advocacy Capacity: By the end of the grant period, the annual capacity for these services will be **561** children and families. Grant funding and in-kind match will support an increase 225 slots (Y2 – 45; Y3 –60; Y4 – 60; Y5 – 45; Y6 – 15). An additional 20 Home and Community Based Waiver slots will be funded through the county. The total care coordination capacity includes conversion of existing case management programs to a care coordination model and 100 slots for the YFP program.

Individualized Services and Supports: By the end of the grant period, individualized services and supports (respite, family support, skill-building, mentoring) will be available for **1,000** children and families. Projection assumes that all children receiving care coordination will additionally receive at least one individualized support. Based upon the experience of the SPOA, many families with SED children do not need/desire care coordination services, but simply are seeking additional supports. This capacity increase assumes approximately 500 families per year will seek such supports.

Other: As ACCESS evolves, it is expected that additional capacity for home-based and crisis residential services will increase in response to family needs.

The *quality* of services will be improved through an extensive performance management/quality improvement process driven by the current performance management activities of the MCOMH. Areas to be incorporated include: functional outcomes, child and family satisfaction, access (timeliness, racial/ethnic disparities, sources of referral), adherence to individualized care principles (strengths based indicators, family/youth involvement, recognition of culture, use of natural community supports in the ISP), evidence-based practices, emergency and inpatient services, out-of-home placement and retention in community-based services.

Participation in Development of Implementation Plan

The development of this plan is based upon an extensive involvement by all stakeholders in a variety of activities aimed at hearing and reflecting their voices in the design of ACCESS. The Monroe County System of Care Task Force was convened in March 2004 charged with identifying barriers to meeting the needs of children with SED and their families and recommending strategies for the design of a system of care. Membership included families, *community leaders* (United Way, Medical Insurers, Medical Society), *state and local child serving systems* leadership (NYS and Monroe County Offices), providers from a variety of systems serving children, and organizations from communities of color. A Family Work Group, Older Adolescent Work Group and a Youth Work Group contributed to the Task Force's findings. The Task Force Report (FLHSA, 2004) has been presented to numerous community groups for further dialogue. Several community forums have been held to address specific issues including access, waiting lists for services and emergency/crisis response. An assessment of the Single Point of Access (SPOA) process was conducted in late 2003, including community forums related to improving the design of this entry point for services. The recommendations generated by the Task Force, its work groups, the SPOA assessment and community forums are integrated into the design of ACCESS.

Obtaining meaningful participation of *family members* and family run organizations was essential. The Task Force included family members and the Family Work Group served to

broaden the voice of families. Ongoing meetings have been held with Better Days Ahead and the Family Advocates Network Support, a group of family advocates from a variety of provider agencies in the community. The MCOMH Parent Partner has been involved and has been a co-presenter to community groups. The design of ACCESS was improved by family involvement and input. A *Youth* Work Group conducted and/or arranged for focus groups with child and youth recipients of services. Through Better Days Ahead, youth were invited to participate in planning sessions and the SAMHSA technical assistance calls related to youth-guided care. Strategies to further foster youth involvement are delineated in the service delivery section.

The Monroe County *Cultural Competence* Advisory Committee has been actively involved in the cultural competence activities that will be incorporated into ACCESS. This committee will serve as the Cultural Competence Council for ACCESS. The leader of the County's Cultural Competence Initiative, Lenora Reid-Rose, has been actively involved in developing this application. Targeted discussions related to ACCESS have been held with community minority agencies (e.g., Urban League of Rochester, Puerto Rican Youth Development) and their commitment is reflected in the attached MOU's.

Nonfederal Match Dollars:

Monroe County will be contributing approximately \$1.7 million in non-federal in-kind match dollars in Year 1. These funds are comprised of \$1.47 million in child welfare Preventive funds (65% state/35% county) to support care coordination capacity increases and \$227,000 in mental health funds (59% state/41% county) to support the core infrastructure. The value of in-kind expert consultant time from universities, substance abuse, private agencies and other County departments is not included in this match.

SECTION B: SERVICE DELIVERY

Eligibility Criteria, Referral Sources, And Enrollment Procedures:

All children ages 0-21 who have a serious emotional disturbance (SED) and their families will be eligible for ACCESS. Children will have a diagnosable disturbance on Axis I according to DSM-IV-TR criteria and evidence at least moderate impairment in a minimum of two functional areas (self care, family life, social relationships, self-direction and/or learning ability). Outreach efforts will engage underserved/less effectively served African-American and Latino families. ACCESS will enhance capacity to more appropriately serve youth and emerging adults ages 14-21 who are in recovery and/or transitioning to adult services. Integrating the successful Youth and Family Partnership (YFP) model, ACCESS will continue to serve youth up to age 18 served by multiple systems.

The Single Point of Access (SPOA), which has been the entry point to high intensity mental health services, will serve as the intake point for ACCESS. Referrals to SPOA come from mental health providers and to a lesser degree from probation, the child welfare system and families whereas YFP referrals originate in the juvenile justice and child welfare systems. Aggressive outreach and social marketing efforts have already begun to broaden the referral base to SPOA to include pediatricians, neighborhood-based centers, schools and others.

ACCESS intake will be centrally located in the community at hours convenient for families. At initial contact, families will be provided with information at their literacy level, in their language and in different formats that explains the enrollment process. Staff will use culturally appropriate assessment methods and review of SED criteria for eligibility. Those meeting SED criteria will be enrolled in ACCESS. From this assessment and the expressed wishes of the family and youth, families will be linked to a care coordinator and family advocate to begin the development of a Child and Family Team (CFT). Those who do not meet SED criteria will be linked to other appropriate resources which will allow families to experience the "no-reject" and unconditional care approach that is Monroe County's vision.

Service Provision Components

Required Mental Health Services: The mental health system includes all of the services required in the RFA. ACCESS enrollees will have priority access to these services. The Monroe County Children's System of Care (SOC) Task Force Report (2004) identified community priorities for increased capacity for skill-building and care management. The current complement of respite, in and out of home and overnight options, will be expanded. Through the use of grant funding, additional care coordination capacity will be developed in Year 1 (Y1) and Year 2 (Y2) to reduce extensive waiting lists. Expansion of in-home therapies such as Functional Family Therapy (FFT), Home Based Crisis Intervention (HBCI) and the development of Multi-Systemic Therapy (MST) and other services will be a priority during the initial years of funding. These evidence-based interventions have proven effective with the targeted subpopulations. Other evidence-based and promising practices will be selected (Y1) and implemented (Y2 & 3), including practices for African American and Latino youths and families. During Y1, partnerships will be developed with grassroots and indigenous communities so that culturally-based advocacy and alternative and traditional healing practices for all racial/ethnic minorities are integrated into individualized service plan (ISP). Assuring seamless transitions between the child and adult systems at developmentally appropriate times will be a focus. ACCESS will promote self-care for youth and establish procedures for the transition to adult services, when indicated. With an emphasis on recovery, self-management and community integration, it is likely that fewer will require transition to adult services. Linkages are also being developed with the local social services unit responsible for transition planning for foster children.

Optional Services: To enhance use of optional services, an extensive training initiative will develop the capacity of child-serving staff from all systems at all levels to fully embrace a strengths orientation and culturally appropriate attitudes, assessment and intervention strategies. Consistent with SOC values, all will be introduced to the recovery orientation, concepts of hope and resilience. To more effectively meet the needs of those whose primary language is not English, a cadre of interpreters will be trained using the "Mental Health Interpreting: A Mentored Curriculum" developed by Dr. Robert Pollard. As evidence-based/promising practices are identified in Y1, training strategies for implementation of selected practices in Y2 and 3 will be developed. ACCESS will expand mentoring and recreational programs to create opportunities for integration of ACCESS enrollees into normalized environments. A pool of flexible dollars will be available for use for other needs identified by the CFT. Community-based residential options (e.g., crisis residence, short-term group homes and therapeutic foster care) will be expanded to support the continued engagement of youth with their existing educational program and community-based services. ACCESS will use crisis residential services currently available through Youth Emergency Services (YES), a collaboration of six agencies, to meet this need. Expansion of these services will initially be funded through a mix of grant funding, reinvested mental health allocations and insurance reimbursement.

Non-mental health services: Monroe County has a full range of *substance abuse treatment* for youth including outpatient, intensive outpatient, residential and inpatient care funded by the Office of Alcohol and Substance Abuse Services (OASAS), Medicaid, private insurance and County deficit support. ACCESS will continue to involve substance abuse providers in all planning efforts and to offer specialized training on integrated treatment for co-occurring disorders and other evidence-based practices. Substance abuse treatment will be integrated into the Individual Services Plan (ISP) for any youth with a co-occurring disorder.

Substance abuse prevention, and more intensive intervention services, are available in schools, at specific providers, and through the juvenile justice system. During Y1, formal agreements with prevention providers will be developed to assure that enrolled youth have access to appropriate prevention services. ACCESS will also map where enrolled students live

and work with local prevention providers to assure that resources are available in these areas. Each ISP will address access to prevention services. Using the expert consultant, partnerships with community based and indigenous resources will be explored Y1.

ACCESS will integrate primary care services into the ISP for *youth with chronic illnesses* using initiatives such as Unity Behavioral Health/Primary Care which provides mental health services in pediatric practices across the county, serving a high proportion of African-American and Latino families. To promote this integration, ACCESS will work closely with Unity, school-based health centers, the Department of Health, Monroe County Medical Society, American Academy of Pediatrics NY Chapter 1 and the Physician's Mental Health Task Force (comprised of pediatricians and psychiatrists). Primary care providers will be included in the CFT and reimbursement will be sought from insurers to support their participation.

ACCESS will coordinate with each child's home school district for evaluation and in-school *literacy* remediation/intervention services. During Y1, ACCESS will develop MOU's with organizations providing tutoring/literacy services such as the Urban League of Rochester, Literacy Volunteers, and the Center for Youth Services. The CFT will link youth to one of these or other school/community based resources. ACCESS will seek grant-funding and other sources of support to sustain these initiatives. ACCESS will also encourage expansion of existing *vocational* options for youth that build upon their hopes and dreams, providing opportunities to learn and earn in mainstream educational or work settings.

Monroe County has served as an implementation site for ACT (Adults and Children Together) Against Violence. ACT is a national early *violence prevention* project that raises awareness and educates parents, teachers, and others about their role in helping children learn positive social skills to avoid violence. Many of the training materials and publications are available in Spanish. ACCESS will offer ACT to early childhood providers as a prevention effort as exposure to violence has been correlated to the presence of mental health issues later in life (Eron et al., 1994). ACCESS will also partner with the Monroe County Health Department's Safe Start Initiative on violence prevention.

Key Service Activities

Delivery of Clinical Interventions

ACCESS will assure that proper *diagnosis and treatment* using DSM-IV-TR criteria and information from the cultural formulation section are obtained and integrated into the CFT. Psychiatric evaluations will be available through psychiatrists and a partnership with the University of Rochester Psychiatric Nurse Practitioner training program. The assessment process will assure attention to the life domain areas (Dennis, 1990): psychological/emotional, spiritual, cultural/ethnic, safety, medical, educational/ vocational, social, family, residential, legal and income/economics as well as the impact of substance abuse, trauma and violence. Psychological and neurological evaluations will be requested as needed. ACCESS will finalize an integrated holistic assessment conducted in full partnership with families that will meet the mandates of all systems and reduce redundancy. Resulting plans will be highly individualized and to the extent possible, include specific treatments consistent with the existing evidence-base.

ACCESS will engage families in a *community-based*, collaborative process which meets needs in the least restrictive and most clinically appropriate manner while considering the cultural context. Through the use of cultural brokers, who will serve as an intermediary and bridge cultural gaps, a thorough review of neighborhood-based options will be conducted to develop service locations that are indigenous to racial/ethnic minority communities. School-based mental health and student support centers will offer an additional alternative for care. The Mobile Crisis Team and Crisis Specialists (walk-in crisis services at scattered sites), and components of Youth Emergency Services (YES), will be integrated into ACCESS to assure that those in crisis can be served in the community.

As African-American youth are more often diagnosed with severe disorders and often first receive care through the juvenile justice system (NMHA, 2004), ACCESS will develop improved capability in the area of *gender/culturally appropriate diagnosis/assessment* to appropriately respond and divert these youth. Through training, ACCESS will enhance staff skills and comfort levels in exploring the cultural implications/attributions for behavior and understanding culturally appropriate/accurate diagnosis. Cultural brokers will inform this process through explanation of cultural practices that have implications for assessment/diagnosis. Through partnerships with local Gay, Lesbian, Bi-sexual and Transsexual organizations, the ability to better understand, more appropriately assess, and respond to issues of gender/sexual orientation will be developed. ACCESS will use analyses of diagnostic categories by race/ethnicity and gender to customize training and supervision at the practice level.

ACCESS will use broad-based *clinical training* strategies offered by teams of youth, families, racial/ethnic minorities and professionals, as according to experts, training is critical to the integration of wraparound (Meyers & Miles, 2003). Partnering with the resources allocated to the NYSOMH Western Region Evidence-Based Practice initiative, ACCESS will assist clinicians to develop skills in evidence-based practices. Expert consultants will be used in this area as the needs of the enrolled population are clarified. ACCESS will partner with local universities to enhance human service and medical curricula to improve understanding of cultural implications for diagnosis and intervention. A comprehensive coaching model in the CFT process supported by Community Care Systems, Inc. of Wisconsin (Grailer, 2004) will be integrated into ACCESS.

Monroe County currently offers *evidence-based interventions*, such as Common Sense Parenting, Incredible Years, STEP, Dialectical Behavior Therapy (DBT), and Functional Family Therapy (FFT). Capacity for services with the most promising outcomes for minority populations will be enhanced and offered in an array of community settings. Economic incentives will be considered for practices that enhance provider-client communication and trust and demonstrate outcomes for racial/ethnic minorities. A review of diagnostic information for ACCESS enrollees will provide information regarding the need for other evidence-based practices. Increased use of FFT for those with juvenile justice involvement will be a priority. Increased capacity for the provision of DBT will be a focus for those with symptoms consistent with Borderline Personality Disorder and Cognitive Behavior Therapy for those with depression and/or trauma. Discussion regarding available evidence-based approaches will be included in each CFT meeting and integrated into the ISP. Determining if differential outcomes exist for these evidence-based approaches will be a first step towards identifying evidence-based practices for expansion. Research and consultation will also be a priority to ascertain what practices have been identified as most promising for minority populations. This information will support the integration of more culturally relevant, evidence-based approaches.

Care Management Services

The *individualized* Child and Family Team (CFT) process developed by Community Care Systems, Inc. and implemented successfully by the Youth and Family Partnership (YFP) will be the standard *care coordination* practice for ACCESS. Care coordinators will engage families in a strength and cultural discovery to understand the family's unique culture, strengths and needs and drive the type and mix of services taking into account the implications of gender and cultural/linguistic aspects of receiving services. Care coordinators and family members work in partnership to identify members for their team who will be supportive and help to meet their identified needs. The care coordinator will facilitate this process and support the family in identifying resources. This approach allows the family to develop supports for themselves and reduce reliance on the care coordinator (Dunham, 2002). Care coordinators will be trained

facilitators skilled in conflict resolution. Differences of opinion will be managed within the team process while assuring family and community safety.

ACCESS will transform case management to care coordination, in which care coordinators serve as CFT facilitators and are not responsible for doing it all, as this process disempowers families and erroneously implies a families' lack of ability to do for themselves. This transformation will require a radical reconceptualization and therefore, *extensive training*. Using the expertise of MCOMH's contract management organization, Coordinated Care Services, Inc., in partnership with Community Care Systems, Inc., ACCESS will develop a *wraparound* training plan for all care coordination agencies, families and youth that includes CFT process facilitation, strengths and cultural discovery, and team and individualized plan development. Professional coaching from experts will support in vivo training, proven more effective in shifting practice behaviors (Rast & Bruns, 2003). A broader training strategy will shift all child-serving systems and providers to a more strengths-based family driven approach. Ongoing training will be offered at no cost to all stakeholders, systems and providers and include: cultural/linguistic competence, family-driven and youth-guided practice implications, developing natural/ informal supports and the use of data to support quality improvement processes at the individual practice, provider/agency, and the system levels.

Individualized Service Plans (ISP)

The *individualized service plan will be developed* through the CFT process. The initial Strengths and Cultural Discovery begins the process of strengths and needs identification. This exploration is conducted with all CFT members, is summarized by the care coordinator and shared at the CFT meeting. The team will prioritize needs and create appropriate action plans. The family, supported by the care coordinator, will share their vision and ask the team for support to achieve this vision. The path that leads them to realization of their vision will be one which is built upon their strengths and guided by all team members, who share responsibility for family success. Individualized service plans (ISP's) will be reviewed monthly and revised to reflect achievement and newly identified needs. Service Plan *Integration with IDEA Parts B& H, IEP's and Title IV-B* will occur through school or Early Intervention staff participation in the CFT and integration of the Individualized Education Plan (IEP) with the ISP. The ISP will use appropriate services available through the student's IEP including school-based social work, counseling, speech therapy, etc. ACCESS will develop consistent processes with the 19 districts to assure full integration of the IEP into the ISP. Successful relationships developed by the YFP will support this process. ACCESS will work with DHS-Division of Child and Family Services to assure that an appropriate array of resources and services, including mental health, family support, preservation and reunification are available through one integrated planning process. The current practice of integration of child welfare components into the ISP developed for the YFP will be extended and eliminate duplicative plans. If through the CFT process an identified resource includes a family support, preservation or reunification service offered under the Division of Child and Family Services, it will be ACCESS practice to integrate these providers into the CFT process. Similarly, children identified through Early Intervention will use the CFT process to construct an integrated ISP.

Components of the ISP: The SPOA team will be trained to *establish need* and confirm eligibility criteria. Once directed to ACCESS, a Care Coordinator will be assigned to begin the Strength and Cultural Discovery, through which a justification of need for service will be documented. The care coordinator, in discussions with the family and others, will provide the description of initial needs which necessitate enrollment into ACCESS. The CFT process follows a set of steps which includes *recognition of existing strengths* by all team members. This information is presented to the CFT, which begins with a review of strengths, setting the tone for

how work will be conducted. There is recognition of the strengths and abilities that the youth, family and other team members bring to the table which is then used to support them over time.

The CFT participates in a collaborative process to **develop objectives and prioritize needs**, with the family's voice, supported by the care coordinator, guiding the process. The team develops goals and objectives that are specific, appropriate, attainable and measurable. The objectives **build on the family's strengths** by using them to meet needs. The CFT will engage in **a methodology for meeting objectives**, brainstorming solutions that build on strengths to meet needs. All answers to the question, "what will it take to keep this child safely in the community?" are considered. During the final decision-making process, the family as expert, with support from the team, selects strategies that fit their way of thinking most consistently. In an ideal team process, the methods pull from the strengths of the entire team and each team member assumes collective ownership over the plan and the outcomes. The probability for success increases as families are supported through varied methods and feel their support system "wrap around" them. **Provision of non-mental health services** that are identified as critical will be subsidized through third party reimbursement and other flexible funds. Teams will have access to a cultural broker to facilitate community linkages. The process will be holistic and address family needs in all life domains. If service needs are identified in other areas (e.g., physical health, substance abuse, financial or employment services) the responsibility for resource linkages will be determined by the team.

Upon meeting eligibility criteria for ACCESS, youth and families will be enrolled into one of four care coordination services, be assigned a Care Coordinator, and begin to develop the CFT. The determination of a **care management lead agency** for the family will be based on an assessment of several factors including: family preference, multi-system involvement, intensity of need, and cultural/linguistic needs. CFT meetings will be held on a monthly basis and provide the forum for **ISP plan review and revision**. At a minimum, a new individualized service plan which builds on the strengths and lessons learned in previous plans, will be committed to writing every 90 days. Each care coordination entity will engage in their own **quality assurance review process**. Consistent standards will be developed by the Care Review team. The Clinical Director will lead a process for quality assurance reviews of all care coordination providers quarterly. Utilization of standardized assessment tools developed by Community Care Systems, Inc. or Florida Mental Health Institute's System of Care Practice Review (Hernandez, 2005) will be used to assess family's perceptions of the CFT process and resulting service mix.

All youth and families will have the opportunity to **grieve or appeal** decisions. Families will be encouraged to seek resolution within the CFT process with the support of a Family or Youth Advocate. All families will also have the option to contact the ACCESS Clinical Director, the Key Family Contact/Project Co-Director or Youth Coordinator, who will be required to research and review the complaint and seek methods for resolution. If necessary, a Special Review Team may be convened that incorporates supports as requested by the youth/ family and other appropriate parties to seek resolution. The process will assure that youth and families feel supported and may include the use of culturally diverse family partnerships to support this resolution. As ACCESS will be family driven and youth guided, it is hoped that formal grievances can be minimized as family and youth voice will be a constant presence guiding the team to mutually acceptable solutions that adequately address needs.

Family-Driven Care

Families and **family partnerships have been involved in the design and evaluation** of CCSI, YFP, and SPOA and have been at the table informing the design of ACCESS, helping to identify barriers and create solutions to meet needs. ACCESS will continue to cement partnerships with families through the full-time Key Family Contact/Project Co-Director, hiring and training additional family advocates through Better Days Ahead (BDA), partnering with

parents on all training, forming the Family Council, assuring participation with a minimum of three family members on the Governing Body, using families to design the evaluation and collect data, and having family members co-chair councils.

BDA, a *parent-run support organization*, is a member of the Federation of Families for Children's Mental Health, providing support groups, respite services, family education, advocacy, information and referral. BDA parents are included in MCOMH planning. The Key Family Contact/Project Co-Director and the Youth Coordinator will be full-time employees of BDA. Through ACCESS, BDA will develop a wide array of services and supports for youth and assure that family and youth advocates are representative of the diverse population. BDA will create a broader cadre of bilingual/bicultural family and youth advocates to more aggressively outreach to communities of color. Opportunity to effectively partner with local ethnic-specific organizations will be explored. Building the capability to offer a broader range of services and programs in Spanish will be a priority.

The *Key Family Contact* will serve as Project Co-Director to assure shared decision-making between professionals and parents at the leadership level. This person will serve on the Governing Body, Chair the Family Council and participate in the evaluation. The Parent Partner will provide additional support. These two positions will coordinate efforts with the Technical Assistance/Social Marketing Manager and Lead Cultural Broker to maximize engagement with communities of color. The Key Family Contact/Project Co-Director will also oversee individualized support and advocacy efforts for ACCESS enrollees and will develop a long-range parent recruitment model which engages all aspects of the diverse community and encourages broader participation in ACCESS.

MCOMH currently funds Family Support initiatives with nearly \$300,000 of *financial support*. Resources are also available through the Home and Community Based Services Waiver and the SPOA. Opportunities for *sustainability* by tapping the various fiscal resources in the County will be explored, including current MCOMH funding, Office of Children and Family Services and State Education Department funding streams, private insurance carrier coverage or Medicaid reimbursement. Opportunities for joint grant-seeking between MCOMH, BDA and ethnic specific organizations will be sought to maximize revenue for these activities. ACCESS will bring practice in line with a family-driven model, cementing the partnership between *professionals and family members*. Training geared at understanding the values base and practice implications will be offered by training teams comprised of family-professional partners. The pool of family advocates developed at BDA will be assigned to specific sites across the County to serve as consultants to these organizations. These relationships will support implementation of family-driven practices. Each family advocate will also be assigned a professional mentor who will assist them in developing the skills, knowledge and confidence to appropriately represent families. The Governing Body will be co-chaired by a Family Member who will have been given the appropriate training to feel comfortable in this critical role.

Compensation and fiscal support, including reasonable stipends for childcare, transportation and travel time will be developed by BDA, and market-based hourly rates will be paid regardless of whether a family advocate is participating in training, advocacy/family support work, conducting evaluation activities, or participating in a Council or Governing Body meeting.

Youth Guided Care

The CFT process includes *youth involvement* in the development of their ISP. CFT meetings are not held without the youth present unless it would be harmful for them to attend. Youth will be actively involved in the planning process by identifying strengths, interests and abilities. The Youth Coordinator and other youth advocates will be available to support youth through the CFT process. This will have the mutual benefit of providing an opportunity for youth to mentor enrollees, building their confidence, competence and self-esteem, while also providing

advocates the opportunity to identify young people for involvement in ACCESS governance, training, and evaluation activities. The Governing Body will have a minimum of three actively involved youth. The Youth Council will broaden youth voice in ACCESS.

Several young people have participated in the ACCESS planning process. ACCESS will assure that all youth relationships are mutually beneficial so young people benefit from their participation through compensation, increased skills, and/or other individually defined goals. **The Youth Coordinator** will serve on the ACCESS Governing Body. S/he will be expected to develop and co-chair the Youth Council. Several initiatives can support these activities including the Teen Empowerment Program of the City of Rochester and the Prevention, Access, Self Empowerment and Support project of the MCOMH and Coordinated Care Services, Inc. Each youth will also have the opportunity to select an adult mentor from ACCESS or the broader community to support them in the acquisition of necessary skills. These mentors will be appropriately compensated. The Youth Coordinator will outreach to the broader community and engage other youth in ACCESS. During initial years of funding, a full training track will be created which provides a consistent approach to developing young people for these roles.

Cultural and Linguistic Competence

ACCESS will address **Title VI of the Civil Rights Act** by assuring that mental health services and supports will *exceed* the requirements of the law and fulfill the *intent* of Title VI and V. Staff and community training will address, at a minimum, issues of health care disparities, intentional discrimination, medical redlining, and barriers for immigrant populations. Written materials will be provided in English, Spanish, and other languages/formats as needed. Recruitment of bilingual/bicultural staff will be a priority. Interpreters for anyone who requires this service will be available at no cost. **CLAS/CMHS Guidelines** will be met through the use of the Cultural Competency Assessment Scale (Siegel, et al., 2003) which measures the cultural competence of behavioral health organizations and is currently being validated through an NIMH grant and the Agency Narrative and Self-Evaluation Tool (Coordinated Care Services, Inc., 2001) which has been a required element of MCOMH provider contracts. This tool was developed through the County's Cultural Competence Initiative using the CLAS and CMHS Cultural Competence Standards as guidelines. The NCCC checklist, **Planning for Cultural/Linguistic Competence** has provided the framework for developing policies, structures and practices for provider agencies in Monroe County for many years. This checklist has supported training and technical assistance efforts with all behavioral health agencies and will be extended to all participants in ACCESS.

Recognizing that **disparities** in mental health care exist and are caused by myriad factors, a more thorough understanding of the type, extent, and root causes of disparities in Monroe County is essential. The Cultural Competence Council will be responsible for reviewing all data regarding access, utilization, outcomes, satisfaction through cultural lenses to explore the extent of disparities and recommend improvements in services, processes and procedures to reduce/eliminate disparities in ACCESS. The Cultural Competence Council will work with the evaluation team and appropriate Councils to assure that satisfaction surveys are culturally and linguistically appropriate. This includes developing **Organizational Policies** requiring a cultural competence plan which will delineate staff training, define resources for recruitment of a culturally diverse workforce, and assure review and revision of policies and procedures to support culturally competent care. The Cultural Competence Council will review agency plans and make recommendations. The **Individualized Service Plan (ISP)** will contain a section related to the child and family's cultural context. The CFT process includes a Strength and Cultural Discovery to ensure that cultural beliefs, values and practices are a part of the ISP. ISPs

will be reviewed by the Care Review team using criteria established in partnership with the Cultural Competence Council to assure cultural relevance. The Council will review findings and support the development of recommendations. Evaluation efforts which include CFT observations and/or interviews will also assess consistency with the family's cultural context.

ACCESS will assure *meaningful participation* in service, administrative and governance structures. The Governing Body, councils, and work teams will have representation from families, providers, and natural/informal supports reflecting the county's cultural diversity. The Lead Cultural Broker will be a driving force in creating and sustaining meaningful participation from diverse constituencies. Partnerships with nontraditional organizations will include faith-based organizations, ethnic-specific advocacy/neighborhood organizations, and merchants. Intent to participate in the ACCESS Governing Body/Councils has been secured from Puerto Rican Youth Development, the Urban League of Rochester and the Office of Faith-Based Initiatives.

The *Management Plan* includes a Cultural Competence Coordinator, a Lead Cultural Broker, and a Cultural Competence Council, all of which will facilitate organizational change. Provider contracts will require a cultural competence plan and clinical practices that incorporate cultural and linguistic principles. Consultants from diverse backgrounds have been engaged in ACCESS and position descriptions were created to assure that persons of color will meet qualifications. Recruitment strategies will include relevant mediums to adequately reach minority candidates. *Service Expansion* will be directed to services whose outcomes reflect that they address disparities and meet the needs of children of color. ACCESS will work with Dr. Olivares to expand Lazos Fuertes, an adult clinic partnership between an ethnic-specific organization and a community mental health center, to expand service to children. The Governing Body's review of funding and service allocation decisions will reflect community partnership. ACCESS will support bicultural recruitment and education of bicultural people interested in careers in mental health. ACCESS will create a resource directory of services provided by non-traditional community-based agencies to facilitate partnerships which will engage racial and ethnic minorities in service delivery and also compile a comprehensive list of key cultural contacts who will serve as a consultative resource to all ACCESS providers.

ACCESS will identify and implement *Evidenced-Based Practices* having proven/promising results with African American and/or Latino youth. ACCESS will rely upon the CLAS/CMHS Guidelines to promote cultural relevancy of all services and supports delineated in an ISP. All proposed interventions will be reviewed for evidence related to cultural subgroups. The Cultural Competence Council will make recommendations regarding the appropriateness of adapting models where the study population did not reflect cultural diversity. ACCESS will designate the current Monroe County Director of Cultural Competence and Diversity Initiatives to serve as the ACCESS *Cultural Competence Coordinator*. ACCESS will hire a Lead Cultural Broker who will assure that constituent organizations are progressing in their cultural and linguistic awareness, knowledge, and skills. The ACCESS Cultural Competence Coordinator will provide direction and oversee system-wide cultural competency.

SECTION B: SUSTAINABILITY/LINKAGES

Primary Goal and Objectives

Goal: Monroe County ACCESS will transform mental health care so that the infrastructure, values, oversight, and financing mechanisms support and sustain a culturally relevant system of care that is family-driven, youth-guided, and includes promising and evidenced-based practices.

Objectives:

1. Every child with SED and his/her family will receive care directed by a Child and Family Team (CFT), a wraparound planning process, transforming mental care from traditional program-oriented care to the CFT process.

2. Family and Youth Voice will be equitably represented, and drive all decision-making throughout ACCESS.
3. Enhance access to quality mental health care for all children with SED and their families, particularly those of African American and Latino descent who are underserved by the traditional mental health system.
4. Mechanisms will be created to promote recovery and smooth transitions into and out of care.
5. A funding structure will be created that maximizes the integration of various funding streams to support an effective and sustainable system of care.

Goals and Objectives Linkage to Transformation, RFA Priorities and State Reforms

The goal of ACCESS is to fundamentally transform the systems in Monroe County at all levels to improve outcomes for children with SED and their families. Section A of this application outlines the gaps, barriers and inadequacies of the Monroe County systems that impede realization of the New Freedom Commission and RFA goals for transformation. This section reflects how the ACCESS objectives will meet these goals, taking full advantage of state reform efforts, and effectively addressing local barriers that impede transformation.

Objective 1 – The Child and Family Team Process: ACCESS will transform mental health care from a traditional program-oriented system to a Child and Family Team (CFT) process; all care decisions and plans will be directed by this wraparound process. Each child and family enrolled in ACCESS will participate in a CFT process, resulting in an individualized service plan, supported by a care coordinator and family advocate. ACCESS will expand the Coordinated Children’s Services Initiative (CCSI) leadership team to serve as the Governing Body, who will ensure that the necessary policies, procedures, structures, services, and financing strategies are in place to support and sustain the CFT process. Extensive training will be provided to infuse the core values of ACCESS across child-serving systems. The entry point for ACCESS will incorporate the Single Point of Access (SPOA) and expand this entry point to include all children with SED, not only those with the highest need. This objective addresses the New Freedom Commission and RFA goals of consumer and family-driven mental health care, with care guided by an individualized plan of care and is linked with the NYS interagency CCSI reform and the NYSOMH SPOA reform aimed at simplifying and improving access to mental health care for high need children with SED, incorporating these reforms into ACCESS.

Objective 2 – Family and youth voice: Leadership positions will be established within ACCESS for families and youth. The Key Family Contact position will serve as the Co-Project Director and recruitment for other key positions will be targeted to families and communities of color. ACCESS will build the capacity of the Better Days Ahead family organization to effectively be the catalyst for infusing the family and youth voice in the system and its decision-making. Family advocacy capacity to conduct outreach and provide family advocates to the CFT process and the SPOA entry point will be increased. The CCSI governance structure will be enhanced to incorporate multiple family and youth participants, including Family and Youth Councils. Training will be provided for families and youth in areas they deem necessary to increase their knowledge base or skills to feel comfortable participating in governance. Families and youth will be compensated for their time with stipends/wages and reimbursement for transportation and childcare. This objective addresses the New Freedom Commission and RFA goals related to consumer and family driven care and the full participation of families and youth in service planning and development and is linked with state CCSI and SPOA reforms and their emphasis on family involvement.

Objective 3 – Enhance access and address disparities: The expanded CCSI governance structure incorporates participation by the early intervention/childhood system. Social marketing strategies aimed at increasing awareness and reducing stigma will be developed in partnership with the AdCouncil Rochester and using SAMHSA national marketing resources.

ACCESS will incorporate culturally competent mechanisms for outreach, access, engagement and sustaining child and family involvement. The SPOA process will incorporate culturally and linguistically relevant assessment tools and materials and the CFT process will include a Cultural Discovery Process. A Research to Practice Council will be established to identify, implement and evaluate evidence-based practices with proven efficacy with racial and ethnic minority populations, utilizing the resources of the Western Region Evidence-Based Practice Initiative. Cultural brokers will be incorporated at all levels of the system as a strategy to address barriers to participation and to expand involvement in the CCSI governance structure and its Cultural Competence Council. Cultural competence training will be woven throughout the system's structures and service delivery components building on the Monroe County Cultural Competence Initiative and its linkages to the NYS Multi-Cultural Advisory Committee. This objective addresses the New Freedom Commission and RFA goals related to the elimination of disparities, the incorporation of culturally and linguistically competent practices, and the delivery of excellent mental care using research-based practices and is linked to the state CCSI, SPOA and the NYS OMH "Winds of Change" evidence-based practice and accountability initiative and its Western Region Evidenced-Based Practice Initiative local implementation, as well as to the NYS OMH Multi-Cultural Advisory Committee.

Objective 4- Mechanisms for recovery and smooth transitions into and out of care:

Youth services will focus on a array of mental health, optional, and non-mental services that promote independence and wellness self-management skills. A policy will be developed to allow for individual determination regarding transition to adult services rather than age. Transition planning will be fully integrated with the CFT process, with protocols established to smoothly link youth to the adult SPOA. The Research to Practice Council will identify evidence-based practices for emerging adults for implementation by ACCESS, using the linkages with the Western Region Evidence-Based Practice Initiative. The SPOA will be enhanced to improve its response to children and families identified through outreach. This objective addresses the New Freedom Commission goals of early mental health screening and assessment and understanding the importance of mental health and the RFA goals related to expanding community capacity and the provision of a broad array of services and supports and is linked to the state CCSI, SPOA and "Winds of Change" initiatives.

Objective 5 – A funding structure to support and sustain ACCESS addresses the New Freedom Commission and RFA priorities for enduring change. Sound financing strategies and a sustainability plan are the lynchpins for transformation. ACCESS proposes a comprehensive financing and sustainability strategy that begins on day one. Using existing funded structures to build from provides a strong base for sustaining ACCESS. This strategy begins with the building of the initiative on the platform of an existing statewide reform effort (CCSI), integrating other state reform efforts (SPOA, "Winds of Change") and incorporating a local interagency system of care service delivery pilot with an established sustainability and growth record (Youth and Family Partnership). The sustainability team will work to develop financing strategies that integrate funding and maximize all available resources and results in continuation of all ACCESS structures and services after graduation from federal funding.

Sustainability – Nonfederal Match

Sustainability planning has been an integral part of preparing this application and will be continued with the immediate establishment of an interagency Sustainability Team. The SAMHSA Sustainability Toolkit (DHHS, 2004) will guide this ongoing planning process. Strategies for further exploration by the Sustainability Team include identification of increasing non-federal match dollars and strategies to institutionalize system of care structures and services within on-going funding streams.

A comprehensive array of services and supports from multiple systems will be incorporated into ACCESS service delivery through the CFT process. The required and optional mental health services and supports are currently funded through Medicaid, private insurance, and state and local funds. Non-mental health services available through the substance abuse, primary health care and developmental disabilities systems are funded through Medicaid, private insurance and state and local funds. Non-mental health services available through the juvenile justice, child welfare and education systems include federal, state and local funds, including Title IV-B and IDEA funds. Service expansion of the YFP will be incorporated into the care coordination capacity of ACCESS as non-federal match support. The expansion is financed by Preventive service funding, based on a 65% state and 35% county matching formula. It is important to note that there is no “cap” on counties’ ability to increase Preventive funding at this time under a favorable matching formula.

SAMHSA Grant - Matching Funds Summary							
Match Source	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
Monroe County	607,618	624,984	643,733	714,855	1,065,300	1,258,642	4,915,132
New York State	1,087,200	1,120,679	1,154,299	1,285,146	1,934,699	2,292,451	8,874,474
Total Match	1,694,818	1,745,663	1,798,033	2,000,000	3,000,000	3,551,093	13,789,606

The projections for non-federal match and sustainability are based upon a financing strategy that projects the growth in non-federal match contributions from savings generated by reductions in out-of-home placements. The savings and reinvestment strategy is based on an extensive residential cost study and fiscal model developed for the YFP. Under this model, the average annual cost per residential placement for Monroe County is \$81,396, of which \$50,823 is local county cost. Given the potential for additional savings and reinvestment, increased Preventive services funding is projected as a major source of non-federal match to create additional care coordination, and other program and individualized service capacity over the 6 year grant period. This strategy also represents a viable option for sustainability into the future.

Coordination with Other Federally-Funded Initiatives

Mental Health Block Grant funds currently support children’s crisis residential and outpatient, mobile crisis, SPOA and vocational services. These required and optional mental health services are included in ACCESS. ACCESS will coordinate with other federally funded initiatives through formal written agreements, MOU’s and reciprocal participation in each others’ governance structures. ACCESS will coordinate with the following federally funded initiatives: Safe Start Initiative (DOJ): Monroe County Department of Health is the grant recipient and several ACCESS partners are on its coordinating body. Safe Start targets children exposed to violence and will make referrals to ACCESS, particular for trauma-related mental health services. Safe Schools/Healthy Students: MCOMH is a collaborating agency in the 2005 proposals with the Rochester City and Greece Central School Districts who have signed MOU’s for ACCESS. SAMHSA Offender Re-entry: A letter of agreement for service coordination with Huther Doyle Memorial Institute, to link eligible youth with SED to ACCESS post incarceration. Drug Free Community Support: Letter of agreement with Huther Doyle/Prevention Partners to incorporate project’s neighborhood empowerment teams into ACCESS social marketing and outreach strategies. SAMHSA Behavioral Health in Primary Care: Letter of agreement with

Unity Health Systems specifies their commitment to serve eligible system of care enrollees in this behavioral health/primary care integration project.

Specific Strategies for Sustainability

The Sustainability Team will include families, youth, community representatives, local philanthropic organizations and agency leaders, especially those with financial expertise. Sustainability planning will be a part of the overall strategic planning process, using the SAMHSA Sustainability Toolkit (DHHS, 2004). The plan will specify steps to be taken each year to ensure that ACCESS is thriving in year seven and beyond. The Governing Body will oversee the Team's work with regular monitoring of progress and annual update of the plan.

The key to enduring transformation is the ability to sustain the guiding vision, values and philosophy. ACCESS will utilize extensive training to make cultural competence, family-driven/youth-guided care, interagency collaboration and the use of evidence-based approaches the standard of care. Governance and management structures are in place to achieve this goal. The ACCESS Governing Body is built from an established, funded interagency reform (CCSI) which will continue to function post grant. Sustaining training assumes that much of the training can be institutionalized within partner agencies' existing in-service and community training, as agencies will need to adapt their own training to meet the staff competencies required for providing services in the transformed environment. Train the trainer approaches will be used in the grant to develop a pool of trainers. ACCESS will work with organizations such as Better Days Ahead, the Mental Health Association and NAMI to incorporate system of care training. Community and youth leadership and empowerment training currently available through the City of Rochester Neighbors Building Neighbors Project and the Teen Empowerment Project will be tapped for training and mentoring family members, youth and community participants.

The Sustainability Team will develop strategies to secure ongoing financial support for the service array. Evaluation data will be coupled with social marketing to highlight ACCESS benefits, demonstrating the potential advantages of investment for each system. Savings from reductions in out-of-home placement will be reinvested over time to finance community-based service. Another strategy will entail marketing ACCESS services not currently reimbursed by Medicaid or third party insurers (respite, family support, in-home support, skill-building, short-term crisis residential, care coordination) as cost-savings measures to secure reimbursement. ACCESS will work with New York State regarding the possible conversion of grant funded care coordination to Medicaid funded Home and Community Based Services Waiver slots, the expansion of the Medicaid rehabilitation option to children's services, and maximizing the use of EPDST funds within ACCESS. The Team will include a representative from the local Medicaid authority and strategies to maximize Medicaid funding will be cognizant of local match requirements and cost/benefit analysis of expanded reliance on Medicaid.

Among other possible approaches are: maximizing funding from other federal sources for ACCESS and increased mental health funding through new state dollars and/or re-directing mental health funding currently used on adult services. Community private and foundation support will be sought and ACCESS will work with the United Way to incorporate ACCESS as a priority in their investment strategy. ACCESS also expects to work over the course of the next six years, to build capacity in general youth programs (training, mentors, extra supervision staff, etc.) to enable them to open their services more fully to children with SED. The expectation is that these supports can, over time, be shared by the non-mental health funders of the programs.

The ACCESS administrative staff component is financed through in-kind support and grant funding. A core administrative staff complement will be sustained and continue to function as a team post-grant. Strategies for continuation of staff positions involve institutionalizing the functions into partner agencies. MOU's include specific commitments of in-kind staff support to be maintained throughout the duration of the grant and as an in-kind contribution to

sustainability (Principal Investigator, Clinical Director, State and Local Agency Liaison, Parent Partner). This commitment also includes in-kind expert consultant contributions (cultural competence, MIS, fiscal management, performance management/quality assurance, training, community relations, evidence-based practices). It is expected that many of these functions will be absorbed into the on-going oversight functions of the MCOMH and its management services organization, Coordinated Care Services, Inc. ACCESS partner agencies will pursue strategies to sustain grant funded positions such as realignment of staff responsibilities to absorb system of care administrative functions and redeployment of existing positions to ACCESS (Project Director, Technical Assistance/Social Marketing Manager, Lead Cultural Broker). Funding will be secured through new dollars and/or reallocation of existing funds to maintain the critical expanded capacity for Family and Youth involvement (Key Family Contact/Project Co-Director, Youth Coordinator, Parent Partner). The local evaluation capacity will be absorbed into the on-going performance management functions of the county and possibly augmented by future research demonstration funding to further evaluate effectiveness.

SECTION D: EVALUATION PLAN

The National Evaluation will be the foundation for assessing the effectiveness of ACCESS. During the first year of the project, the local evaluation team will work closely with the designers of the National Evaluation, and ACCESS governing team, families, and key staff to guide the development of local efforts. The local evaluator, Children's Institute (CI), is deeply committed to the principles of ethical research methods, rigorous evaluation practices, community collaboration, and cultural and linguistic competence.

Evaluation activities will be reviewed by the Research to Practice Council chaired by the Evidence Based Practices Consultant, and will include staff from CI, family members, youth, ACCESS Clinical Director and Lead Cultural Broker, representatives from child-serving agencies, and expert consultants in the fields of mental health and measurement. A strategic plan will be developed during the first year of the project that will guide, direct, and coordinate both the National Evaluation and local evaluation efforts. To conduct process and product evaluations, assessments at three levels will include: 1) child and family outcomes, other variables and characteristics, and demographics for baseline and follow-up data; 2) system level change and levels of care and care coordination within and between local organizations for documenting accessibility and outcomes; 3) to document the intensity and duration of services for program quality and to assure fidelity of project implementation. The evaluation team will report to the Governing Body on a regular and frequent basis. All aspects of the evaluation will be reviewed for cultural appropriateness on an ongoing basis.

The major responsibilities of this team will include:

1. Work with the National Evaluation Team to implement the national evaluation and the longitudinal outcome study and participate in a 2 to 3 day site visit by the national evaluators every 18 months to assess the training and technical assistance sessions.
2. Work with the Governing Body to develop a logic model to specify resources, activities, and outcomes to explicitly articulate the program theory and to set the stage for the National Evaluation and the local program evaluation as well as sustainability.
3. Plan and facilitate the integration of the MIS with the system of care.
4. Develop a training plan for data collection, data entry, verification of data, data storage, data retrieval and reporting and ensure that the system is implemented.
5. Develop and implement a regular reporting schedule to treatment teams, the Governing Body, and others for continuous quality improvement and shared decision-making.
6. Coordinate cost allocation methodologies with the finance/budget team to determine costs of serving children and families.

7. With the Research to Practice, Family, Youth and Cultural Competence Councils and other representatives, develop protocols and instruments in at least both English and Spanish for all data collection including surveys, interviews and focus groups.
8. Together with the above-noted Councils, coordinate plans for training interviewers, focus group moderators, and provider staff who collect data from families and children.
9. Develop reporting and dissemination formats in writing and orally for all stakeholders at appropriate literacy levels for the varying target audiences.
10. Develop and implement plans to disseminate evaluation findings frequently to promote the sustainability of the project beyond the Federal funding years.
11. Publish research and evaluation findings and present results at conferences to promote local, state and national policies for integrated systems of care.
12. Lead efforts to obtain the Institutional Review Board (IRB) approval for data collection and for conforming to the HIPAA standards and requirements.
13. Develop security and confidentiality standards to ensure privacy for families.

Data from the national evaluation and the local evaluation will be used for continuous quality improvement and to ensure that the project is implemented as planned. The evaluators will meet regularly with the Governing Body to present updates on the implementation of ACCESS and the status of the data collection. As evaluation outcomes are documented, including short-term, intermediate, and long-term outcomes, recommendations will be made for improving the system. This information will be used for sustaining ACCESS beyond the federal funding period. Similarly, cost-effectiveness will be tracked by service use for behavioral health services. Service unit data will also be collected and used for feedback on the cost of sustaining the system of care.

Children's Institute staff with ***knowledge and experience*** work collaboratively with early childhood, school, and community personnel regarding training and the implementation and evaluation of numerous early education and care, school, and community based programs. CI is a nonprofit 501(c) (3) organization, whose mission is to strengthen children's social and emotion health and well being through collaboration and sound research and evaluation. CI's professional staff include a total of 6 PhDs (5 in psychology and 1 in education and human development), one MD/MPH, 15 masters degree staff (5 in education and human development, 4 in social work, 3 in statistics and/or information technology, and 3 in public policy. Most have academic appointments with the Center for Community Study (CCS) of the University of Rochester Department of Clinical and Social Psychology. The key CI evaluators for the ACCESS project include A. Dirk Hightower, Ph.D. and Rusti Berent, Ph.D. Drs. Hightower and Berent each have over twenty years of experience in program evaluation at the local, state, and national levels and have successfully worked together in the Rochester community for the past ten years on many evaluation projects. Both disseminate research and evaluation findings in papers and presentations locally, statewide, and nationally.

Dr. Hightower will be responsible for the overall oversight of the evaluation team. Under his leadership, Children's Institute's Primary Mental Health Project has won the National Mental Health Association's Lela Rowland award for Outstanding Prevention Program of the Year in 1984 and 2004, and once for the Children of Divorce Intervention Program in 1991. Both of these programs are also recognized by the NY State and U.S. Departments of Education as validated and effective programs. In 2004, the Children of Divorce Intervention Program received the U. S. Department of Health and Human Services Award for Program Excellence. Dr. Berent will be the key contact for the national and local evaluation efforts, and will direct the writing of outcome findings for appropriate audiences and stakeholders including families, administrators, providers and clinicians, and local and state policy makers. She has evaluated local multi-site programs at Family Resource Centers, school-based programs in several local

school districts, teacher mentoring programs, and Rochester Even Start, among others. She has trained over 1500 front-line and professional staff on the Rochester Area Logic Model and has also taught Program Evaluation and Research Methods at the University of Rochester. Other local community evaluation partners include staff from Coordinated Care Services, Inc. who serve as performance managers for MCOMH and maintain the local Behavioral Health Community Database. Their experience with data management and analysis will reduce duplication of data collection and ensure a comprehensive focus on the evaluation effort.

CI has substantial **facilities and resources** to support this project. It is located in a 12,000 square foot office/research complex including the Dr. Emory L. Cowen Prevention Library, a mini conference/training center and data processing center. For telecommunications, CI has a dedicated 24-channel fiber optic T-1 line, a computer system with over 50 computers linked to two Windows NT servers. A third NT server handles the financial software and a fourth server provides for large file transfer services. This server will be used for file transfer of data from programs that are involved in this project. Optical mark readers are utilized for efficient and accurate data processing. Besides a full complement of Microsoft Office software, CI also has SAS and SPSS, AMOS, Stata, LISREL, and HLM statistical packages. CI has extensive expertise in developing, managing, and maintaining large-scale data management systems for a variety of human service agencies and government entities in New York.

CI uses the latest in technological software and expert analysts to **support data entry, storage, management, analysis and reporting**. As part of the University of Rochester, CI has superior technical resources. CI systems can provide summary reports on the numbers served by the entire range of specified demographics and variables as well as referral and tracking reports. A quality assurance process ensures data accuracy and completeness. All data will be reviewed on a monthly basis and cleaned through automated and manual checks. Data will be collected at point of entry for families and children. The evaluation team will develop procedures for data entry. All data including pre-tests, post-tests, surveys, interviews, will be kept in a secure room in a fire-retardant, locked file cabinet in the project's dedicated office. Data collected at point of entry and other sites will be secured and immediately brought to the project office. A dedicated secure computer with high-speed internet access will be used for data entry and reporting. Once the input forms are entered into the database, a unique identifier will be assigned to the child and no names will be visible. The computer database will be secured and password protected. Only the Lead Evaluators will know the password. Privacy and confidentiality issues are critical and will be emphasized during trainings and in meetings.

One of the challenges during the first year of the grant will be to develop an efficient plan to integrate **administrative and service utilization** data available through multiple sources into a system that gathers the information required for the National Evaluation. While state-mandated reporting requirements will likely make it difficult to consolidate all reporting into a single system, integration will be achieved by maximizing use of existing systems where the functionality currently exists to support local processes, and effecting linkages to other mandated systems via data export or other methods to minimize duplication and provider burden. The assessment of MIS capabilities and development of an integrated approach to information management will need to go hand-in-hand with the planning activities slated to take place Y1.

Three adult **family members** and up to three **youth**, reflecting the diverse cultural backgrounds of the community, will be members of the evaluation team and full participants in the evaluation activities including the design, data collection, interpretation of data and decisions regarding the presentation and use of the data. Family members and youth will be involved in developing questions for interviews, focus groups, and surveys, they will be trained to conduct data collection and will assist in training others. In addition, they will be trained to analyze, interpret and report the data. The Cultural Competence Council will also be involved in these

activities. Plans will be developed to address the needs of people who do not speak either English or Spanish. The evaluation team will ensure that all data collection materials are linguistically/culturally appropriate. As a core component to the quality assurance function, an existing record review protocol will be enhanced and expanded to review the records of children enrolled ACCESS. Record reviews will assess quality of care and fidelity. Family reviewers will be integrated into site review team functions. Finally, both the Goal Attainment Scale (1968) and the Family Assessment Form (McCroskey et al.,1997) will be used to engage program participants in realistic, measurable goal setting and achievement in their treatment settings. Both tools are widely used in mental health programs with diverse populations and serve the dual purpose of documenting individual participant change and overall program outcomes.

Local evaluation activities will incorporate a mixed methods approach using both qualitative and quantitative data. The design will address process implementation and systems outcomes by examination of changes at the organizational level, service delivery and staff levels. Program effectiveness and behavioral changes for program participants will focus on outcomes at the family and child level. The evaluation team will develop the research questions to be asked and answered. Research questions to be addressed at the organizational level include: 1) Do the organizational frameworks that have been established promote collaborative, interagency services among child serving system? 2) To what extent have cross-systems initiatives been implemented? What are they? 3) How effective are the frameworks in promoting system of care principles among providers and in what ways has service delivery behavior changed relative to systems changes? 4) Have disparities in utilization patterns been reduced/eliminated? 5) Has the project resulted in administrative efficiencies such as common intake forms, shared information systems, integrated assessments and tracking systems? 6) How many youth transitioned to adult services? At what point did this occur? 7) Has the project produced system cost savings and if so, how? 8) How does the project identify and remove barriers that impede inter-agency and cross-system service delivery? 9) To what extent is the new system of care perceived by stakeholders as being representative of and meeting the needs of different ethnic and racial groups? 10) What procedures are in place to sustain systems work beyond the federal funding period?

At the service delivery level, research questions to be addressed include issues of accessibility, operational implementation, and program effectiveness: ***Accessibility:*** 1) What are the characteristics and number of the children and families served? 2) Where are the majority of referrals originating? 3) What are the retention and discharge rates, and do they vary by ethnicity? 4) What quality improvements are being implemented to increase accessibility and reach targets? 5) Have new programs been funded and/or expanded to address the needs of the underserved? ***Operational implementation:*** 1) To what extent are principals adopted by providers and reflected in their practices? 2) To what extent are families/youth involved in the system of care planning and feel empowered? 3) What is the level of satisfaction of families/youth and staff in the system of care? 4) What evidence-based practices and model programs have been implemented and to what extent are they delivered with fidelity? ***Program effectiveness:*** 1) Has the project resulted in fewer out of home placements and reduced number of care days in residential placements? 2) Are fewer children with serious emotional disturbance (SED) removed from mainstream classrooms or hospitalized? 3) Are there fewer children with SED who have Child Protective Services reports? 4) Has the project improved outcomes for children having cross-systems involvement or co-occurring disorders? 5) Have processes/programs been developed to facilitate transition of youth to adulthood and/or adult services? 6) What changes have occurred in child behavior and family functioning? 7) What program components have been most successful in producing changes? 8) How satisfied are families/youth with the system of care and what are the perceived strengths and weaknesses of the system? Do perceptions vary by ethnicity?

In order to address the research and evaluation questions, interviews, focus groups, surveys, individual behavior and family functioning assessments, record reviews, meeting minutes, logs and attendance records will be collected, analyzed and interpreted. For quantitative measures, means, standard deviations, percentages and other descriptive statistics will be used. For qualitative measures, data will be studied to identify recurring patterns and themes. All data will be triangulated to increase the reliability and validity of the analysis and subsequent interpretation. It is critical for systems capacity-building that evaluation activities are well-integrated into provider activities and one way to do that is to ensure that the evaluation tools are immediately useful for those collecting the data. The proposed evaluation measures, their target and purpose, timeline and type of analysis are outlined in Appendix 3. Each will be evaluated by the evaluation team for its overall usefulness and cultural appropriateness. The evaluation team will integrate local and National Evaluation instruments for a well rounded, efficient and effective program evaluation.