Regional Family, Youth, and System Partner Round Table

Manual and Resource Guide

October 30, 2015

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Background and History

State and Regional Family, Youth, and System Partner Round Tables (FYSPRTs) were developed under the Department of Social and Health Services' (DSHS) Washington State System of Care (SOC) Expansion Project as a key component for ensuring behavioral health and other public child-, youth-, and family-serving systems in Washington State are coordinated and informed by input from multiple stakeholders.

FYSPRTs and their Connection to Systems of Care

Systems of Care are defined as "A spectrum of effective community-based services and supports for children, youth, and young adults with or at risk for mental health and related challenges and their families that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs in order to help them function better at home, in school, in the community, and throughout life." Core system of care principles are: **(1) community-based, (2) family-driven and youth-guided,** and **(3) culturally and linguistically competent**.

By convening a group of invested stakeholders, including family and youth, system partners, providers, community leaders, system representatives and others, and engaging them in a systematic process of evaluating system-level needs and strengths and identifying strategies for improvement, FYSPRTs are intended to promote development of a system of care that is based on **community** priorities. By ensuring that families and youth are key collaborators, and are in core positions of leadership, systems of care become more **family-driven and youth-guided**. Finally, by ensuring that this community mobilization process is representative of the diversity of the community and focuses on issues such as disproportionality and cultural and linguistic competence of services and supports, systems of care become more **culturally and linguistically competent.**

FYSPRTs and their Connection to the *T.R. et al. v. Kevin Quigley and Dorothy Teeter Settlement Agreement*

The FYSPRT structure was later adopted within the *T.R. et al. v. Kevin Quigley and Dorothy Teeter Settlement Agreement* as the *Children's Mental Health Governance Structure.* The System of Care values and principles were also adopted, with a few modifications, within the Settlement Agreement, as the Children's Mental Health Principles, and later changed to the Children's Behavioral Health Principles. The Settlement Agreement is located at the following link: https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/childrens-mental-health-lawsuit-and-agreement.

The Governance Structure consists of inter-agency members on an Executive Leadership Team of state administrators, the Statewide, Regional, and Local FYSPRTs, an advisory team, and various policy workgroups who inform and provide oversight for high-level policy-making, program planning, and decision-making in the design, development, and oversight of behavioral health care services and for the implementation of the *T.R. v. Quigley and Teeter Settlement Agreement*.

FYSPRT Structure and Purpose

The Statewide, Regional, and Local FYSPRTs are designed to influence the functioning of local and state child-serving systems, and to promote proactive changes that will improve access to, and the quality of, services for families and youth with complex behavioral health challenges, and the outcomes they experience. FYSPRTs are grounded in the Washington State Children's Behavioral Health Principles (See Appendix A, *Glossary of Key Terms**)*** and provide a forum for local information exchange and problem solving, as well as an opportunity for identifying and addressing barriers to providing comprehensive behavioral health services and supports to children and youth.

The Statewide FYSPRT is informed by the work at the Regional and Local levels. It problem-solves statewide challenges and barriers brought forth by the regions and statewide system partners, and promotes success and solutions that may be helpful to other regions in the state. The overarching FYSPRT goal is to ensure family/youth/local community stakeholder involvement in policy development and decision-making, including the provision of Wraparound with Intensive Services (WISe).

The Regional FYSPRT is an essential part of the Governance Structure that meaningfully engages families and youth, governmental/tribal partners and others who are interested in and committed to the success of youth and families in an equitable forum to identify local needs, review local/regional data, problem-solve and address issues at the local and regional levels. With a goal of improving outcomes for youth, the Regional FYSPRT brings unresolved needs forward to the Statewide FYSPRT with recommendations about how to meet those needs.

At a minimum, there will be a Statewide FYSPRT and ten Regional FYSPRTs, one for each of the nine Behavioral Health Organization Regional Service Areas (formerly Regional Support Network) and one "Fully Integrated Managed Care" Regional Service Area region, across Washington State (See Appendix B for a map of the regions).

If not already developed, Local FYSPRTs will be created and organized within the communities of the Regional FYSPRTs, by June 2018.

Purpose of the Manual

The purpose of this manual is to provide a consistent set of standards that clearly describe the core roles, elements, and functions of FYSPRT infrastructure and operations. The manual also aims to orient FYSPRT leaders and participants to FYSPRT activities and provide information and resources from national leaders in Systems of Care and Wraparound efforts, to support FYSPRT operations. Information from national leaders will be included in the body of the manual along with additional resources for FYSPRTs, provided in the form of a "*Resource Guide"* located in Appendix G of this Manual.

For the purposes of this manual, the "Benchmarks" described throughout the manual are to be completed by June 2018.

This manual is a living document. It will continue to be refined and revised as we learn from communities. The most current version of the manual will be posted on the FYSPRT website at: https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/family-youth-and-system-partner-round-tables-fysprts.

Mission of the FYSPRTs

The **mission** of Washington State's ten Regional Family, Youth, and System Partner Round Tables (FYSPRTs) is to bring all necessary parties together to contribute to continuous improvement to children's behavioral health services and supports. Regional FYSPRTs strive to provide an equitable forum for families, youth, systems, and communities to strengthen and sustain community resources that effectively address the individualized behavioral health needs of children, youth and families.

Regional FYSPRTs play a critical role, within the Children's Behavioral Health Governance Structure, in informing and providing oversight for high-level policy-making, program planning, and decision-making, and for the implementation of the T.R. Settlement Agreement. As described further below, Regional FYSPRTs will:

- Convene a broad array of stakeholders to collect, review, and/or interpret relevant data and evaluation results and develop system improvement strategies;
- Serve as a mechanism for bringing voices from local communities into one regional entity;
- Respond to calls for feedback from higher level entities such as the Statewide FYSPRT, relevant state agencies, and DSHS' cross-system Executive Leadership Team (ELT);
- Regularly develop formal reports (e.g., regional needs assessments) for review by higher-level entities who can then act accordingly through policy, fiscal, regulatory, and other actions;
- Receive regular reports from higher-level entities on priorities for action and policy, fiscal, regulatory, and other actions taken in response to input from the regions.

The FYSPRT **vision** is that, through respectful partnerships, families, youth, systems and communities will effectively collaborate to proactively influence, and provide leadership to address challenges and barriers faced by the behavioral health service system for children, youth and families in Washington State.

Population of Focus

FYSPRTs are key components to making local, regional, and statewide system-improvements throughout the continuum of care for children's behavioral health. An added emphasis is placed on improving outcomes for those identified as Class members in the T.R. Settlement Agreement. Class members are defined as:

"…any child, youth, or young adult eligible for DSHS services (i.e., Medicaid eligible and up to 21 years of age) whose emotional or behavioral challenges have led them to be in need of intensive behavioral health treatment, in an out-of-home-placement, and/or at risk of needing such placement or intensive treatment."

Authority

Establishment of and support to State and Regional FYSPRTs is derived from the goals, commitments, and exit criteria of the Settlement Agreement and Proposed Order for *TR versus Quigley and Teeter* (No. C09-1677 – TSZ), which stipulates that the Washington State children's behavioral health delivery system will ***"maintain a collaborative governance structure that includes child-serving agencies, youth and families, and other stakeholders."***

The Settlement Agreement also stipulates that:

1. DSHS and the Health Care Authority (HCA) will use a sustainable family, youth, and inter-agency Governance Structure to inform and provide oversight for high-level policy-making, program planning, decision-making, and for the implementation of this Agreement.

2. The executive team of the Governance Structure will be used to make decisions about how its child-serving agencies meet the systemic needs of the population of focus.

3. DSHS and HCA will engage families, youth and local community representatives through FYSPRT and other methods. The family, youth, and local community representatives will act as full partners in the governance committees and groups.

FYSPRT Infrastructure

Administrative Structure
The Regional Support Network (RSN) /Regional Behavioral Health Organization (BHO)/Early Adopter Region (herein referred to as "region" or "regional") will establish and resource the Regional FYSPRT as part of local/regional structures, in compliance with DSHS/Division of Behavioral Health and Recovery (DBHR) standards, guidelines, and contractual expectations, as well as expectations under the *T.R. v. Quigley and Teeter* Settlement Agreement.

As described above, FYSPRTs will be critical to informing high-level policy-making, program planning, decision-making, and for the implementation of this Agreement. See

the Figure in Appendix C, for a visual of the Governance Structure. FYSPRT will also have the ability to influence other areas of the continuum of care at local, regional, and statewide levels, by following the operational requirements described in this manual. Although there are a set of non-negotiable, specific expectations that each region must meet for youth and family participation in children's behavioral health policy and practice (outlined in the contracts with DBHR and discussed throughout this manual), each region has wide discretion to design creative options for achieving that goal in a way that will best meet the needs of its youth, families, and communities. For example, by building upon past work that was accomplished by previous FYSPRTs:

- Maintain an existing FYSPRT, within the new boundaries, and develop new agreements for working together under the terms of the regional contractual expectations.
- Identify a current entity to fulfil FYSPRT functions that includes all necessary members.
- Merge current entities (i.e. FYSPRTs and RSN Committees) into a new entity that includes all necessary members.
- Develop a new entity that includes all necessary members, and reduce the duplication of similar functions within previously established entities.

Moreover, there are options for how the regions may oversee and support Regional FYSPRT operations. For example:

- The regional contractor may appoint a "Convener" of the FYSPRT (i.e. historical FYSPRT contractors or other family and/or youth organizations) and delegate the appointment of FYSPRT members and operations of the Regional FYSPRT to the Convener.
- The regional contractor may convene the FYSPRT.
- Based on how regional contractor define their community(s), they may select to have more localized groups that feed into their regional structure, to better meet the needs of that Region and address challenges and barriers as close to the community level as possible.

Regardless of the administrative structure adopted, certain expectations must be met:

- The administrative structure chosen must support adherence to the expectations in the current manual and the *T.R. v. Quigley and Teeter* Settlement Agreement
- FYSPRTs must be adequately independent of regional contractor operations that family and youth representatives are able to exercise independent leadership and speak freely. While family and youth independence is important, the idea of a shift in leadership paradigm is also crucial. Examples to safeguard these expectations include certain core expectations, some of which are explicated in this manual, including:
    - The use of a "Tri-Lead" structure that blends leadership across families, youth, and system partners;
    - Empowering members (i.e., families and youth) to share leadership responsibilities;
    - Consistency in vision and message of the FYSPRTs around advising regional and state improvements that can promote system of care principles;

- Maintenance of independence of FYSPRTs from other decision-making entities that focus on system management and operations;
- Provision of funding and other resources to support FYSPRT members –such as travel support and on-site child care – that aid in ensuring family and youth participation;
- Establishment of locally developed and endorsed "ground rules" for engagement, discussion, decision-making and meeting protocols that assure a sense of safety for participants;
- Regular assessment/evaluation of participants' experiences, including ratings and feedback on sense of independence and relevance;
- Training on the history, mission, and purpose of FYSPRTs, use of data and information, approaches to effective decision-making, leadership, and advocacy; and
- Provision of mentoring opportunities for families and youth that includes provision of guidance from experienced family, youth, and community leaders.

Ideally, the Regional FYSPRT convener shall be based in the Regional Service Area. It is allowable, however, for regional contractor to utilize historical FYSPRT contractors to continue this work. In these instances, if possible, the Regional FYSPRT should provide a local workspace for the convener.

As the quote below from a Family Leader of Family Alliance reminds us, regardless of who convenes the FYSPRT meetings, the basis of these meetings is about collaboratively working together as equal partners in system improvement efforts.

> ***"People do not attend local community meetings because they are required to do so. People are there because they find usefulness and meaning for these groups."***

Representation on the Regional FYSPRTs

- Representation from the Regional FYSPRT shall be diversified and include transition age youth/youth partners, family, and system partners.
  - Family and Youth representatives should include people who have received substantial services in the system, like WISe, in addition to youth and family representatives who are employed or funded by providers or systems.
- Each Regional FYSPRT will identify Tri-Leads (a Youth, Family, and System Partner). Regional Tri-Lead Representation shall be assigned using the rotating schedule identified within the current Regional FYSPRT Charter, see Appendix D.
- By June 2018, each county shall identify at least one family member and one transition-age youth/youth partner representative to provide information to the Regional FYSPRT Tri-Leads regarding strengths and needs at the county level.
  - Note: *Based on how regional contractors define their community(s), they may select to have more localized groups, at any point in infrastructure development, that feed into their regional structure, to better meet the*

needs of that Region and address challenges and barriers as close to the community level as possible.

- By June 2018, these youth and family representatives should comprise a large portion of the membership of Local FYSPRTs.

Representation on the Statewide FYSPRT

- Representation from the Statewide FYSPRT shall be diversified and include state-level system partners and youth/youth partners and families from each region.
- Regional FYSPRT Tri-Leads will participate as members of the Statewide FYSPRT. The Regional FYSPRT will identify and support at least two (2) Tri-Leads to attend each in-person Statewide FYSPRT meeting.
  - Tri-Leads review and provide feedback to DBHR staff, as requested, regarding documents as related to Statewide FYSPRT responsibilities such as but not limited to:
    - Monthly reports and semi-annual reports for grants
    - Other documents as requested
  - Tri-Leads act as a communication liaison to report information back from the Statewide FYSPRT to the Regional FYSPRT, and will present information from the Regional FYSPRT to Statewide FYSPRT. See the *Promoting Effective Communication across Levels of the Governance Structure* section (beginning on page 13, and Appendix G, Section 6) for further information about communication between the levels of the Governance Structure.
- Regional Tri-Leads and Regional FYSPRT members shall be identified to participate on identified subgroups of the Statewide FYSPRT.

Representation on the Local FYSPRT

Based on the needs assessment and the strategic planning framework, Regional FYSPRT will develop localized FYSPRTs that meet the needs of their Region by 2018.

- Representation from the Local FYSPRT shall be diversified and include local-level system partners and youth/youth partners and families from each local FYSPRT.
- Local FYSPRT Tri-Leads will participate as members of the Regional FYSPRT. The Local FYSPRTs will identify and support at least two (2) Tri-Leads to attend each Regional FYSPRT meeting.
  - Tri-Leads review and provide feedback to the Regional FYSPRT
  - Tri-Leads act as a communication liaison to report information back from the Regional FYSPRT to the Local FYSPRT, and will present information from the Local FYSPRT to Regional FYSPRT.
- Local FYSPRT Tri-Leads and/or Local FYSPRT members shall participate on identified subgroups of the Regional, and potentially Statewide FYSPRTs.

FYSPRT Operations

Composition of Leadership

Regional FYSPRTs will be tri-led by a family and a youth/youth partner, with lived experience, and a system partner. Family and youth representation on the overall FYSPRT will be "substantial" (at a minimum 51% youth and family membership). The Regional FYSPRT will reflect the ethnic and racial composition of the target population to the maximum extent possible.

It is recommended that Tri-Leads will serve a term of two years upon their first appointment. Regional Charters should inform selection of specific Tri-Leads. It will be necessary that Tri-Leads can and will meet the qualifications for the position's responsibilities. Experiences nationally in systems of care suggest effective family and youth leaders have significant, direct systems/service experience; the capacity to listen actively, reflect thoughtfully, blend the perspectives of diverse stakeholders; reframe discussions from a proactive, strength-based perspective; and experience working with and guiding other youth and families in such capacities. For a description of characteristics of effective leaders (regardless of their role in child and family systems of care), see Appendix G, Section 1.

To assure continuity of FYSPRT operations, leaders may continue to serve following expiration of their first term (see Appendix D for a description of the Tri-Lead position and responsibilities in the Regional FYSPRT Charter and see Appendix A for the definition of a Tri-Lead).

Role of FYSPRT Tri-Leads

The Tri-Leads work with the Convener to ensure meeting tasks and deliverables are completed. Specifically, the Tri-Leads will be responsible for leading and organizing the Regional FYSPRT meetings, as well as conveying information to the Statewide FYSPRT and vice versa to the Regional FYSPRT. Collectively they will ensure safe and collaborative meetings so FYSPRT members can share their unique perspectives and experiences, sometimes in an anonymous manner, to improve outcomes for youth and families in their region. FYSPRT Tri-Leads will:

- Be active participants and leaders in order to facilitate meetings.
- Maintain regular contact with other system partners, Family Organizations, Youth Organizations, and/or youth leaders/facilitators of youth-led meetings and activities.
- Promote System of Care values in all aspects of their work.
- Identify community partners and resources for continual collaboration.
- Record, summarize, and present information to the community.
- Create a youth and family guided infrastructure so members feel supported and safe to share feedback (often anonymously with Tri-Leads) to increase independence and success.
- Participate in training opportunities and identify needed technical assistance and skill development opportunities for system partners, youth, and families.
- Support other state initiatives related to Children's Behavioral Health.

For more detail, please refer to the FYSPRT Charter for specifics on the Youth, Family, and System Partner roles and responsibilities.

Role of FYSPRT members

It is intended that the Regional FYSPRT leverage the experiences, expertise, and insight of key individuals, organizations, and departments that are committed to building a System of Care for children's behavioral health. Regional FYSPRT members provide support and guidance for their region on FYSPRT related activities and tasks. Individual members will:

- Identify local and regional strengths, including effective and promising initiatives/projects and examples of community and system agencies that support systems of care values and principles.
- Participate in collaborative problem-solving to improve access and quality of services and outcomes for children, youth, young adults, and their families.
- Identify barriers/challenges and options for resolving issues.
- Bring community, individual, and agency strengths in completing necessary tasks.
- Educate and influence service delivery systems and the community in system of care values and principles (See Appendix E for values and principles).
- Effectively engage family and youth members, including areas such as strategic planning and outreach.

Contractor Expectations

The regional contractor shall develop, promote and support Regional and Local FYSPRTs to fulfill their functions within the Governance Structure, in alignment with Washington State's Children's Behavioral Health Principles and the FYSPRT Manual. Promotion and support of the Regional FYSPRT includes but is not limited to the following activities:

- Recruiting members
- Providing administrative support
- Provision of resources and fiscal management
- Arranging meeting space
- Informing local/regional priorities
- Collecting and reporting required information
- Develop and support Local FYSPRTs within the region (by June 2018)
- Other activities in support of the Regional FYSPRT

Ensuring adequate representation

- It is imperative that the regional contractor/Convener is represented at all meetings, including invitations to RSN Administrators, members of the Board of Directors, and the Mental Health Ombuds.
- The regional contractors/Convener shall engage with tribal governments and Washington counties, identified within the Service Area, to ensure the inclusion and representation of family, transition age youth/youth partners, and system partners in the development and implementation of the Regional FYSPRT.

- The Regional FYSPRT will be comprised of representation from Community System Partners, such as:
    - Behavioral Health provider(s) (i.e. Mental Health and Substance Use Disorder Treatment Providers)
    - Children's Administration
    - Developmental Disabilities Administration
    - Education/Local Education Agency
    - Faith Community Leaders
    - Foster Care Provider(s)
    - Juvenile Justice
    - Law enforcement
    - Local/Regional Advocacy Groups
    - Physical health care/public health
    - Other interested community stakeholders

      *See Appendix F for more comprehensive list of potential Regional FYSPRT members
- Regional FYSPRT members will act as full partners within the work of the FYSPRT. The contractor shall include youth, family, and system partner representation in all aspects of the development of the Regional FYSPRT, while seeking to sustain and/or build upon the prior work of the Regional FYSPRT(s).
    - The composition of the Regional FYSPRT shall include a minimum of 51% Youth and Family membership
    - The Regional FYSPRT must develop and implement a process for youth and families members to apply for travel support (for example, mileage reimbursement and other meeting attendance costs). Details of meeting support must be provided to members so they are aware of and can access this support.
- The Regional FYSPRT will develop policies and procedures for voting (see examples in Appendix G, Section 12).
- The Regional FYSPRT will be expected to maintain an up- to- date, formal roster of members, with expectations for terms of appointment for Tri-Leads maintained as described in the Composition section (See example in the ***Resource Guide,*** Appendix G, Section 3).
- The Regional FYSPRT will be expected to submit updated membership rosters to DBHR. The membership rosters shall include the name and affiliation(s) of members (family, youth, system partner) and also include the name, affiliation, email address and phone number for Regional FYSPRT Tri-Leads.
- To aid in the recruitment of family and transition age youth/ youth partners for Regional FYSPRT membership, Family and Youth Run Organizations (FYROs) will be actively engaged in identifying and recruiting possible members.

Promoting Development of Youth and Family Leaders

In order to ensure proactive development of the regional system of care as well as effective functioning of FYSPRTs – there should be a commitment to promoting development of youth and family leaders at all levels.

At a system level, such leadership is often promoted by activities such as:

A. Increasing funding and other resources to support youth and family attendance at meetings, including travel support a meals, and on-site childcare.
B. Expanding or creating opportunities for policymakers and administrators to hear directly from families and youth.
C. Building in policy requirements that give families and youth roles in policymaking bodies.
D. Enhancing networking capacity of parents, youth, and other family members.
E. Invest in family and youth advocacy organizations and services directed by youth and families.
F. Supporting technical assistance offered by the federal government to states and communities that do not have formal systems of care grants.
G. Promoting and funding the development of a public health model that embraces a universal focus on children's mental health and addresses the needs of the most troubled children and youth.

At a local level, promotion of family and youth leadership by entities such as regional collaborative entities (e.g., FYSPRTs) can include activities such as:

- Identifying family and youth/youth partner leaders to participate in available trainings;
- Partnering with family and youth run organizations to support leadership development.

At a local level, promotion of family and youth leadership by entities such as family and youth run organizations can include activities such as:

- Holding Family Leadership Institutes to train families to become effective advocates;
- Coaching families to develop advocacy and negotiation skills;
- Launching or joining statewide youth and family networks;
- Developing toolkits for family and youth and family and youth organizations to increase business management and leadership skills;
- Creating networks of volunteers; and
- Recruiting and assisting family members and youth to speak at grand rounds, schools, and conferences.

A much more comprehensive list of examples, written by Beth Stroul (2015), is provided in Appendix G, Section 1.

Promoting Effective Communication across Levels of the Governance Structure
As described above, Regional FYSPRTs play a critical role, within the Children's Behavioral Health Governance Structure, in ensuring a full communication loop between state, regional, and local stakeholders that promotes the continual improvement of the system of care for children, youth, and families. Regional FYSPRTs will:

- Convene a broad array of stakeholders to collect, review, and/or interpret relevant data and evaluation results, in order to develop system improvement strategies;

- Serve as a mechanism for bringing voices from local communities into one regional entity;
- Respond to calls for feedback from higher level entities such as the Statewide FYSPRT, relevant state agencies, and DSHS's cross-system Executive Committee;
- Regularly develop formal reports (e.g., regional needs assessments) to assist in identifying local/regional priorities, as well as for review by higher-level entities who can then act accordingly through policy, fiscal, regulatory, and other actions;
- Receive regular reports from higher-level entities on priorities for action and policy, fiscal, regulatory, and other actions taken in response to input from the regions.

For more examples of promoting effective communication, see the communication section of the Regional FYSPRT Charter in Appendix D, and Appendix G, Section 6.

Promoting Communication at the Regional and Local Levels

- The Regional FYSPRT will develop and implement communication mechanisms for informing the community about progress and information and changes from the Statewide/ELT level.
- Following communication protocols established in the *T.R. Quality Management Plan*, the Regional FYSPRT will inform the Statewide/ELT about local progress, needs and barriers, and recommendations about WISe implementation. The ELT will review this information and report back on any decisions or recommendations to the Statewide FYSPRT, through attendance of an ELT member at the Statewide FYSPRT.
- The Regional FYSPRT support at least two (2) Regional FYSPRT Tri-Leads to attend each Statewide FYSPRT meeting on a rotating schedule to bring information from the Statewide FYSPRT meeting back to the Regional FYSPRT members (and Local FYSPRT Tri-Leads, as Local FYSPRTs are developed and information can be shared with Local FYSPRT members) for information sharing and feedback requests at the regional and local levels.
- The Regional FYSPRT will review and be prepared to provide feedback to DBHR, as requested, regarding documents related to Statewide FYSPRT responsibilities, and information requests for relevant grants.

Reviewing Outcome and Process Data and Reports

- Starting in January 2016, Regional FYSPRTs will review reports and provide feedback, including the Wraparound with Intensive Services (WISe) reports at least once per quarter, to identify trends, relevant strengths and needs for improvement (e.g., against state benchmarks), system barriers, system challenges and local service needs for youth and families.
- Regional FYSPRTs will help resolve issues by 1) either by taking action at the local or regional level, or 2) elevating the issue to the Statewide FYSPRT. Updates to the Strategic Plan and/or Annual Plan should be considered, based on these reviews.

- In addition, Regional FYSPRTs will review other publically available or ad hoc reports relevant to the functioning of the child and youth system of care, e.g.:
    - Statewide System Performance Reports
    - Child and Adolescent Needs and Strengths (CANS) reports
    - Reports generated by the UW Evidence Based Practice Institute (EBPI)
    - State and Regional Evaluation Reports
- ***Benchmark***: Regional FYSPRTs will allocate time at **2 meetings annually** to the review of quality assurance reports provided by DSHS/DBHR regarding regional service processes.
- ***Benchmark***: Regional FYSPRTs will allocate time at **2 meetings annually** to plan, review, and interpret local data on strengths and needs of the regional service delivery system for children, youth, and families.

Participating in Training

- Regional FYSPRTs will support members to engage in FYSPRT-related training and technical assistance meetings or events as developed/ supported/ sponsored by DBHR or entities contracted by DBHR.

Regional FYSPRT Policies

Regional FYSPRTs will develop their own written policies and procedures and post them to the Regional FYSPRT webpage, as they become available, to address the following:

1. Meeting frequency and considerations for quorums
2. Attendance and representativeness
3. Meeting rules and norms
4. Voting
5. Membership Requirement Compliance
6. Committee Structure
7. Quality Assurance Processes (data review, collection, reporting, and use)
8. Travel and other meeting support

Examples of relevant materials to guide Regional FYSPRTs to establish these policies and procedures are available in the ***Resource Guide*** located in Appendix G, Section 12 of this Manual.

Annual FYSPRT Products

Nationally, effective local and regional collaboration entities are typically called upon to undertake a systematic priority-setting process to guide resource and service development. These activities result in products that aid in the entity's ability to identify needs, inform communities, and document successes and needs for further improvement. This sequence of activities helps maximize the regional entity's (i.e., FYSPRT's) effectiveness and relevance, and guides its activities.

Toward these ends, the Regional FYSPRT will annually conduct activities that produce three products that provide "blueprints" for progress and success: (1) a regional needs assessment, using the region's tool/method of choice to assist in the planning and development of Regional and Local FYSPRTs; (2) a current strategic plan for the region; and (3) a FYSPRT annual plan, that describes what the FYSPRT's specific role will be in achieving positive outcomes.

1. Developing a Needs Assessment (Summary of Regional/Local Needs)

- The Regional FYSPRT will collect data from stakeholders (including FYSPRT members and other system, family, youth, and community stakeholders). The FYSPRT will review and interpret WISe data, gaps analysis data from the UW EBPI, state and local reports on system performance, and any other data available. With this information, they will document strengths and prioritize needs for improvement, and submit a report to DSHS, no less than annually, on priority needs for children, youth, families, programs, services, local supports, and system development in the region.
    - See Appendix G, Section 4 for examples of Needs Assessment procedures and types of materials and information to include in the Needs Assessment.
    - Using the Region's tool of choice, each community will have the flexibility to determine how this plan will look and function for them. Examples in the Appendix G, Section 4 Resource Guide are Benchmarks.
    - In an effort to reduce duplication of effort, present and former FYSPRT regional representatives are encouraged to work together when assessing needs. Identification and documentation of needs can be achieved by compiling results of other required or ad hoc needs sensing and data collection exercise, through regular FYSPRT activities such as meetings, and/or using tailored procedures such as:
        - A Nominal Group Decision Process
        - The *Partnerships for Success* community mobilization activity
        - Online and in-person surveys and/or focus groups (see Appendix G, Section 4 for examples of the above)
- The needs assessment will be completed annually and should result in a written report, beginning 2016, outlining:
    - Local/regional strengths and barriers with regard to the development and sustainability of the Regional FYSPRT.
    - Recommendations regarding the development and operation of the Regional FYSPRT.
    - Recommendations and a proposed timeline for the development of Local FYSPRTs (for example: how many, where they should be located, how they will work with the Regional FYSPRT and with WISe Community Collaboratives, and strengths and barriers with regard to development and sustainability).
    - Resources available that promote social marketing of the Washington State Children's Behavioral Health Principles, and behavioral health awareness.

- Resource needs (for example, requests for technical assistance, training, family/youth leadership development needs).

2. Developing a Regional Strategic Plan
Drawing upon the results of the needs assessment, local planning meetings, FYSPRT evaluation results, and/or other source information (see above), the Regional FYSPRT should undertake a process of developing or reviewing a five-year strategic plan for the region's child and youth behavioral health system of care. The development of the strategic plan should be submitted to the state, and reviewed (and updated as needed) no less than annually.

Additional details on key components of a strategic plan, approaches to developing them for systems of care, and sample logic models are provided in the following link: (http://gucchd.georgetown.edu/products/Toolkit_SOC_Resource6.pdf).

By March 31, 2016, a framework for a strategic plan must be submitted to the state that shows initial thinking/steps towards the development of a five-year strategic plan.

Benchmark: The Regional FYSPRT will submit a Strategic Plan including no fewer than three priorities for the region's system of care development. Ideally, the strategic plan will also include a logic model, describing a theory of how specific strategies and action steps will lead to positive child/youth, service, and system outcomes.

3. Developing a FYSPRT Annual Plan
Following the development of the Regional FYSPRT's Strategic Plan in 2016, an annual action plan specific to the FYSPRT should be created. Using the Region's tool of choice, each community will have the flexibility to determine how this annual plan will look and function for them. Examples in the ***Resource Guide*** are **Benchmarks**.

The annual plans should include: goals/action steps/those assigned/ timelines for core activities specific to the FYSPRT, including outreach/recruitment, training/leadership development, special projects, areas of planning focus, training, social marketing, etc.

- The Regional FYSPRT will provide quarterly reports to describe any progress towards completing action steps identified in the annual plan (see Appendix G, Section 5 for examples from other states) and any progress towards completing action steps identified in the strategic plan.
    - Reports will be reviewed by the DBHR Contract Manager and by the quality review structure identified in the T.R. Quality Management Plan.

Benchmark: The Regional FYSPRT will establish five priorities for the activities and efforts of the FYSPRT, in partnership with DSHS/DBHR, based on identified needs, and submit an annual work plan based on these priorities. The annual plan will include information on how FYSPRT members will work collectively to support meeting the needs of these priorities, and any additional effort to identify priorities for action and needs for improvement.

Meetings and Meeting Frequency

Beginning on or before January 2016, the Regional FYSPRT:

- Will hold monthly meetings with a quorum of at least 51% of current membership in attendance (as defined by the Regional Charter and/or FYSPRT Policies and Procedures).
- Meetings will take place within the designated region and in a setting accessible to families, youth, system partners, and stakeholders.
    - Meetings will be open public meetings; however, voting can be restricted to FYSPRT members. Since meetings are open, the number of attendees can and should exceed the number of official members. Meetings should be scheduled at convenient times for families, youth and other stakeholders, included evenings and weekends.
    - Meeting information will be publicized to stakeholders via outreach, the FYSPRT webpage for each Region, and other strategies.
    - Meetings must be tri-led, with agendas developed with input from the FYSPRT membership and meetings facilitated jointly by the three leads (family, youth, and system partner). Agendas and written materials (including quarterly data reports) should be distributed in advance with sufficient time for review/preparation prior to the meeting.
- Materials must be made publicly available on the FYSPRT's website, including:
    - Regional FYSPRT agendas and meeting minutes
    - Dates, locations, and times of past and upcoming meetings
    - A Regional Charter
    - Policies and procedures (as they become available)
    - Results of the needs assessment and a strategic plan framework (as they become available)
    - Links to relevant local/regional/statewide resources and information

- The Regional FYSPRT will document participation in each meeting.
- State partners need to be clear about representation for regional or local meetings, as to avoid duplication of effort. Regional and local meetings should have a clear purpose and agenda ahead of time, in order to assist state and regional system partners in determining adequate representation.
- Regional FYSPRT meetings should identify and address systemic strengths, challenges, and barriers to service delivery and inform state-level policy by:
    - Elevating systemic issues, identified at the local and regional levels, to the Statewide FYSPRT and other appropriate state-level entities,
    - Developing and implementing communication mechanisms for informing the regional and local community about progress and information and changes from the Statewide/ELT level,
    - Following communication protocols established in the T.R. Quality Management Plan, inform the Statewide/ELT about progress, information, and recommendations from the local and regional levels.

Conducting Evaluation of FYSPRT Activities

Evaluation of process and outcome is a cornerstone of effective system of care operations. Specific expectations of FYSPRTs regarding evaluation include the following:

- Quarterly, beginning in 2016, the Regional FYSPRT will use the FYSPRT Evaluation Tool and FYSPRT Evaluation – Narrative Team Effectiveness Questionnaire (see *Conducting Evaluation of Regional/Local Activities* in Appendix G, Section 9) to gather data to identify areas of strengths and areas of improvement related to the function and effectiveness of Regional and Local FYSPRT meetings.
- The Regional FYSPRT will regularly evaluate the perceptions of its members and other stakeholders regarding the effectiveness of the FYSPRT in conducting its core activities, such as:
    - Relevance and comprehensiveness of its Needs Assessment, Strategic Plan, and Annual Plan (See below)
    - Progress towards Annual Plan goals/strategies
    - Effectiveness at Promoting Communication and conducting Social Marketing
    - Using reviews of Outcome and Process Data and Reports to make recommendations and identify strengths and needs
    - Effectiveness/Impact on systemic change
    - Attendance lists/number of unduplicated parents and youth participating in activities related to FYSPRTs
    - Number of trainings and FYSPRT-related activities the Regional FYSPRT convener supported FYSPRT members to attend
    - Number of Local and Regional FYSPRT meetings held throughout the region

For examples of specific evaluation strategies for community-based entities such as FYSPRTs and family- and youth-run organizations, please see Appendix G, Section 9.
Benchmark: Collected during every Regional FYSPRT meeting.

Funding

Through March 31, 2016, resources for Regional FYSPRTs will be available through contracts between DSHS and RSNs, with funds available to any independently contracted “Convener” through contracts between the RSN and that entity. Resources provided to Regional FYSPRTs will be expected to support:

1. The deliverables of the contract between DSHS and the regional contractor.
2. Coordination of FYSPRT activities that assist in meeting the strategies and goals identified in the strategic and annual plans.
3. Meeting and travel support for participation by family, youth, and community stakeholders.

Successful undertaking of the above activities and implementation of creative strategies, detailed in annual action plans, may require strategic combining of funding from different sources (e.g., the Mental Health Block Grant, the T.R. Settlement Agreement, and the System of Care grant, regional resources, partner agency resources, community resources, grants and awards, etc.).

Appendix A

Glossary of Key Terms

Definitions: The words and phrases listed below shall each have the following definitions:

a. **"Division of Behavioral Health and Recovery"** or "DBHR" means the DSHS-designated state mental health authority to administer the state and Medicaid funded mental health programs authorized by RCW chapters 71.05, 71.24, and 71.34.

b. **"DUNS"** or "Data Universal Numbering System" means a unique identifier for businesses. DUNS numbers are assigned and maintained by Dun and Bradstreet (D&B) and are used for a variety of purposes, including applying for government contracting opportunities.

c. **"Family"** is defined as a family member who can demonstrate lived experience as a parent or primary caregiver who has raised a child and navigated multiple child serving systems on behalf of their child or children with social, emotional, and/or behavioral healthcare needs.

d. **"Family/Youth Run Organizations"** are organizations, in which the board is made up of at least 51% family/youth members with lived experience, that is dedicated to supporting youth with mental, emotional, behavioral, or substance abuse needs.

e. **"Full partners"** are persons or entities who play an active role in the development and implementation of activities under the "T.R. v. Quigley and Teeter" (formerly Dreyfus and Porter) Settlement Agreement. Full partners have the same access to data and equal rights in the decision-making processes as other members of the Governance structure.

f. **"Fully Integrated Managed Care"** Regional Service Area will be Skamania and Clarke counties. Another term used to identify this early adopter region is Managed Care Organization (MCO) or Early Adopter.

g. The **"Governance Structure"** consists of inter-agency members on an Executive Team of state administrators, the Statewide, Regional, and Local FYSPRTs, an advisory team, and various policy workgroups who to inform and provide oversight for high-level policy-making, program planning, and decision-making in the design, development, and oversight of behavioral health care services and for the implementation of the T.R. v. Quigley and Teeter settlement agreement.

h. **"Local Family Youth System Partner Round Table"** or "Local FYSPRT" draw membership from the communities and neighborhoods of each area covered by the Regional FYSPRT to locally engage families and youth, civic/tribal partners and others who are interested in and committed to the success of youth and families to inform and support the activities of the Regional FYSPRT.

i. **"Regional Family Youth System Partner Round Table"** or "Regional FYSPRT" is an essential part of the Governance Structure that meaningfully engages families and youth, governmental/tribal partners and others who are interested in and committed to the success of youth and families in an equitable forum to identify local

needs, review local/regional data, problem-solve and address issues at the local and regional levels to improve outcomes, and bring unresolved needs forward to the Statewide FYSPRT with recommendations about how to meet those needs. Regional FYSPRTs are grounded in the Washington State Children's Behavioral Health Principles.

j. **"Tri-Lead"** is a role, developed to create equal partnership, among a family, a transition age youth and/or youth partner, and a system partner representative who share leadership in organizing and facilitating Regional FYSPRT meetings and action items.

k. **"T.R. v. Quigley and Teeter (formerly Dreyfus and Porter) Settlement Agreement"** is a legal document stating objectives to develop and successfully implement a five-year plan that delivers Wraparound with Intensive Services (WISe) and supports statewide, consistent with Washington State Children's Behavioral Health Principles.

l. **"Transition Age Youth"** are individuals between the ages of 15 and 25 years of age.

m. **"Washington State Children's Behavioral Health Principles"** are a set of standards, grounded in the system of care values and principles, which guide how the children's behavioral health system delivers services to youth and families. The Washington State Children's Behavioral Health Principles are:

- Family and Youth Voice and Choice
- Team Based
- Natural Supports
- Collaboration
- Home and Community-based
- Culturally Relevant
- Individualized
- Strengths Based
- Outcome-based
- Unconditional

n. **"Wraparound with Intensive Services"** or "WISe" means intensive mental health services and supports, provided in home and community settings, for Medicaid eligible individuals, up to 21 years of age, with complex behavioral health needs and their families, in compliance with the T.R. v Quigley and Teeter (formerly Dreyfus and Porter) Settlement Agreement.

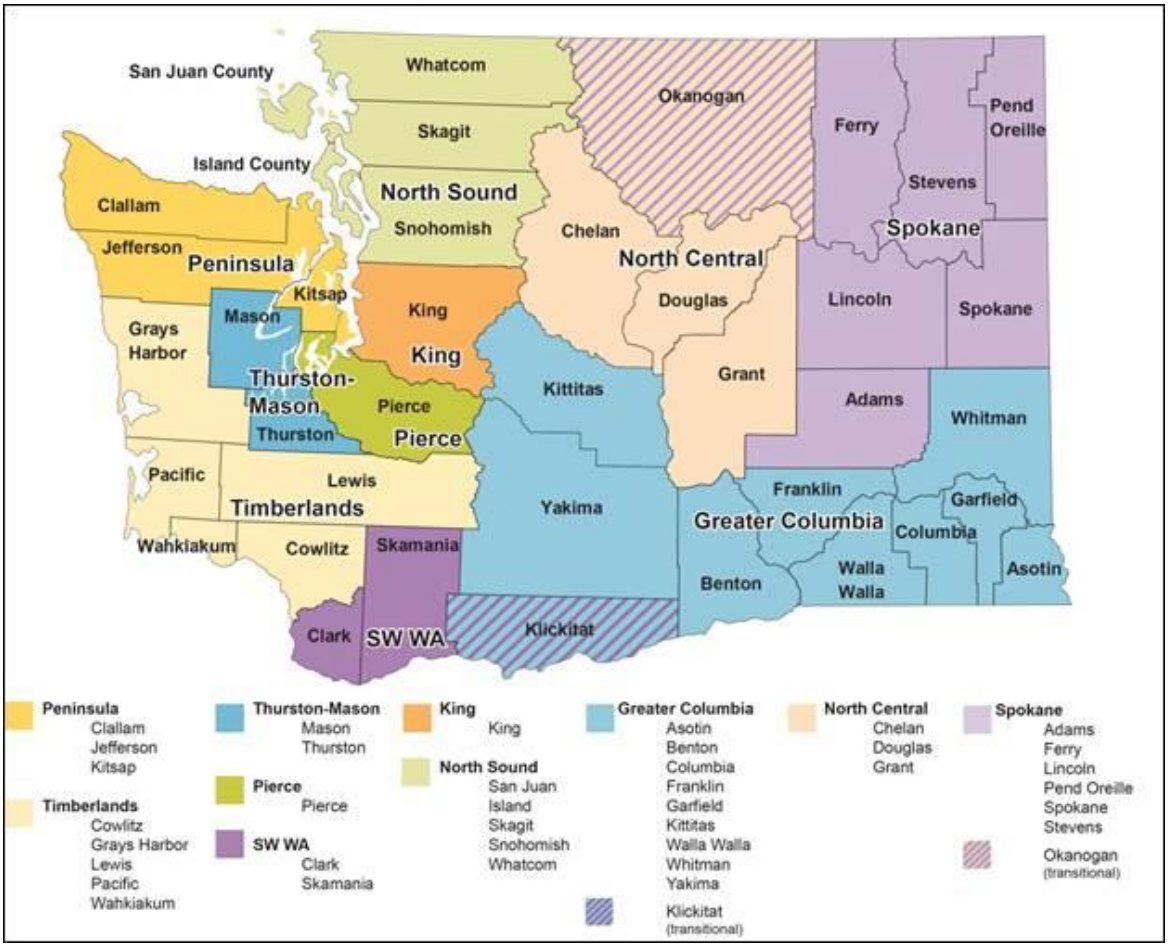
o. **"Youth Partners"** are young adults over the age of 18 with lived experience as a youth in the behavioral health system, and who are providing peer support and/or coordinating services with youth.

Appendix B

Map/list of Behavioral Health Organizations (formerly Regional Support Network) regions of Washington State

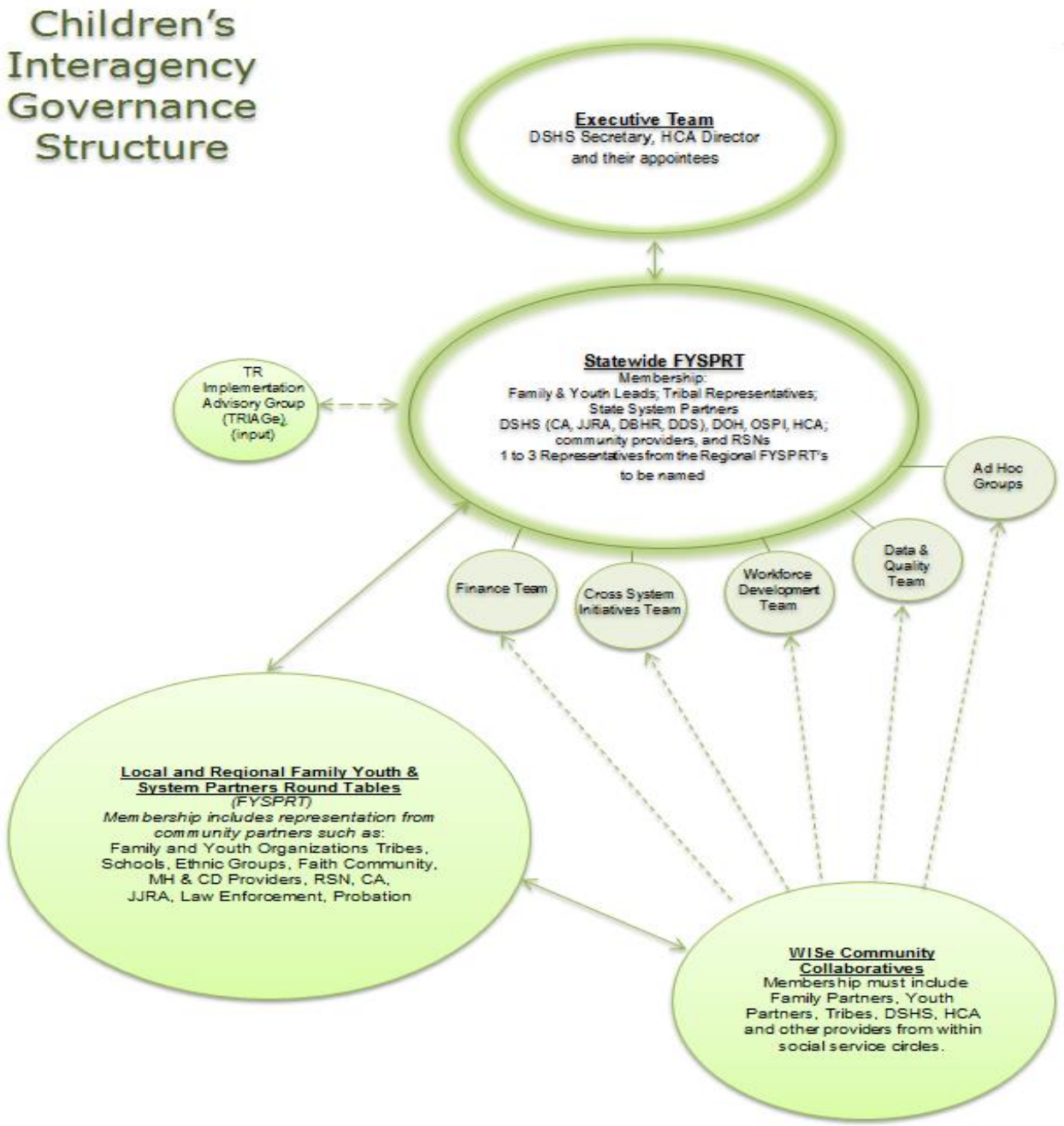
Under SB 6312, Behavioral Health Organizations (BHOs) will become the unique local entity that holds responsibility and financial risk for providing substance use disorder treatment and all of the mental health services currently managed by the Regional Support Networks (RSNs).

DSHS and the Health Care Authority have designated geographic Regional Service Areas (RSAs) for purchasing physical and behavioral health care services, which are shown below on an updated map describing how the regions will evolve over time. BHOs will be responsible for behavioral health services within their RSA. RSAs are geographic regions; they are NOT administrative authorities. Counties in **Early Adopter RSAs** will adopt a purchasing model in which care is delivered through Managed Care Organizations (MCO).



Appendix C

Washington State Children's Behavioral Health Governance Structure



Appendix D

REGIONAL FAMILY YOUTH & SYSTEM PARTNER ROUND TABLE (FYSPRT)

For Washington State's Systems of Care Project

CHARTER

Project Name: Regional Family, Youth & System Partners Round Table (FYSPRT) Charter
Prepared By: Jeanette Barnes and the Structure Workgroup
Date: March 13, 2014

A Purpose and Function of the Regional FYSPRT

FYSPRT Purpose

The Washington State Family, Youth and System Partner Round Tables (FYSPRTs) provide an equitable forum for families, youth, systems, and communities. FYSPRTs strengthen sustainable resources by providing community-based approaches to address the individualized behavioral health needs of children, youth, and families. They leverage the experiences and expertise of all participants dedicated to building seamless behavioral health services, and:

1. Provide a working partnership among family, youth, systems, and community partners, bringing broad perspective to build and strengthen relationships inclusive of family/youth voice in decision-making processes.
2. Identify family, youth, systems, and community needs.
3. Create options and opportunities to address family and youth priorities.
4. Promote Family- and Youth-Driven solutions to address system challenges and barriers
5. Develop common ground through mutual learning amongst all participants.
6. Provide leadership and influence for the establishment and sustainability of Washington State Children's Behavioral Health System.
7. Provide input on long-term strategies in support of fully implementing changes to Washington State Children's Behavioral Health System.
8. Ensure accountability through evaluation.

Primary Functions

FYSPRTs support and track the six goals of the Washington State System of Care (SOC) which are to:

1) Infuse SOC values in all child-serving systems.

2) Expand and sustain effective leadership roles for families, youth, and system partners.

3) Establish an appropriate array of services and resources statewide, including home- and community-based services.

4) Develop and strengthen a workforce that will operationalize SOC values.

5) Build a strong data management system to inform decision-making and track outcomes.

6) Develop sustainable financing and align funding to ensure services are seamless for children, youth, and families.

QUORUM for Decision Making

- At least fifty one percent (51%) of membership need to be present for a quorum for the purpose of making a decision

Decision-Making Responsibilities

The Regional FYSPRT is responsible for:

- Developing Decision Making Protocols following consensus process
- Prioritizing strategies and activities that support the expansion of Systems of Care

B Regional FYSPRT Membership

Regional FYSPRT membership is comprised of Family, Youth and System Partner Regional and Local Tri Leads. Participants outside the membership are also welcome to attend and provide input and feedback regarding community needs.

Suggestions for Participant Make-up at the Regional Level:

- Representatives of local systems
- Community leaders that reflect the diversity in the community
- Community Organizations/networks/ coalitions (Goodwill, Boys and Girls Club, at-risk youth)
- Faith Community
- Children's Administration
- Juvenile Justice
- Mental Health
- Chemical Dependency
- Developmental Disabilities Admin.
- Law Enforcement
- School district and ESD staff
- Military
- Early Learning – Head Start
- Tribes
- Family & Youth groups/organizations
- Family/Youth leaders
- Public Health
- 12-step groups
- Youth-led programs
- Employers
- Division Vocational Rehabilitation
- Kinship groups
- Adult consumers
- Advocacy groups
- Foster Care youth and family groups
- College and University Campus groups

Membership Minimum Ask:

- Commitment to participate

Tri – Lead -

- Terms - preferred minimum ask of 2 years

- System Partner Tri-Lead—At the discretion of the FYSPRT contractor the first right of refusal will be given to the Children's Care Coordinator employed by the regional contracting authority to take the role of System Partner Tri-Lead
- Youth Partner Tri-Lead –At the discretion of the FYSPRT contractor the Youth Tri-Lead will be connected to the Youth 'N Action movement
- Family Partner Tri-Lead -- At the discretion of the FYSPRT contractor the Family Tri-Lead will be connected to the contracting organization

- Attendance - open
- Describe and set a value of participants' time including family, youth and system partners – *needs to be developed further*

Role of a Regional FYSPRT Participant

It is intended that the Regional FYSPRT leverage the experiences, expertise, and insight of key individuals, organizations, and departments that are committed to building a Systems of Care for children's behavioral health. Regional FYSPRT members are not directly responsible for managing project activities, but provide support and guidance for those who do. Thus, individually, members will:

- Through education, collaboration and participation influence the movement toward the infusion of system of care values and principles in community organization, workforce development, policies, practice, financing, and structural change.
- Bring community, individual and agency strengths in completing necessary tasks.
- Identify barriers/challenges and approaches to resolve issues.
- Identify strengths/initiatives/projects of existing community and system agencies that support systems of care values and principles.
- Educate our system of care partners as we develop and grow.
- Develop problem solving approaches for moving forward.

Tri Lead Position Descriptions and Responsibilities

Youth	Family	System Partner
Ability to check and respond to emails at least twice a week, unless otherwise communicated	Ability to check and respond to emails at least twice a week, unless otherwise communicated	Ability to check and respond to emails at least twice a week, unless otherwise communicated
2 year minimum from appointment	2 year minimum from appointment	2 year minimum from appointment
Participate in regularly scheduled meetings	Participate in regularly scheduled meetings	Participate in regularly scheduled meetings
Attend all state-wide FYSPRT meetings	Attend all state-wide FYSPRT meetings	Attend all state-wide FYSPRT meetings
Participate in YNA meetings and activities as determined	Maintain regular contact/connection with Family Organization(s) in your region if applicable	Maintain regular contact with system partners in your region
Under age 25 and has personal lived experience	Is a parent or caregiver of a child with system involvement	Has demonstrated ability to foster relationships with youth and family

Youth	Family	System Partner
Preference youth in transition, has connections with youth leaders, understands youth culture, peer – lived experience recovery as a youth	Has connections with family leaders, understands family culture, peer – lived experience as a parent/caregiver, of a child with multisystem involvement	Has demonstrated ability to foster relationships with youth and family, is a champion for family driven and youth guided services, consistent with System of Care Values
Has actively participated in community for a minimum of 6 months	Has actively participated in community for a minimum of 6 months	Has actively participated in community for a minimum of 6 months
Is able to identify community partners and resources	Is able to identify community partners and resources	Is able to identify community partners and resources
Has access to email and phone on a consistent basis	Has access to email and phone on a consistent basis	Has access to email and phone on a consistent basis
Has the ability (or is willing to with training) to facilitate meetings	Has the ability (or is willing to with training) to facilitate meetings	Has the ability (or is willing to with training) to facilitate meetings
Ability to record information and share	Ability to record information and share	Ability to record information and share
Leadership Training	Leadership Training	Leadership Training
Quarterly check-ins with support staff	Quarterly check-ins with support staff	Quarterly check-ins with support staff
Include some kind of on-going evaluation	Include some kind of on-going evaluation	Include some kind of on-going evaluation
Attend all FYSPRT's meetings and activities	Attend all FYSPRT's meetings and activities	Attend all FYSPRT's meetings and activities
Participate in YNA meetings and activities as determined	Participate in activities/meetings etc. with Family Organization(s) in your region if applicable	Participate in meetings with system partners to share the system of care values and perspectives
Participate in regularly scheduled community meetings	Participate in regularly scheduled community meetings	Participate in regularly scheduled community meetings
Summarize and present materials and information from FYSPRT meetings to community	Summarize and present materials and information from FYSPRT meetings to community	Summarize and present materials and information from FYSPRT meetings to community
Record and bring back information from youth in communities to FYSPRT meetings	Record and bring back information from families in communities to FYSPRT meetings	Record and bring back information from system partners in communities to FYSPRT meetings
Support WA state initiatives related to Children's Behavioral Health	Support WA state initiatives related to Children's Behavioral Health	Support WA state initiatives related to Children's Behavioral Health
Identify needed trainings and technical assistance for youth in communities. Assist with identifying youth/family/system partners and creating resources and	Identify needed trainings and technical assistance for families in communities. Assist with identifying youth/family/system partners and creating resources and	Identify needed trainings and technical assistance for system partners in communities. Assist with identifying youth/family/system partners

Youth	Family	System Partner
skill development opportunities to infuse voice throughout the system	skill development opportunities to infuse voice throughout the system	and creating resources and skill development opportunities to infuse voice throughout the system
Participate in Tri-Lead preparatory activities prior to regional and state meetings	Participate in Tri-Lead preparatory activities prior to regional and state meetings	Participate in Tri-Lead preparatory activities prior to regional and state meetings

Contract Lead:

- Participate in preparation of SOC progress reports to be submitted to SOC Project Manager as described in grant requirements
- Track demonstrations of success integrating the SOC goals in activities and events.
- Gather SOC related activity information to submit for federal reporting in the TRAC System Review the status of the project.
- Review SOC outputs for compliance with grant requirements and expectations of key stakeholders.
- Participate in writing the SOC plan representing respective Regional FYSPRT perspective.
- Provide timely SOC progress reports to chain of command authorities for feedback and support.

AD HOC Committees

As needed for Regional FYSPRT and Local FYSPRT development, Regional Tri Leads, and other FYSPRT leadership will participate in Ad Hoc Committees to address needs in a collaborative manner, including youth, family, and system partner voice.

COMMUNICATION

Communication is intended to flow between all levels of the governance structure. Regional FYSPRT Tri Leads will bring information from the Statewide FYSPRT to Regional meetings for information sharing in their community and also bring concerns, themes from Regional meetings to the Statewide FYSPRT as needed. When problem solving around an item or situation is needed, Regional members will first contact their Regional Tri Leads for discussion and brainstorming. If needed and appropriate, the item or situation will be added to the next Regional FYSPRT agenda for discussion with the group. If the item or situation is not resolved within the Regional FYSPRT group, the Regional FYSPRT Tri Leads would take the concern to the Statewide FYSPRT Tri Chairs for discussion and possible addition to the Statewide FYSPRT agenda.

Communication Responsibilities for Regional FYSPRT Tri Leads

- Create agenda for Regional FYSPRT meetings
- Attend Statewide FYSPRT meetings and report meeting updates and outcomes to the Regional FYSPRT.

- Post meeting notes and schedules to the website.
- Maintain communication with local FYSPRTs, community members, and work groups.
- Utilize the communication diagram as appropriate.
- Disseminate Statewide FYSPRT materials for review and recommendations to Regional and Local FYSPRT participants.
- Participate in information sharing among Regional FYSPRTs.

SOCIAL MARKETING

Each Regional FYSPRT will have a social marketing plan including both a website and brochure to share information with the community.

Minimum website components include:

1. Meeting dates, locations, and times
2. Contact information
3. FYSPRT Mission and Vision
4. Uniform Banner to encompass all images
5. Contacts and information on local FYSPRTs (if available)
6. Link to the Statewide FYSPRT page
7. Map showing “your” FYSPRT and others
8. Calendar of events
9. Highlights about what youth, families, system partners are doing or work they have accomplished
10. FAQs – What is SOC, What is a FYSPRT, and an FAQ targeted to Youth
11. Resources about SOC
12. Statement about sponsored by DBHR and the website link
13. Toolkits
14. Meeting notes from Regional and Local FYSPRTs
15. Contact information for who to talk with if you want to start your own FYSPRT

Minimum brochure components include:

1. Banner of Regional FYSPRTs Banners
2. What is a FYSPRT?
3. FYSPRT Mission and Vision
4. Map of FYSPRT Region and Local FYSPRTs within the Region
5. “Why should you participate” paragraph
6. Dates/Time/location that meetings occur or link of where to get that information
7. Contact information for FYSPRT
8. Regional FYSPRT web address and Statewide FYSPRT web address
9. Statement about sponsored by DBHR and the website link www.dshs.wa.gov/dbhr/childrensbehavioralhealth.shtml
10. Quotes from youth, family, and system partners, etc. (the personal touch)

C Regional FYSPRT Meetings

Meeting Schedule – meet on a regular schedule as determined by the FYSPRT Community

Meeting Agenda – Will be set by the Tri-Leads based on input from FYSPRT community. Agenda will be distributed to members at least one week before the meeting occurs.

Meeting Operations - Identified Roles

- Facilitator
- Time Keeper
- Note Taker
- Orientation Lead - to greet new members and participants

Meeting Norms or Comfort/Value agreement - To Be Individualized by each Regional FYSPRT

Examples:

- meetings begin/end on time
- 1 person at a time
- cell phone use agreement

ACTIVITIES – to be determined by FYSPRT participants based on community needs tying into statewide activities.

- Support for conference and training participation as resources permit
- Social Marketing Piece (i.e. PSA) work in progress
- MOU Template – *find different language, suggestions for different language include Collaborative Agreement or Partnership Agreement*

Appendix E

System of Care Core Values and Guiding Principles

Core Values

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.

2. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.

3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

Guiding Principles:

The following[1] represent the foundational principles of the system of care philosophy that systems of care are designed to:

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.

2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.

3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.

4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.

5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.

6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding

boundaries and mechanisms for system-level management, coordination, and integrated care management.

7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.

8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.

9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.

10. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.

11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.

12. Protect the rights of children and families and promote effective advocacy efforts.

13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

[1]Stroul, B., Blau, G., & Friedman, R. (2010). *Updating the system of care concept and philosophy*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Appendix F

Potential Regional FYSPRT members

- Representatives of local systems
- Community leaders that reflect the diversity in the community
- Community Organizations/networks/ coalitions (Goodwill, Boys and Girls Club, at-risk youth)
- Faith Community
- Children's Administration
- Juvenile Justice
- Mental Health
- Substance Use Disorders Treatment Providers
- Developmental Disabilities Admin.
- Law Enforcement
- School district and ESD staff
- Military
- Early Learning – Head Start
- Tribes
- Family & Youth groups/organizations
- Family/Youth leaders
- Public Health
- 12-step groups
- Youth-led programs
- Employers
- Division Vocational Rehabilitation
- Kinship groups
- Adult consumers
- Advocacy groups
- Foster Care youth and family groups
- College and University Campus group

Appendix G: Resource Guide

The Resource Guide was created in an effort to provide Regional FYSPRTs with materials that may aid in undertaking their core activities and completing their expected deliverables. These resources are derived from national technical assistance documents, relevant to systems of care and family and youth leadership, as well as local examples of policies, tools, and deliverables.

The resources provided in this guide are intended to be used as examples to support implementation and sustainability in your FYSPRT. Resources and templates can be modified to meet regional and local needs (or not used at all, if more appropriate tools or procedures already exist within your region).

The following sections are included in this Resource Guide. Please view the materials compiled in each section (many of which are provided via links to web-based resources) and the accompanying description(s) for more information.

1. General Guidance to System of Care Building

Materials in this section are intended to assist FYSPRTs and those managing FYSPRT activities to identify, build, and engage leaders, and to promote productive cross-stakeholder collaboration to improve local and regional systems of care for children, youth, and families.

A. Principles of Effective Leadership

Guides for building effective leadership can be accessed via the ***Building Systems of Care: A Primer, 1st Edition*** online at: http://gucchd.georgetown.edu/products/PRIMER_CompleteBook.pdf

- Specifically Section II "The System-Building Process" located on pages 143-164 of the document.

Eight Principles of Leadership

1. Leaders communicate a shared vision.
2. Leaders centralize by mission and decentralize by operations.
3. Leaders create an organizational culture that identifies and tries to live by key values.
4. Leaders create an organizational structure and culture that empowers their employees and themselves.
5. Leaders ensure that staff are trained in a human technology that can translate vision into reality.
6. Leaders relate constructively to employees.
7. Leaders access and use information to make change a constant ingredient of their organization.
8. Leaders build their organization around exemplary performers.

For more about the principles of Leadership, see: http://cpr.bu.edu/resources/newsletter/principled-leadership-mental-health-systems#The_Eight_Principles_of_Leadership

B. Cultivating Leaders

Cultivating Leaders: State Examples
Hawaii: • Leadership development has not been used as an expansion strategy. A leadership development program has been sponsored by the state agency (1 day per week for 10 weeks). The program focused on both the theory and practice of leadership and involved mental health system leaders and family leaders throughout the agency but was not specifically designed to focus on cultivating leaders for systems of care per se.
Maryland: • Vehicles for leadership development have included leadership academies, bringing key state and local leaders to system of care community meetings, training institutes, and other forums for education, training, and cultivation of leaders for the system of care approach. • The Maryland Coalition of Families offers a Family Leadership Institute to support family members in becoming leaders in their communities, in the state, and nationally.
Michigan: • The state has brought Georgetown Technical Assistance Center staff to do leadership training for state and local system of care leaders funded by Mental Health Block Grant dollars. Follow-up activities are incorporated into the training.
Rhode Island: • A new focus on cultivating state leaders is being implemented by providing leadership

development in training and coaching and through work with community lead agencies. The state is exploring the potential use of a university to provide leadership development for state and provider-level system of care leaders.
- The Rhode Island Parent Support Network has worked to cultivate family leadership.
- Some leadership development has occurred by supporting key individuals to attend Georgetown University leadership academies.

Example from "Effective Strategies for Expanding the System of Care Approach", September 2011 Report. Source: http://gucchdtacenter.georgetown.edu/publications/SOC%20Expansion%20Study%20Report%20Final.pdf

C. PRINCIPLES TO GUIDE COLLABORATION

Principles to Guide Collaboration

- **Build and maintain trust so collaborative partners are able to share information, perceptions, and feedback and work as a cohesive team.**
- **Agree on core values that each partner can honor in spirit and practice.**
- **Focus on common goals that all partners will strive to achieve.**
- **Develop a common language so all partners can have a common understanding of terms such as "family involvement" and "culturally competent services."**
- **Respect the knowledge and experience each person brings.**
- **Assume best intentions of all partners.**
- **Recognize strengths, limitations, and needs; and identify ways to maximize participation of each partner.**
- **Honor all voices by respectfully listening to each partner and attending to the issues they raise.**
- **Share decision making, risk taking, and accountability so that risks are taken as a team and the entire team is accountable for achieving the goals.**

Stark, D. (1999). *Collaboration basics: Strategies from six communities engaged in collaborative efforts among families, child welfare, and children's mental health.* Washington, DC: Georgetown Child Development Center, National Technical Assistance Center for Children's Mental Health.

For more on effective collaboration and system building strategies in children's systems of care, see: http://www.tapartnership.org/SOC/SOCimplementingStructuring.php?id=topic1

D. OVERCOMING BARRIERS TO COLLABORATION

Challenges to Collaboration/"Barrier Busters"	
CHALLENGE	**BARRIER BUSTERS**
Language differences: Mental health jargon vs. court jargon	• Cross training • Share each other's turf • Share literature
Role definition: "Who's in charge?"	• Family driven/accountability • Team development training

	• Job shadowing • Communication channels • Share myths and realities
Information sharing among systems	• Set up a common data base • Share organizational charts/phone lists • Share paperwork • Promote flexibility in schedules to support attendance in meetings
Addressing issues of community safety	• Document safety plans • Develop protocol for high-risk kids • Demonstrate adherence to court orders • Maintain communication with District Attorneys • Myths of "brick and mortar"
Maintaining investment from stakeholders	• Invest in relationships with partners in collaboration • Share literature and workshops • Track and provide meaningful outcomes
Sharing value base	• Infuse values into all meetings, trainings, and workshops • Share documentation and include parents in as many meetings as possible • Strength-based cross training • Develop QA measures based on values
Wraparound Milwaukee. (1998). *Challenges to collaboration/"barrier busters."* Milwaukee, WI: Milwaukee County Mental Health Division, Child and Adolescent Services Branch.	

2. Contractor Expectations

This section of the resource guide includes examples of products and other materials that may aid in completing contractual expectations for managing the FSYPRT process and completing expected deliverables.

A. BOILERPLATE CONTRACT LANGUAGE REGARDING FYSPRT OPERATIONS

In alignment with System of Care Core Values, the Contractor shall promote and support the Regional Service Area FYSPRT by providing the activities and staff, and otherwise do all things necessary or incidental for the performance of work. Promotion and support of the Regional Service Area FYSPRT includes but is not limited to the following activities: recruiting members, providing administrative support, fiscal management, arranging meeting space, and other official activities in support of the Regional Service Area FYSPRT.

The Contractor shall collaborate with Washington counties, to ensure the inclusion of family, transition age youth/ youth partners, and system partners in the development and implementation of the Regional Service Area FYSPRT.

The contractor shall ensure that all members of the Regional Service Area FYSPRT will act as full partners within the work of the Regional Area FYSPRT.

B. SAMPLES FOR COMMUNITY ENGAGEMENT PROCESS

SYSTEM LEVEL	OUTCOMES
Cross agency collaboration and fiscal blending	• Community needs are prioritized over those who are providing services • Cross agency trainings are available • Collaboration of SOC team with 211 • Agencies who receive benefits from EBPs share in costs/risks of implementation • Monthly meeting of agency representatives (learning collaboratives)
Improvements in collaborative planning	• CLC services are billable under Medicaid, private insurance, or some other form of payment • SOC will be able to give input into state level changes at MHD • Representation by parent/youth org that is regionally active
Strategic plan	• Plan is agreed upon by community partners, youth, and agencies • Participation in meetings, activities, committees by community reps • Strategic plan milestones are reached • Signed MOU's and recommitment to plan
Sustainability plan	• Funding mechanisms are identified and implemented throughout the project

	• 1/10th 1% sales tax leveraged for program sustainability • Statewide coalition of SOC teams • Available good evidence of SOC project outcomes • Regular communication with legislative members and representatives

BRIDGE LEVEL	
Community able to respond to identified needs	• Multiple options for services • No waiting lists for services • Increase in natural supports • Lower caseloads • Fewer youth sent out of the community • Alignment of needs assessment and new programs
Coordinated services for youth involved in multiple systems	• One plan for treatment • One form – no redundancies in paperwork (Such as ROI's) • More than one system involved in the planning process • Integrated data systems • Stakeholders engaged in meetings • Presence of a community plan • Less redundancy in services • Reduction in trauma of youth based on lack of information • Family and youth needs are matched to the right services
Implementation plan	• Plan which incorporates guiding principles • Unified implementation plan rather than individual plans • Sign-off on a unified implementation plan • Agreed upon timeline for implementation • ROI agreements between agencies • Increased transparency between agencies • Agencies to provide services in collaboration • Stakeholders/community members/agencies give "real" input into plan
Reduction in stigma associated with help seeking and mental health challenges	• Increasing access to services • Campaigns in schools and communities • Increase involvement by non-consumers • Attendance at tribal mental health agencies increases • Reduction in suicide at the population-level • Reduction in Juvenile Justice/Recidivism at the population-level • Youth supports • Presence of LGBTQSI-2S support groups • Having information on airwaves (TV or radio) • Increase in pride in culture (for Native and mixed-race/-heritage youth) • Increase in strength based talk • Decrease in profiling/stereotyping

	• Increase in attendance at trainings by physicians, families, youth ○ And, groups attending are diverse • Decrease in family-reported stigma
Reduction in disproportionality	• Decrease in stigma • Types and quality of services received • Proportionality (2 types – service pop reflects general pop; service pop reflects pop of need) • Service use and access is proportionate to population • Service use and access is proportionate to need • Diversions for 1st time offenders proportionate to offender population • Proportionality in (MH, JJ, CA) service use • Child Welfare (kinship and foster) families access services at similar rates

PRACTICE LEVEL	
Reductions in MH symptoms/functional impairment	• Decreases in in-patient care • Decreases in functional impairment • Decreases in number of suicide attempts • Decreases in substance abuse rates • Decreases in youth domestic violence
Reductions in length of stay and out-of-home placements	• Increase age at first offense • Decreases in youth-at-risk petitions • Decreases in out of home placements • Decreases in contempt's • Increases in appropriate placements in terms of racial/kinship • Increases in well-trained foster parents
Improvements in academic, social, and emotional health	• Increases in student GPA • Increase in school attendance • Decreases in use of school discipline

NEXT STEPS:

- Complete the Needs and Resource Assessment
- Identify measurement strategies for outcomes
  - Coordinated with TriWest and the local evaluation
- Identify key activities that represent best practices to logically address outcomes

C. TEMPLATE FOR MEMBERSHIP ROSTER

[Name of Committee] [Year/Term]

Membership Roster

	Member	Org. Affiliation (if any)	Contact (email / phone)	Term of Membership	Youth/Family/System Partner?
1					
2					
3					
4					
5					
6					
7					
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31					
32					
33					
34					
35					

Quoracy

1 Total Number of Members		
2 Members present		
3 Total Quoracy (Line 2 / Line 1)		
4 Family and Youth present		
5 Family and Youth Quoracy (Line 4 / Line 2)		

Dates of Meetings:

	Date	Time	Venue	Notes
1				
2				
3				
4				
5				
6				

Other Requirements:

Table Layout Access requirements for members Book appropriate rooms Audio/Visual Parking for external members

updated: [add date]

3. Ensuring Representativeness

This section focuses on how to engage Family, Youth, and other community organizations to help ensure full stakeholder representation on a regional FYSPRT, and meaningful engagement and leadership by diverse members of a FYSPRT.

A. How Systems of Care Structure Family Involvement

How Systems of Care are Structuring Family Involvement at Various Levels of the System	
LEVEL	**STRUCTURE**
Policy	• At least 51 percent vote on governing bodies • As members of teams to write and review RFP's and contracts • As members of system design workgroups and advisory boards
Management	• As part of quality improvement processes • As evaluators of system performance • As trainers in training activities • As advisors to selecting personnel
Services	• As members of team for own children • As family support workers, care managers, peer mentors, system navigators for other families

Examples of Role of Families/Youth in Managed Care and Systems of Care
At Systems/Policy Level: Planning & Design, Monitoring, Quality Assurance, Evaluation
At Service Delivery Level: Service Planning, Care Management, Peer Support
In Paid Staff Roles: At Systems Level, At Service Level
Role of Family Organization

Pires, S. (1999). *Examples of roles of families/youth in managed care and systems of care.* Washington, DC: Human Service Collaborative.

B. USING A YOUTH DEVELOPMENT STRUCTURE TO PROMOTE AUTHENTIC YOUTH INVOLVEMENT

A Youth Development Structural Perspective	
Changing the systems that serve young people will require fundamental changes in assumptions about who is served and what is offered/expected. Answers to each of these key questions flow directly from the youth development perspectives:	
WHO:	**ALL YOUTH, NOT JUST DISADVANTAGED YOUTH** Disadvantaged youth, youth with problems, must be served in the context of a formal support system that addresses the needs of all youth. Policy and programming cannot be deficit driven.
WHAT:	**PROMOTION OF YOUTH DEVELOPMENT, NOT THE REDUCTION OF YOUTH PROBLEMS** The reduction of youth problems is best accomplished through engaging all youth in activities that develop and apply broad competencies, and encourage and sustain their connectedness and contribution to individuals, groups, and community.
WHERE:	**COMMUNITIES, NOT JUST INSTITUTIONS OR PROGRAMS** Positive youth development hinges on the existence of supportive communities. Strong institutions and effective programs are critical, but they are only a piece of the solution. Developed one by one, they rarely congeal into a web of community supports.
WHEN:	**THROUGHOUT ADOLESCENCE AND YOUNG ADULTHOOD, NOT JUST WHEN PROBLEMS ARISE** The nature and array of community supports should change with age, but supports must be readily available for longer periods of time.
WHY:	**YOUTH ARE CURRENT RESOURCES, NOT FUTURE ASSETS** Smart investors only invest in sound investments. There will never be a national commitment to **invest** in **all** youth adequately. Commitment will come when there is a strong perception that youth are valuable **now** for what they can contribute and that there are current, valued roles that at risk youth can play.

Politz, B. (2000). *A youth development structural perspective,* Washington, DC: Academy for Educational Development. Center for Youth Development.

C. BARRIERS TO YOUTH PARTICIPATION

Barriers to Youth Participation	
As Identified by Adults	**As Identified by Youths**
• Time • Funding • Staffing • Access to youth • Lack of training (in how to work with youth) • Politics • Parents • Adult staff not empowered • Program evaluation requirements • Weak leadership • Racism	• Ageism/Adultism • Money • Racism, sexism, homophobia • Stereotyping by appearance • Time • Transportation • Language • Lack of access to information • Lack of access to opportunities • Lack of support from adults • Few role models • Lack of motivation

Politz, B. (1996). *Barriers to youth participation.* Washington, DC: Academy for Educational Development. The Center for Youth Development.

For additional ideas about promoting youth leadership and engagement, see: http://www.everyday-democracy.org/tips/5-ways-overcome-barriers-youth-engagement

D. PROMOTING FAMILY-RUN ORGANIZATIONS AND FAMILY LEADERSHIP AT THE CHILD AND FAMILY LEVEL

Below are examples from "The Role of Family-Run Organizations in Systems of Care: How Partnerships with States can Achieve Shared Goals" (Stroul, 2015).

Roles of Family-Run Organizations at the Child and Family Level

- Provide information and referrals
- Provide hotline/helpline services
- Provide parent peer support services
- Provide youth peer support services
- Provide system navigation services
- Provide respite services
- Provide support groups for families and youth
- Provide education and training programs for families and youth
- Provide services for families and youth in partner child-serving systems
- Provide social and recreational activities for families and youth in partner child-serving systems
- Provide community outreach and social media outlets to provide information and support to families and youth

Roles of Family-Run Organizations at the *Child and Family Level*	
Provide information and referrals	• Delaware Family Voice holds a monthly call for parents to ask questions about their Medicaid coverage for their children or about issues with the children's mental health system. • Iowa Federation of Families for Children's Mental Health provides information to parents and youth on diagnosis, medications, services, and understanding and exercising their rights.
Provide hotline/helpline services	• Nebraska Federation of Families for Children's Mental Health is an active partner in a Family Helpline for children's behavioral health • Rhode Island Parent Support Network developed and implemented a Peer Mentor Program that provides a toll free helpline for families in need of support, information, and referral that is staffed by parents with lived experience.
Provide parent peer support services	• Maryland Coalition of Families for Children's Mental Health provides parent peer support to families caring for a child with mental health needs; peer support services are Medicaid billable. • Michigan Association for Children's Mental Health provides parent peer support services that are Medicaid reimbursable (Parent Support Partner Project). • Nebraska Federation of Families for Children's Mental Health provides parent peer support and family navigator services to families involved with the child welfare system. • Nebraska Federation of Families has a contract with the state child welfare agency to provide parent peer support services to families involved with the child welfare system. • Tennessee Voices for Children contracts with the three Medicaid managed care organizations in the state to provide parent peer support services that are Medicaid billable.
Provide youth peer support services	• Georgia Parent Support Network provides youth peer support services through a Youth Transition Peer Center
Provide system navigation services	• Maine Parent Federation initiated a program called "Family Support Navigators" who help families identify their needs, develop family support plans, and gain the skills and knowledge needed to effectively navigate systems on their own in the future. Family support parents are provided additional training to become navigators. • Maryland Coalition of Families for Children's Mental Health has a Military Family Navigator who specializes in supporting military families caring for a child with mental health needs.
Provide respite services	• Georgia Parent Support Network provides respite homes serving over 300 youth per year. • Oregon Family Support Network provides respite services to families.

Provide support groups for families and youth	• D.C. Total Family Care Coalition provides support groups including a group for families with a child currently or previously placed in a psychiatric residential treatment facility. The group provides support, information, and resources to assist youth to transition back to their homes and community successfully.
Provide education and training programs for families and youth	• Maryland Coalition of Families for Children's Mental Health provides educational programs including Navigating the Transition Years and Active Parenting. • Montana Family Support Network provides a 12-week training program in the evidence-based Nurturing Parenting Program that addresses areas including developmental stages of children, empathy, appropriate discipline techniques, building self-worth, etc. • Nebraska Federation of Families for Children's Mental Health was contracted by the managed care organization to pilot the Targeted Parenting Assistance Program that makes online parent education modules available for families of children with behavioral health challenges. • Utah Allies with Families developed an educational program with four components – From Hope to Recovery for parents/caregivers, Sibshops for siblings, Kid Power for the identified child, and Childcare for young children. • Virginia Family Network developed a training program to teach parents skills for advocating for their child.
Provide services for families and youth in partner child-serving systems	• Kansas Keys for Networking provides a Targeted Parent Assistance Program, a program to assist youth in state custody graduate from high school and pursue post-secondary educational opportunities. • Massachusetts Parent/Professional Advocacy League has partnered with the juvenile justice system to provide assistance to families who turn to the court to obtain services. Juvenile judges have requested that this service be expanded.
Provide social and recreational activities for families and youth	• Rhode Island Parent Support Network hosts social events bringing hundreds of children and families together to create natural support communities.
Provide community outreach and social media outlets to provide information and support to families and youth	• D.C. Total Family Care Coalition holds outreach activities to increase mental health awareness and engage family members and youth in system of care activities, including presentations at health fairs and other community events on mental health stigma and how to access mental health resources. • Idaho Federation of Families for Children's Mental Health uses technology and social media to connect and provide educational opportunities to families, including webinars and interactive video programs available statewide. • Idaho Federation of Families for Children's Mental Health held

	a suicide awareness "Bowl a Thon" with over 150 youth. • Montana Family Support Network hosts a wellness festival for high school and middle school youth through Youth MOVE.

E. FAMILY LEADERSHIP AT THE STATE/LOCAL SYSTEM AND POLICY LEVEL

Examples from "The Role of Family-Run Organizations in Systems of Care: How Partnerships with States can Achieve Shared Goals" (Stroul, 2015).

Roles For Family-Run Organizations at the State and/or Local System and Policy Level

- Identify needs and initiate advocacy for children's behavioral health services and systems of care
- Participate in the development of policies and processes
- Participate in the design and implementation of services and supports
- Participate in the development of financing for services and supports
- Participate in the evaluation of policies, services, and supports, and participate in research
- Recruit, educate, and support family members and youth to participate at the system/policy level
- Develop family and youth leaders to participate at the system/policy level
- Train and certify parent peer support providers and youth peer support providers
- Provide training to professionals, families, and youth related to children's behavioral health and systems of care
- Conduct conferences for families and professionals related to children's behavioral health and systems of care
- Participate in the development and delivery of strategic communications related to children's behavioral health and systems of care

Roles of Family-Run Organizations at the State and/or Local *System and Policy Level*	
Identify needs and initiate advocacy for children's behavioral health services and systems of care	• Wisconsin Family Ties addressed the lack of a state-level organizational focus on children's mental health and instrumental in establishment of the state Office of Children's Mental Health.
Participate in the development of policies and processes	• Alabama Family Ties has representation on a large number of state-level committees and works closely with the state's protection and advocacy organization. • Idaho Federation of Families for Children's Mental Health advocated for language added to pending legislation establishing children's mental health committees in all seven regions of the state. • Michigan Association for Children's Mental Health worked to include a formal "Family-Driven, Youth-Guided Policy" in the state plan. • Nebraska Federation of Families for Children's Mental Health participated in the creation of legislation to develop and implement a statewide system of care. • Nebraska Federation of Families for Children's Mental Health was

	appointed by the Governor to the Children's Commission, a high-level leadership body to create a statewide strategic plan for child welfare reform. The organization was also appointed as one of the three tri-chairs of the system of care expansion planning initiative to develop a comprehensive strategic plan to expand and sustain the system of care approach. • New Hampshire Granite State Federation of Families is a lead partner in all children's behavioral health policy and planning in the state, providing family perspectives and experience-based expertise. Including the system of care expansion initiative, Safe Schools Healthy Students initiative, and Children's Behavioral Health Collaborative. • Texas Federation of Families for Children's Mental Health and Alamo Area Youth MOVE have participated in planning and developing the statewide system of care expansion initiative. • Wisconsin Family Ties led a six-year advocacy effort that resulted in legislation regulating the use of seclusion and restraints in schools.
Participate in the design and implementation of services and supports	• Kentucky Partnership for Families and Children created regulations for parent and youth peer support providers (Family Peer Support Specialists and Peer Support Specialists) with the Dept. of Behavioral Health; peer support is now Medicaid billable. The organization is working to include regional and state-level peer support coaches. • Massachusetts Parent/Professional Advocacy League has surveyed families and helped develop training and tools for support to primary care physicians to provide behavioral health services. • Montana Family Support Network certified workers in the evidence-based practice Triple P that teaches parenting strategies to address current parenting issues and concerns and prevent future problems. • Nebraska Federation of Families has been a key partner in the development and implementation of a new service, Alternative Response, for early intervention and prevention of involvement in the child welfare system for families. • North Carolina Families United developed early childhood and infant mental health support by developing and training parent peer support providers that specialize in working with families of young children. • Oregon Family Support Network developed goals and strategies to create a consistent array of family support services throughout the state, including support groups, respite services, social activities, advocacy training, one-on-one parent peer support, coaching and supervision of parent peer support providers, and systems navigation services. • South Carolina Federation of Families participated in the implementation of Positive Behavior Intervention and Support (PBIS) programs in schools, early intervention services for youth

	at risk of entering the juvenile justice system, and substance use services. • Wisconsin Family Ties worked with the state to expand the state's wraparound initiative to all 72 counties and 11 tribes.
Participate in the development of financing for services and supports	• Families Together in New York State participated in the design and implementation of Medicaid managed care to ensure financing for family support, respite care, and other services to reduce the use of hospitalization, emergency rooms, and residential facilities. • North Carolina Families United assisted the state transition mental health services to a managed care organizations, without losing system of care values and principles and family and youth voice and choice. • Oregon Family Support Network has served on state advisory committees and task forces to ensure that health care reform planning, service delivery, and evaluation are relevant and meaningful to the families and youth served in the state's behavioral health system. • Utah Allies with Families developed a curriculum, training, and supervision model for parent peer support providers that were accepted by Medicaid, and parent peer support services are now Medicaid billable. • Wisconsin Family Ties played a key role in state budget initiatives resulting in a $29 million increase in mental health funding for 2013-2015.
Participate in the evaluation of policies, services, and supports, and participate in research	• Kansas Keys for Networking completed a multi-year study (using randomized control groups) with a consulting firm that demonstrated the effectiveness of a Targeted Parent Assistance program developed by the organization. The program provides parent and youth peer support, information, and training, and it is being replicated statewide through six regional family-run organizations. • Maryland Coalition of Families for Children's Mental Health participates in research programs supporting families whose children are taking anti-psychotic medication and supporting families whose children are discharged from psychiatric hospitals. • Oregon Family Support Network developed an evaluation tool to demonstrate the effectiveness of parent peer support services.
Recruit, educate, and support family members and youth to participate at the system/policy level	• Kentucky Partnership for Families and Children identifies and trains parent and young adult leaders. • Maryland Coalition of Families for Children's Mental Health holds a Family Leadership Institute to train families to become effective advocates. • Iowa Federation of Families for Children's Mental Health coaches families to develop advocacy and negotiation skills. • Virginia Family Network launched a statewide youth network, including recruiting and training young adults with personal experience to lead youth groups in communities.

Develop family and youth leaders to participate at the system/policy level	• Colorado Federation of Families for Children's Mental Health developed a toolkit for family and youth organizations to increase business management and leadership skills. • Florida Family Café created and supports a Change Agent Network of volunteers throughout the state. • Massachusetts Parent/Professional Advocacy League has assisted youth to speak at grand rounds, schools, and conferences to use their own experiences to improve care for children and youth. • North Carolina Families United trains youth and emerging adults in youth leadership. • North Dakota Federation of Families for Children's Mental Health held a youth leadership training conference for transition-age youth to develop advocacy skills; the training was planned and led by youth. • Rhode Island Parent Support Network developed and implemented training curricula on family and youth leadership. • Virginia Family Network is providing leadership training to parents and youth.
Train and certify parent peer support providers and youth peer support providers	• Colorado Federation of Families for Children's Mental Health created a curriculum for family advocates and family system navigators. • Massachusetts Parent/Professional Advocacy League provides training to parent peer support partners (Family Support Specialists) who help families to access services and gain skills to help their children. • Nebraska Federation of Families for Children's Mental Health is developing a parent peer support certification program in partnership with the state behavioral health agency and the University of Nebraska. • North Carolina Families United developed and delivers a comprehensive training program for parent peer support providers to become nationally certified. • Oregon Family Support Network developed a certified training program for peer support specialists based on an extensive set of skills. Training peer support providers have the ability to bill Medicaid. The organization also developed and implemented a curriculum and training for coaches and supervisors. • Tennessee Voices for Children developed and conducts training for certification of parent peer support providers statewide, including a manual and competency tests. • Utah Allies with Families developed a curriculum to train parent peer support providers (Family Resource Facilitators) and provides training statewide.
Provide training to professionals, families, and youth related to children's behavioral health and systems of care	• Maryland Coalition of Families for Children's Mental Health provides Mental Health First Aid training. • New Hampshire Granite State Federation of Families serves as co-lead for the development and implementation of the New Hampshire Behavioral Health Training Network and provides direct training and mentoring to professional staff working with

	youth and families. • North Carolina Families United provides services to transition-age youth using the RENEW model and trains other youth-serving professionals on how to use this best practice model. • Utah Allies with Families provides training on the impact of mental illness on families, professionals, paraprofessionals, and social work students. • Wisconsin Family Ties developed a curriculum on trauma-free crisis intervention and provides training to child-serving professionals on this and other effective approaches to working with children with behavioral health challenges and their families.
Conduct conferences for families and professionals related to children's behavioral health and systems of care	• Delaware Family Voices held a conference addressing the needs of children with mental health challenges for families and providers; U.S. Senator, Lt. Governor, and Secretary of Health were speakers. • D.C. Total Family Care Coalition held a family conference focused on increasing awareness of available resources, with the participation of a city council member and behavioral health agency officials. • Florida Family Café hosts an annual Youth Summit as an activity of the Florida Youth Council. • Maryland Coalition of Families for Children's Mental Health holds an annual REACH Retreat for Families and a statewide Connections Conference for families. • New Hampshire Granite State Federation of Families co-sponsors annual conferences including the Children's Behavioral Health Collaborative Summit and the New Hampshire Summit on Transition. • Virginia Family Network holds statewide conferences for families, youth, and professionals on family-driven, youth-guided policies and services.
Participate in the development and delivery of strategic communications related to children's behavioral health and systems of care	• Maryland Coalition of Families for Children's Mental Health partners with the Mental Health Association of Maryland to conduct a statewide Children's Mental Health Awareness Campaign. • Maryland Coalition of Families for Children's Mental Health hosts an annual day in the state capital for families to meet with their legislators to educate them on the need for services and supports for children and families. • North Carolina Families United organizes statewide campaigns to reduce stigma for families and individuals struggling with mental health issues as part of Children's Mental Health Awareness campaigns. • Texas Federation of Families takes a leadership role during Children's Mental Health Awareness Day and hosts events, such as a music fest with over 35 Texas singer songwriters.

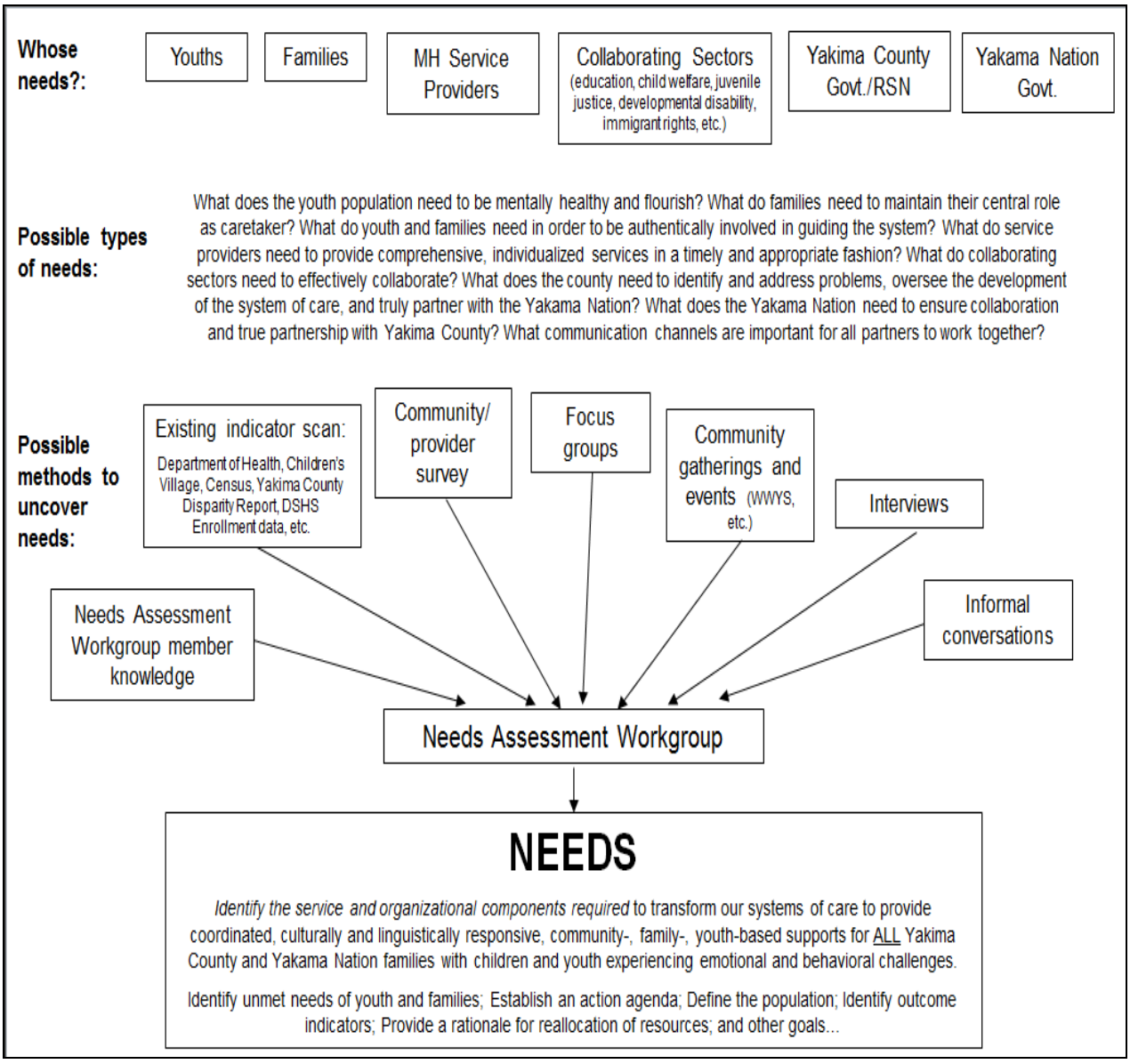
4. Developing A Needs Assessment

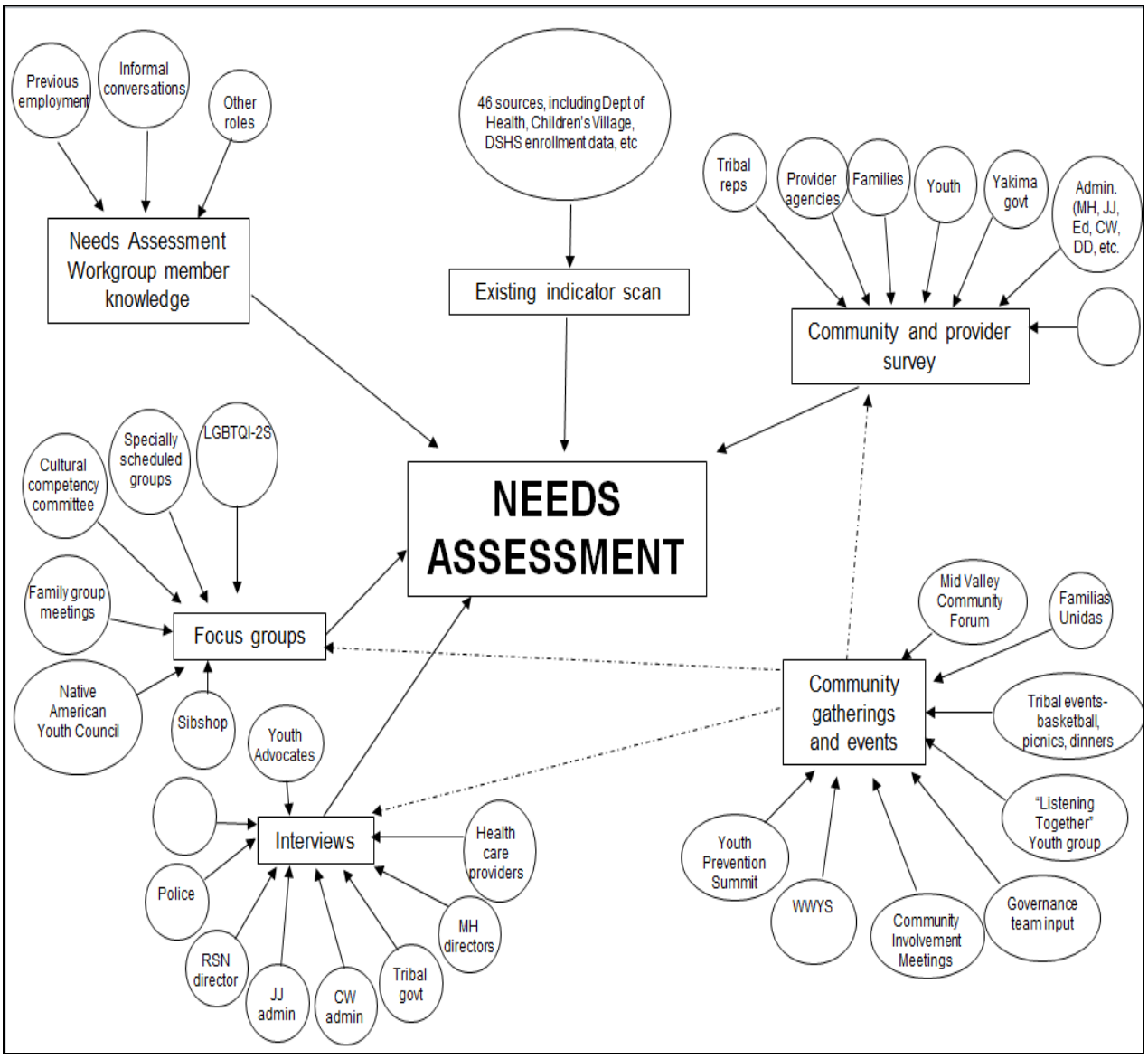
This section provides resources that might support a FYSPRT to plan and complete a Needs Assessment.

A. Examples of Services and Supports Available in a Comprehensive System of Care

Examples of Services and Supports Provided Through a Wraparound Approach
• **Family support and sustenance:** providing emergency assistance for the child, paying for utilities, paying for repair of a car engine, paying for a telephone, paying for participation in Weight Watchers, and so on. • **Therapeutic services:** providing individual/family/group counseling, substance abuse services, a bilingual therapist, a therapist of color, respite care in- or out-of-home, and so on. • **School-related services:** providing school consultation for an academic coach, utilizing behavioral aides or classroom companions at school, paying for school insurance for a classroom companion, buying a chemistry set for Christmas, and so on. • **Medical services:** providing a needed medical evaluation, providing medical or dental care, paying for tattoo removal, teaching sex education, teaching birth control, teaching medication management, and so on. • **Crisis services:** hiring a family member or friend to provide crisis support, utilizing a behavioral aide in the child's home or therapeutic foster home, teaching crisis management skills, and so on. • **Independent living services:** helping to locate and rent an apartment, assisting a youngster to obtain Supplemental Security Income, hiring a professional roommate/mentor, providing a weekly allowance, teaching money management and budgeting, providing driving lessons, teaching meal preparation, teaching parenting skills, teaching housekeeping skills, and so on. • **Interpersonal and recreational skills development:** hiring a friend or finding a "big brother," teaching social skills and problem-solving skills, purchasing a membership in an exercise gym, a YMCA membership, horseback riding lessons, art or music lessons, summer camp registration, class trip, fishing license, bicycle, and so on. • **Vocational services:** providing job training, teaching good work skills, providing a job coach, finding an apprenticeship, providing a mentor at an apprenticeship or other program, paying someone to hire the youth for a job, conducting a vocational skills assessment, and so on. • **Additional reinforcements:** purchasing items such as a radio, makeup, clothing, punching bag, skateboard, trips, activities, photographs for teen magazine, and so on.

B. TWO EXAMPLES OF APPROACHES TO CONDUCTING A NEEDS ASSESSMENT, INCLUDING STAKEHOLDER NEEDS, METHODS, MEASURES, AND DATA SOURCES




Previous employment
Informal conversations
Other roles
Needs Assessment Workgroup member knowledge
46 sources, including Dept of Health, Children's Village, DSHS enrollment data, etc
Existing indicator scan
Tribal reps
Provider agencies
Families
Youth
Yakima govt
Admin. (MH, JJ, Ed, CW, DD, etc.
Community and provider survey
NEEDS ASSESSMENT
Cultural competency committee
Specially scheduled groups
LGBTQI-2S
Family group meetings
Focus groups
Native American Youth Council
Sibshop
Youth Advocates
Interviews
Police
RSN director
JJ admin
CW admin
Tribal govt
MH directors
Health care providers
Mid Valley Community Forum
Familias Unidas
Community gatherings and events
Tribal events- basketball, picnics, dinners
"Listening Together" Youth group
Youth Prevention Summit
WWYS
Community Involvement Meetings
Governance team input

5. Developing an Annual Plan/Strategic Plan

This section is intended to provide examples of states with successful strategic plans, areas of consideration for planning, and a resource link for additional information.

A. STRUCTURE IN OTHER STATES

Examples: Strategic Plans	
Arizona	A strategic plan for statewide system of care development originated with the settlement agreement of a class-action lawsuit in 2001. The plan specified 12 principles reflecting the system of care philosophy that have guided expansion. An annual plan has broad goals and objectives, and each region is required to develop its own system of care plan in accordance with state-level objectives.
Hawaii	The legislature requires a 4-year strategic plan for children's mental health services that is created with input from stakeholders and partner agencies. For each goal, the plan delineates specific initiatives to achieve the goal, benchmarks, and deliverable products, units responsible, and due dates. Examples of plan priorities include implementing a comprehensive practice of improvement program and a strategic financial plan.
Maine	Maine does not use a formal strategic plan but incorporates system of care goals in other plans such as the federal Mental Health Block Grant program.
Maryland	An interagency strategic plan was developed at the Children's Cabinet level and is agreed upon across agencies. Action steps are updated quarterly. The plan has been useful in demonstrating to all stakeholders what needs to occur for statewide system of care expansion.
Michigan	A strategic plan for system of care expansion is formalized in the Application for Renewal and Recommitment (ARR) required from community mental health agencies that are responsible for children's mental health services under the managed care system's prepaid health plans. Communities are required to respond with their own plans with objectives, targets, and timeframes for systems of care implementation.
New Jersey	A detailed concept paper rather than a formal strategic plan guided statewide system of care implementation and was a key factor in providing an agreed-upon vision and goals for the initiative.
North Carolina	The state agency does not use a formal strategic plan, although the state collaborative has a strategic plan for system of care expansion.
Oklahoma	A formal strategic plan has not been used at the state level, but action plans and logic models have guided statewide system of care expansion. System of care plans are required at the local level.
Rhode Island	A strategic plan for system of care development began in 2003 by a legislatively directed task force to "organize an SOC for children, youth, and families," and agreement of system of care principles was achieved at the highest levels of state government. Concept papers with input from communities, providers, and families led to detailed work plans for the two major phases of statewide system of care implementation. Local strategic plans are also mandated.

Example from "Effective Strategies for Expanding the System of Care Approach", September 2011 Report. Source: http://gucchdtacenter.georgetown.edu/publications/SOC%20Expansion%20Study%20Report%20Final.pdf

B. ADDITIONAL WEB-BASED RESOURCES

The following links provide access to materials that may aid in the strategic planning process for a local system of care:
http://gucchd.georgetown.edu/products/Toolkit_SOC_Resource6.pdf

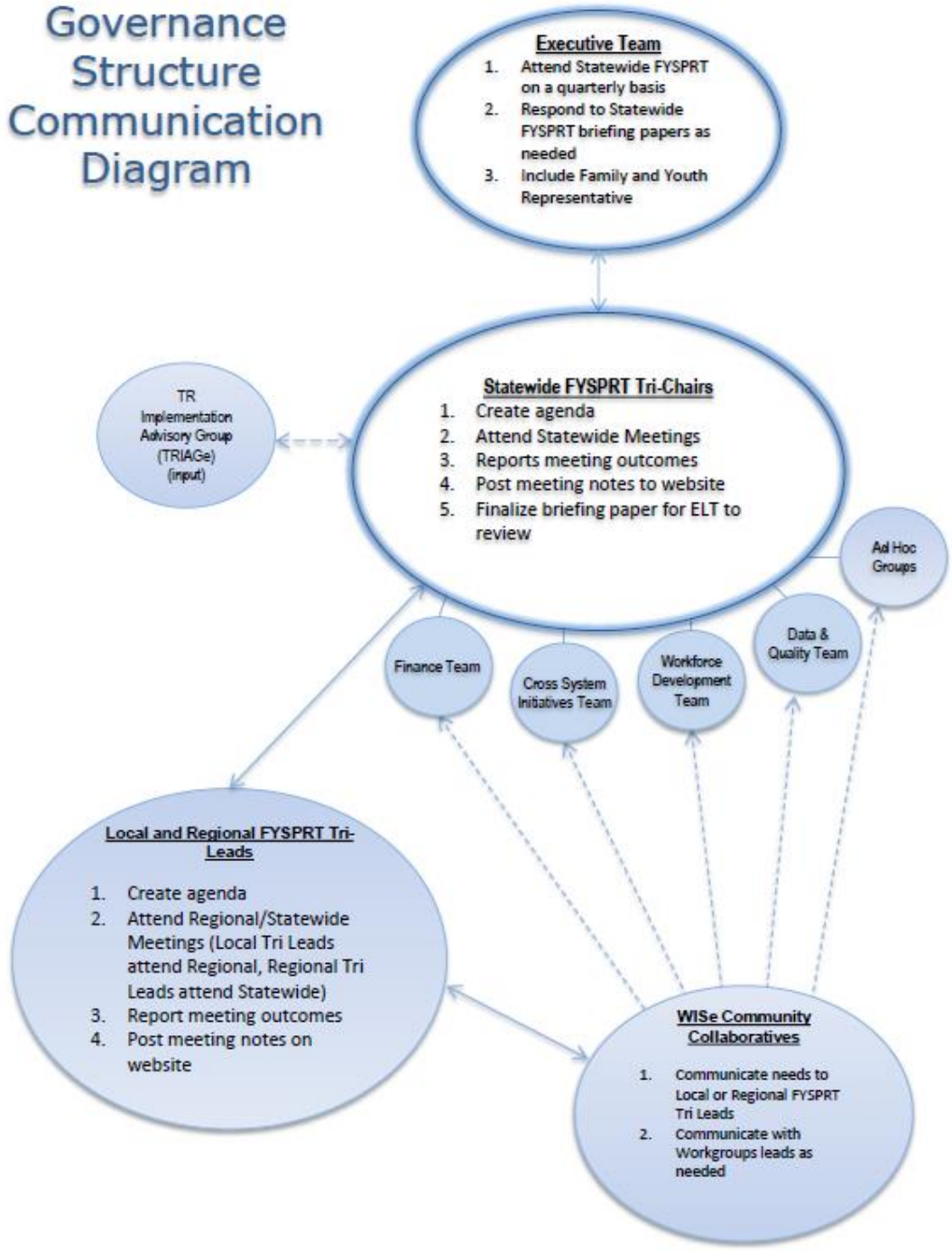
C. ADDITIONAL EXAMPLES OF STATE STRATEGIC PLANS, FOR USE AS EXAMPLES

http://dhhs.ne.gov/behavioral_health/System%20of%20Care/SOCStratPlanFinalwith%20Summary.pdf
http://www.txsystemofcare.org/strategic-plan-to-expand-systems-of-care/
http://www.azdhs.gov/bhs/pdf/plans/CSOC_SFY2012-2017.pdf

6. Promoting Communication

Diagram of ideal communication within the Governance Structure

A. GOVERNANCE STRUCTURE COMMUNICATION DIAGRAM



7. Social Marketing

Ideally, one of the functions of a regional FYSPRT will be to determine needs for social marketing, and participate in social marketing activities. This section presents a few tips and guidelines for effective social marketing.

A. Principles for Effective External and Internal Communication

Examples 1.18A&B
A. On the West Coast one county system of care launched a specific marketing campaign geared to other agencies to create awareness of and buy-in for the system of care, using data strategically to appeal to the interests of each particular agency. For example, with the school system, system builders used data showing improvements in academic performance with involvement in the system of care; with the juvenile justice system, they used data regarding referrals to law enforcement agencies.
B. In a southwestern city, system builders created a recognizable logo and slogan for the system of care, which appear on posters, on the backs of buses, on buttons, bumper stickers, coffee mugs, and notepads. System builders in this community make sure that the natural gathering places for youth and families – i.e., pediatricians' offices, schools, public libraries, fast food restaurants, supermarkets, faith organizations – have supplies of these items in sight, along with informational materials and brochures.

External and Internal Communication Key Questions:

- What structures have we put in place for external communication?
- What are our internal structures for communicating across levels and partners?

B. Effective Communication Vehicles

Overall Communication Goals
• Developing and implementing communication plans for enhanced visibility and crisis management • Generating positive media coverage by cultivating relationships with reporters • Increasing the awareness and involvement of specific, targeted groups of individuals • Changing attitudes or teaching new skills to clients and staff • Generating support from the public, policy makers, and clients for community reforms across your state • Encouraging financial contributions

Bonk, K., Griggs, H. & Tynes, E. (1999). Designing a communication plan. In *The Jossey-Bass guide to strategic communications for non-profits* (Chapter 4). San Francisco: Jossey-Bass Publishers. [Cited in The Evaluation Exchange, 7 (1). Cambridge, MA: Harvard Graduate School of Education, Harvard Family Research Project.]

Communication Tools

Public relations materials are important tools for reaching reporters, donors, policy makers, and others in the target audience. These should include:

- A consistent and easy-to-recognize logo and stationary design
- An easy-to-understand, one-page fact sheet about the organization
- At least one press kit on the issues and activities to be highlighted in the media
- Hard copy brochures and consistent website content
- Video, slides, overheads, and computer presentations
- Reports and studies for public release as news items
- One-paragraph and one-page biographies on spokespeople and agency heads
- Copies of the current newsletter, if there is one
- Copies of newspaper articles about the group

Bonk, K., Griggs, H. & Tynes, E. (1999). Designing a communication plan. In *The Jossey-Bass guide to strategic communications for non-profits* (Chapter 4). San Francisco: Jossey-Bass Publishers. [Cited in The Evaluation Exchange, 7 (1). Cambridge, MA: Harvard Graduate School of Education, Harvard Family Research Project.]

C. EDUCATION AND TRAINING OPPORTUNITIES FOR MEMBERS OF A SYSTEM OF CARE

Education and Training Opportunities for Workers in Systems of Care

Types of Training Programs	Characteristics
University-based, Academic Program	Preservice doctoral, masters, or specialty degrees
College-Undergraduate	Four-year degree
Learning Center Model	Courses, undergraduate/graduate workshops, consulting, resources
Certificate Programs	Specialized academic programs
Agency-sponsored Training	Formal programs, possible career ladder credit
Agency-based Training and Supervision	Informal training, orientation, in agency in-service training
Specialized Workshops	Sponsored by independent training centers and consultant companies
State Training and Technical Assistance Institutes and Programs	Sponsored with state funding for training on state and local identified needs
Training Conferences	Sponsored by associations

Learning Resources	Journals, newsletters, videos, etc.
Informal Contacts	Informal discussion of work-related issues among practitioners on and off the job
Technology-based Approaches	University-based distance learning, use of Internet

Meyers, J., Kaufman, M., & Goldman, S. (1999). Training strategies for serving children with serious emotional disturbances and their families in a system of care. *Promising practices in children's mental health, 5.* Washington, DC: Center for Effective Collaboration and Practices, American Institutes for Research.

D. EXAMPLES OF SOCIAL MARKETING AND COMMUNICATIONS IN OTHER STATES

Examples: Social Marketing and Strategic Communications	
Maine	Social marketing is used to promote system of care expansion, particularly by the family organization and Youth M.O.V.E., including the creation of digital stories, activities for Children's Mental Health Awareness Day, public service announcements, an anti-stigma campaign, a suicide prevention walk, and similar events.
Maryland	Social marketing is used as a strategy to garner support for continuation and expansion, particularly during children's mental health awareness month. State and family system of care leaders have been on TV with Maryland's first lady and other honorary chair people to cultivate broad-based support. The state's children's mental health awareness campaign has won prizes and the number of events in the state has increased dramatically, including TV and radio spots and advertisements on the sides of city buses.
Michigan	Social marketing was not cited as an expansion strategy, although communities have used social marketing to raise awareness and cultivate support, including Children's Mental Health Awareness Day activities, an annual award luncheon, videos on YouTube, newsletters, a Facebook page, and so forth.
New Jersey	The family organization has undertaken social marketing to generate support for the expansion initiative.
Oklahoma	Social marketing has been undertaken through a state-level position funded by a system of care grant. Activities have included system of care branding, an antistigma campaign, a Web site, a quarterly newsletter, and other strategies to generate support for expansion among key constituencies.
Rhode Island	The family organization is the lead contractor for social marketing on systems of care and has created partnerships with the regional Family Care Community partnerships and the Mental Health Association for social marketing. Events connected with Children's Mental Health Awareness Day and other events have been used to generate broad-based support for expansion.

Example from "Effective Strategies for Expanding the System of Care Approach", September 2011 Report. Source: http://gucchdtacenter.georgetown.edu/publications/SOC%20Expansion%20Study%20Report%20Final.pdf

E. WAYS TO INVOLVE FAMILIES AND YOUTH IN SOCIAL MARKETING ACTIVITIES

http://www.cfbhn.org/assets/TIC/SocMarketing.pdf

F. ADDITIONAL WEB-BASED RESOURCES AND EXAMPLES

http://tapartnership.org/enterprise/docs/RESOURCE%20BANK/RB-SOCIAL%20MARKETING,%20STRATEGIC%20COMMUNICATION/General%20Resources/Social_Marketing_Tip_Sheet_-_SOC_XP_12-11.pdf

http://www.txsystemofcare.org/wp-content/uploads/2012/11/TX-System-of-Care-Strategic-Plan-Attachment-B-Social-Marketing-Plan.pdf

http://www.cfbhn.org/assets/TIC/SocMarketing.pdf

8. Reviewing Outcome and Process Data and Reports

This section aims to provide some guidance around and examples of processes for determining priority data and evaluation needs, and developing continuous quality improvement and/or evaluation plans.

A. Steps in the Quality Improvement Process

Steps in the Quality Process	
• Discussions about values • Evolution of principles for action • Development of guidelines for interventions • System guidelines • Clinical guidelines	• Ethical guidelines • Measuring performance • Outcomes • Report cards • Processing feedback

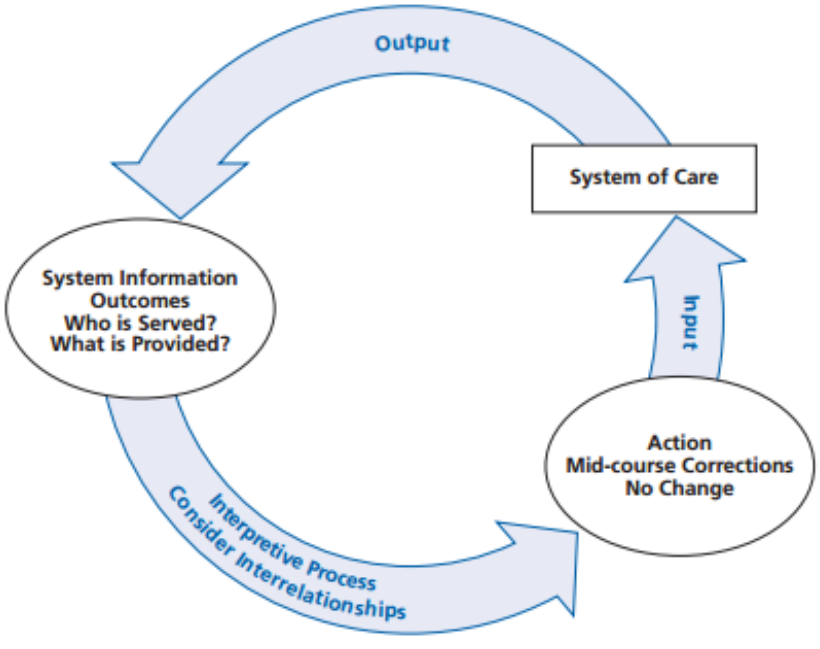
B. Web resources for developing continuous quality improvement plans for systems of care for children's mental health

http://www.tapartnership.org/SOC/SOCevaluatingCQI.php

C. Using data – Sample Feedback Loop

ILLUSTRATION 1.29

Ecology of Outcomes: Using the Results



Hernandez, M., Hodges, S., & Cascardi, M. (1998, May). The ecology of outcomes: System accountability in children's mental health [Special Issue on System Accountability in Children's Mental Health]. Hernandez, M. (Ed.) *Journal of behavioral health services and research, 25* (2).

D. STEPS TO DETERMINING INFORMATION NEEDS TO GUIDE EVALUATION

Questions to ask in deciding "What are your project's priority information needs?"	• What decisions, if any, are the evaluation's findings expected to influence? • When will the decisions be made? By whom? • When must the evaluation findings be presented to be timely and influential? • What other factors will influence decision making? ○ Have the decisions already been made?
Questions to ask in deciding "What to measure?"	• What data and findings are needed to support decision making? • How available are these data? • Are new data collection approaches needed, or are the data available through existing means? • If outcomes and indicators have already been defined, do they support what is needed?

E. RESOURCES AND GUIDANCE FOR DEVELOPING AN ACCOUNTABILITY STRUCTURE AND PLAN FOR WRAPAROUND-INFORMED SYSTEMS OF CARE

http://nwi.pdx.edu/pdf/ImplementationGuide-Theme6.pdf
http://nwi.pdx.edu/accountability/

Data Review Process

Identifying the Representativeness of Data
The first step in understanding and acting on the data is to check the total number of clients represented in the reports provided to see if they match with internal data. Differences in the total number of clients represented in the reports may indicate a problem entering the data into the electronic record system in a timely fashion. This may result in misunderstandings of your program performance and client experience. Any un-entered data needs to be promptly entered into the BHAS system. The BHAS system will allow you to enter the date when the assessment was completed, even if this is well after the fact; it also records the time and date when the assessment was entered into the electronic system. This allows for accurate quarterly reports to be generated, or re-generated.

Identifying and Acting on Meaningful Variation in Outcomes
At every level of the system, there is likely to be some variation in performance. This is especially true as systems first adopt a comprehensive quality improvement system. Over time the goal is to bring all performance up to a designated, scientifically and ethically appropriate standard of practice. Variation exists within different outcomes for the same client, within caseloads, within agencies, within Counties, and within RSNs. Systematic quality improvement is about understanding

and acting on meaningful variation - ceasing the use of ineffective or harmful practices, and increasing the use of health-promoting, locally effective practices.

Practices leading to desired outcomes are not often defined in the outcome data themselves. Instead, the outcome data *point to where to look for effective practices.* Once one knows where to look, a systematic effort to understand practice must be undertaken. This can include the use of formal, objective data, as well as the use of structured narrative or interview processes to identify which practices an individual or group of individuals are using to get the desired results. The state of Washington, via the Quality Service Review process, and annual surveys with children and youth will provide some data on specific practices in use in the system. However, these data are not collected frequently enough, and do not represent the breadth of practice information needed to perform routine ongoing quality improvement activities. RSNs and agencies must be able to describe and act on their practices on an ongoing basis.

Tools for a Structured Review and Identification of Action Steps
Included in this protocol are tools for reviewing data at each of the five key decision points. These review tools allow for the data to be understood in a consistent fashion. In addition to tools for reviewing the data, this protocol also includes prompts for understanding specific practices which may be driving outcomes at each decision point. These are included after the data review tool for each decision point.

A summary sheet is provided to identify at which decision point(s) action can usefully be taken, and when the actions are expected to have their first discernible impacts. Finally, a sheet is provided to record policy recommendations to be considered by persons at the next level of the system. Summary sheets and policy considerations are expected to be communicated quarterly to the appropriate parties.

Access

Access refers to *the conditions under which a person receives services.*
Screening a child or youth is the first step in providing access to services. The Screening Timeliness Summary report tells how many screens are being done, and whether screens are consistently being done in a timely manner; the Clinician Screening Results report tells how many children and youth are screened into each of five levels of care. The projected utilization rate by RSN and County provides a benchmark for understanding the current rate of access compared to the expected access rate as the WISe implementation spreads and matures.

In mature, high-quality healthcare systems, it is expected that 85% of clients routinely receive the most effective practices. Applied to acting on these reports, it would indicate that systems would work towards timely screening for 85% of referred clients, and that the number of clients entering WISe services annually would fall near the mid-point estimate (~5,700 children and youth) provided in the projected utilization rate.

Programs beginning implementation of a performance management system are often well off of the 85% mark. Practices which are currently successful in improving the timeliness and output of

screening must be identified through consultation with direct service and supervisory staff. Effective practices must then be clearly described, and promoted throughout the program. When practices are not sufficiently effective to result in the desire outcome, new practices may need to be identified, taught, coached, and their outcomes monitored.

How much of a test is this of your current WISe practice at this decision point (check one): ☐ **Small Test (0 – 35% of WISe clients represented in these data)** ☐ Medium Test (36-70% of WISe clients represented in these data) ☐ Large Test (71-100% of WISe clients represented in these data)
What results, in numeric terms, were you expecting?
Why were you expecting these results (what data sources were you using to come to these expectations)?
Were the results you obtained in these reports consistent with what you were expecting (check one)? ☐ Very Consistent ☐ Largely Consistent ☐ Inconsistent ☐ Very Inconsistent
With whom did you talk and review these data to understand what practices are responsible for these outcomes?
Were there practices which helped make performance successful? If so, what were these?
Were there practices which would need to be changed in order to make performance more successful? If so, what are these?
What can you act on to grow success?
Who will take the lead on this?
When do you expect this action to be reflected in your data?

Source: *Quarterly Data Review Protocol*, N. Israel, Ph.D. Chapin Hall *for* State of Washington, DSHS DSE 2015.05.05v1.1

F. EXAMPLE OF DATA FORMATTED FOR REVIEW

The full document can be viewed on the FYSPRT website: https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/childrens-behavioral-health.

Children's Behavioral Health

Children's Behavioral Health in Washington State

Back to Contents

Measures of Statewide Performance

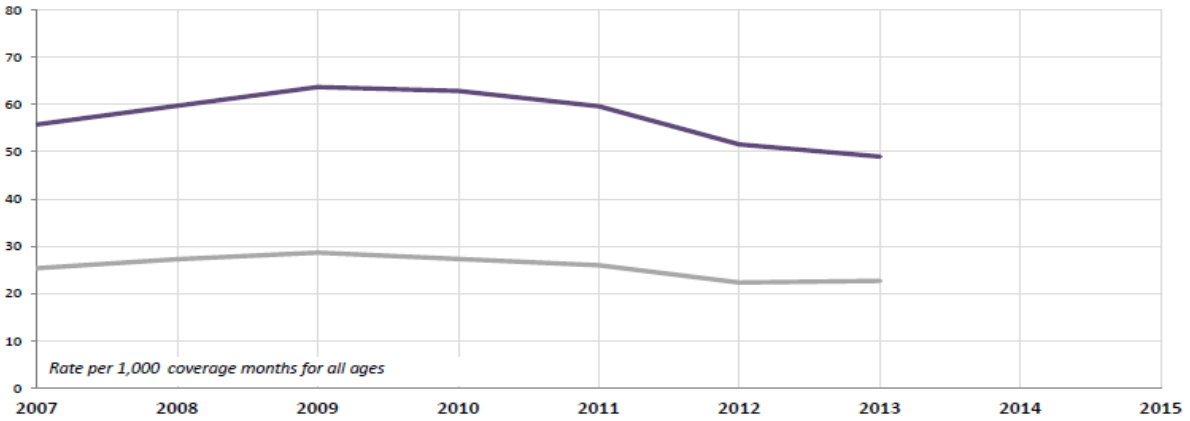
Goals • Outcomes • Indicators

NOVEMBER 2014

GOAL AREA: Health

OUTCOME 1.3 v1

Children and youth with mental health treatment need use emergency rooms at same rate as those without mental health treatment need



LEGEND

All ages with MH tx need

All ages no MH tx need

INDICATOR

The use rate here is defined as the number of emergency department visits in SFY per 1,000 member months. Member months are the months all children had coverage under Medicaid or other forms of medical assistance such as SCHIP.

STATE FISCAL YEAR	2007	2008	2009	2010	2011	2012	2013	2014	2015
Total youth	440,146	441,864	477,219	515,493	545,007	557,328	565,995		
Total youth with MH tx need	94,729	95,609	101,491	109,192	116,844	120,353	123,446		
Youth with MH tx need, rate of ER use	56	60	64	63	60	52	49		
Youth without MH tx need, rate of ER use	25	27	29	27	26	22	23		
BY AGE: 5 - 11 YEARS									
Total youth	227,363	229,329	248,353	268,857	284,907	293,700	301,117		
Total youth with MH tx need	39,531	40,343	42,317	44,948	48,530	50,617	52,445		
Youth with MH tx need, rate of ER use	34	36	38	38	37	33	33		
Youth without MH tx need, rate of ER use	22	24	26	25	24	20	22		
BY AGE: 12 - 17 YEARS									
Total youth	167,061	165,430	177,178	190,332	201,045	206,255	209,909		
Total youth with MH tx need	42,727	42,174	44,313	47,637	50,973	53,354	55,549		
Youth with MH tx need, rate of ER use	56	60	64	61	58	52	50		
Youth without MH tx need, rate of ER use	24	26	28	25	24	21	21		
BY AGE: 18 - 20 YEARS									
Total youth	45,722	47,105	51,688	56,304	59,055	57,373	54,969		
Total youth with MH tx need	12,471	13,092	14,861	16,607	17,341	16,382	15,452		
Youth with MH tx need, rate of ER use	143	153	157	155	147	122	112		
Youth without MH tx need, rate of ER use	59	61	61	58	54	47	44		

SOURCE & POPULATION

DSHS Integrated Client Database. Youth with Medicaid coverage.

9. Conducting Evaluation of Regional/Local Activities

This section provides resources relevant to the FYSPRT activity of identifying priorities for local evaluation and supporting evaluation activities.

A. Sample Logic Models for Local Action

Logic models serve a number of functions. Main among these is their ability to (1) provide a "roadmap" for local implementation, (2) communicate clearly to internal and external stakeholders about the theory of change and strategic plan, and (3) provide a guide for developing a local evaluation plan. We provide information on Logic Models here under "Evaluation," it is important to understand the utility of Logic Models for all these purposes.

For more information on developing logic models, please visit the following URLs:
http://tapartnership.org/enterprise/docs/RESOURCE%20BANK/RB-LOGIC%20MODEL/Tools/Crafting_Logic_Models_Hernandez__Hodges_2003.pdf

http://logicmodel.fmhi.usf.edu/

http://logicmodel.fmhi.usf.edu/LogicModels/Albany-01-10-06.pdf

B. Sample evaluation domains

Evaluation Information Reported on the Contract Outcome Report
• Percentage of parents/caregivers satisfied with services • Percentage of children/youth satisfied with services • Percentage of providers satisfied with services and system support • Percentage of children/youth with improved school behavior • Percentage of children with a history of arrest who avoided re-arrest during services • Average change of score (difference) between standardized assessment scores at beginning and end of services • Percentage of required data forms actually submitted for analysis

Questions to ask in deciding "What instruments to use?"	• What data and findings are needed to support decision making? • How available are these data? • Are new data collection approaches needed, or are the data available through existing means? • If outcomes and indicators have already been defined, do they support what is needed?
It takes people and planning to successfully measure anything	• Choose feasible and low-burden tool and provide clear directions • Incentivize and monitor implementation • Make measures and data relevant and accessible to front-line staff

	• Commit to collecting data longitudinally to evaluate change • Be mindful about data management, data linking, identifiers, and archiving
Types of outcomes data	• Meeting needs or goals that are documented in youth/families' wraparound plans • Increasing child and family assets and strengths and reduction of needs • Improving caregiver well-being • Increasing family and youth empowerment • Keeping youth "at home, in school, and out of trouble"

Satisfaction surveys	• Often program-specific and developed internally
	• Standardized measures exist and include:
	  ○ Client Satisfaction Questionnaires (CSQ-18, CSQ-8, CSQ-3)
	  ○ Measure of Process of Care (MPOC)
	  ○ Measure of Adolescent Service Satisfaction (MASS)
	  ○ Youth and Parent Satisfaction Questionnaire (PSQ, YSQ)

Administrative data	• Information or data collected during the course of normal business, not primarily for evaluation or research • Often collected to keep track of client contracts, service delivery, payment for service, etc. • With some planning and understanding, it can often be a rich and low-burden data source

Sources of administrative data	• Programmatic data from service providers
	  ○ Length of service
	  ○ Services provided – type, intensity, provider, etc.
	  ○ Level of engagement
	• Payment data from payers
	  ○ Medicaid and insurance billing data
	• System-level data from government agencies
	  ○ Multi-system involvement & outcomes
	  ▪ Child welfare, juvenile justice, education, health and mental health, family support, etc.
	  ○ Repeated system involvement and trajectories

C. FYSPRT EVALUATION TOOL

FYSPRT processes are, themselves, an important focus of evaluation of impact. DBHR's QA Team has developed a measure of state and regional FYSPRT effectiveness. You can find the FYSPRT evaluation tools on the FYSPRT website at: https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/family-youth-and-system-partner-round-tables-fysprts

10. Meetings and Meeting Frequency

A. SAMPLE MEETING NOTES FOR WEBSITE POSTING

See the meeting notes on the FYSPRT website, as an example: https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/family-youth-and-system-partner-round-tables-fysprts

11. Regional FYSPRT Policies

This section provides a range of resources that may be useful in developing local and regional policies for conduct of FYSPRT activities, from meeting ground rules to even more straightforward documents such as travel reimbursement forms.

A. EXAMPLE GROUND RULE DOCUMENTS

"Ground Rules" for Group Discussion
1) All members of the FYSPRT should have a chance to speak, express their own ideas and feelings freely, and pursue and finish out their thoughts. 2) The discussion should not be dominated by any one person. 3) A variety of points of view are to be put forward and discussed during meetings. 4) Participants can interpret research findings and discuss problems openly and respectfully, which may require them to set aside official roles in FYSPRT and the broader community. 5) All feedback must be delivered respectfully regardless of whether it is positive, negative, or merely clarifying or correcting factual questions or errors. 6) Arguments, while they may be spirited, must be based on the content of ideas and opinions, not on personalities. 7) Even in disagreement, there should be a collective understanding that the FYSPRT is working together to solve a relevant district problem. 8) When conflicting interpretations of data arise and problems are encountered the FYSPRT must address this diversity through allowing all participants involved in the conflict to state their point of view and their rationale for their stance.

B. EXAMPLE POLICY AND PROCEDURES MANUAL

http://www.templatezone.com/download-free-ebook/office-policy-manual-reference-guide.pdf

C. MEMBERSHIP EXPECTATIONS FOR TERMS OF APPOINTMENT

Regional FYSPRT membership is comprised of Family, Youth and System Partner Regional and Local Tri Leads. Participants outside the membership are also welcome to attend and provide input and feedback regarding community needs.

Suggestions for Participant Make-up at the Regional Level:

- Representatives of local systems
- Community leaders that reflect the diversity in the community
- Tribes
- Family & Youth groups/organizations
- Family/ Youth leaders

- Community Organizations/ networks/ coalitions (Goodwill, Boys and Girls club, at-risk youth)
- Faith Community
- Children's Administration
- Juvenile Justice
- Mental Health
- Chemical Dependency
- Developmental Disabilities Admin.
- Law Enforcement
- School district and ESD staff
- Military
- Early Learning – Head Start
- Public Health
- 12-step groups
- Youth-led programs
- Employers
- Division Vocational Rehabilitation
- Kinship groups
- Adult consumers
- Advocacy groups
- Foster Care youth and family groups
- College and University Campus groups

Membership Minimum Ask:

- Commitment to participate

Tri-Lead –

- Terms – preferred minimum ask of 2 years
    - System Partner Tri-Lead – At the discretion of the FYSPRT contractor the first right of refusal will be given to the Children's Care Coordinator employed by the regional contracting authority to take the role of System Partner Tri-Lead
    - Youth Partner Tri-Lead – At the discretion of the FYSPRT contractor the Youth Tri-Lead will be connected to the Youth 'N Action movement
    - Family Partner Tri-Lead – At the discretion of the FYSPRT contractor the Family Tri-Lead will be connected to the contracting organization
- Attendance – open
- Describe and set a value of participants' time including family, youth and system partners – *needs to be developed further*

Role of a Regional FYSPRT Participant

It is intended that the Regional FYSPRT leverage the experiences, expertise, and insight of key individuals, organizations, and departments that are committed to building a Systems of Care for children's behavioral health. Regional FYSPRT members are not directly responsible for managing project activities, but provide support and guidance for those who do. Thus, individually, members will:

- Through education, collaboration and participation influence the movement toward the infusion of system of care values and principles in community organization, workforce development, policies, practice, financing, and structural change.
- Bring community, individual and agency strengths in completing necessary tasks.
- Identify barriers/challenges and approaches to resolve issues.
- Identify strengths/initiatives/projects of existing community and system agencies that support systems of care values and principles.
- Educate our system of care partners as we develop and grow.
- Develop problem solving approaches for moving forward.

D. VOTING POLICIES AND PROCEDURES AND GROUND RULES FOR GROUP DISCUSSION

Establishing Consensus
1) The FYSPRT will make decisions by establishing "soft consensus" wherein no members vocally object. *When soft consensus is not reached the FYSPRT will decide through one of two types of democratic votes.* a) When there are two feasible options to select from, a two-thirds or more majority vote will be needed to move forward with a given option. b) When there are three or more possibilities to choose among, a plurality will be sought wherein the option that receives the greatest number of votes will be selected even if that number is less than half of the total votes.

E. EXAMPLE REIMBURSEMENT FORM

Reimbursement Form

Logo

First Name

Last Name

Title

Employee ID

Phone

Email

Currency Used

Total Expenses

Please note that employees must file expense reports no later than 30 days following the completion of the trip or of incurring the expense.

Enter expenses below – note that reimbursement will not be provided without dated receipts.

Expense Type	Department	Date	Amount	Details

☐ **Approved** _____ **Date** _____ **Approved By** _____

F. EXAMPLE HONORARIA RECEIPT FORM

PAY TO: ADDRESS:	**DATE REQUESTED:** **DATE REQUIRED:** **REQUESTED BY:** **DISTRIBUTION:** _____ Campus Mail **(check one)** _____ Pick up _____ U.S. Mail

PLEASE CHECK ALL THAT APPLY:

____ Invoice/ Receipt Attached
____ Advance/ Prepaid Order
____ Honorarium/ Award/ Internship
____ IRS Form W-9 Attached _____ W-9 on File

EXPENSE DESCRIPTION (Describe business, academic, and/or research purpose):

Please attach required receipts, invoices, contracts or other supporting documentation.

General ledger account number(s):	Amount
Approval: Department/ Budget Unit Head*	
Approval Business Office	Total Amount of Check

Additional Approval (if necessary)* _____