INVITATION TO NEGOTIATE
AN INTEGRATED LOCAL SYSTEM OF CARE

Issued by
The Governor’s Office for Children
on behalf of
The Children’s Cabinet

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ROBERT L. EHRLICH, JR.  MICHAEL S. STEELE  ARLENE F. LEE
Governor  Lieutenant Governor  Executive Director
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I. Introduction

A. Purpose

This is an Invitation to Negotiate (ITN) between the Governor’s Office for Children (GOC), on behalf of the Children’s Cabinet, and the Local Management Boards (LMB) in the State of Maryland. This ITN provides an opportunity for local jurisdictions through their LMB to build on their Local Access Plans to create a more integrated and accessible system of care (SOC) for families that will improve child and family well-being.

Within this ITN, the State is continuing to promote an SOC philosophy and framework for children and youth, particularly those with or at-risk for intensive service needs. This ITN encourages LMBs to strengthen local capacity by developing structural changes that create better access to service and service coordination for all families through a “Local Access Mechanism;” provide accountable care coordination for children with the most intensive multi-system needs through designated care management units or entities; employ the wraparound approach as a fundamental practice model in children’s services; and develop new service capacity, particularly evidence-based and promising practices. The new FY07 budget available from the State for the various components of the integrated system of care (SOC) is:

- Local Access Mechanisms: $1.8 million
  - Single Point of Access/No Wrong Door
  - Systems Navigation
- New Wraparounds pilot sites: $500,000
  - Wraparounds Pilot Sites that provide accountable care coordination for Community Medicaid Eligible children through designated care management units or care management entities.
  - Funding priority for new Wraparounds pilot sites will be given to rural jurisdictions or regions with at least one rural partner.
- Resource Development for Community-Based Residential Placements: $1 million
  - Priority will be given to proposals for group homes in Baltimore City, the Eastern Shore and Prince George’s and Montgomery Counties (D.C. Metro Region).

It is recognized that service capacity needs may exceed these funding categories. Therefore, discussion about use of other existing resources or new agency-specific resources that are a part of a jurisdiction’s ongoing efforts to develop a full continuum of services within its System of Care is encouraged. Additionally, throughout these areas, the State is urging the development of family and youth partnership capacity at both the case plan and policy levels.

The Children’s Cabinet reserves the right to make changes to this Invitation to Negotiate at any time and will communicate any changes to the applicants and/or awardees. The Children’s Cabinet, through GOC, may negotiate all or part of any proposed budget after award of the grant in the event that funding or program requirements so dictate.

B. Eligibility
This ITN is open to LMBs in all jurisdictions. **It is not mandatory to respond** to this invitation but strongly encouraged. It is the prerogative of each LMB to determine which elements of an SOC, if any, the jurisdiction wishes to pursue in the upcoming year. An LMB may partner with one or more LMBs, in whole or in part, in its response. It is GOC’s expectation that the responses provided to this ITN will be based upon the work that has been started in the local jurisdictions with regard to Local Access Mechanisms and Wraparound services.

If a given jurisdiction chooses NOT to respond to this ITN, the cover sheet must still be submitted with all the signatures of the Local Management Board Members.

**C. History & Background**

The Systems Reform Movement began in Maryland almost two decades ago with the challenge of changing the way services were provided to children and families in their communities. The goals of systems reform were to:

- Change the way services are provided to children and families, and to move toward comprehensive, home and community-based and family-focused services;
- Change the way decisions about services are made to an interagency, collaborative, results-based approach that facilitates public/private partnerships; and,
- Change the way services are funded by de-categorizing funding and redirecting spending from “deep end” out-of-home placement services and, therefore, providing more flexibility for funding decisions based on outcomes.

Among the steps taken to accomplish these goals, the LMBs were expanded to every jurisdiction in Maryland, the Children’s Cabinet identified eight result areas for child well-being with measurable indicators for each result, and a community partnership negotiation process was developed for use with the LMBs. This ITN builds on the original Systems Reform work and addresses the issues of improving access to services for children and families, particularly those with intensive needs, as identified through the HB 1386 (2002) process.

House Bill 1386 was passed in 2002, requiring a statewide assessment and planning initiative to improve community-based services for children with intensive needs. The term “Intensive needs” was broadly defined by House Bill 1386, and is now codified in COMAR 14.31.01.02, as:

> A child who has intensive behavioral, educational, developmental, or mental health needs that cannot be met through available public agency resources because:

1) The child’s needs exceed the resources of a single public agency; and/or
2) There is no legally mandated funding source to meet the child’s needs.
In 2003, Governor Robert L. Ehrlich, Jr. signed *Executive Order 01.01.2003.02*, “Custody Relinquishment and Access to Services for Children,” establishing a Council on Parental Relinquishment of Custody to Obtain Health Care Services ("Council"). The charge of the Council was to identify alternatives for parents who were finding it necessary to relinquish the custody of their children with significant and complex mental health needs and/or developmental disabilities, in order to access needed services. The Council’s efforts, which spanned six months, included intensive subcommittee work that broadened participation in the Council’s deliberations, including expertise from the provider community, the medical community, and the Bazelon Center for Mental Health Law. The Council also sought input from the general public through hearings and written comments. A summary of the final recommendations of the Council identified five areas for improvement:

1) Access to services,
2) Data collection to support decision-making,
3) Targeted resources,
4) Maximizing federal resources, and
5) Service coordination.

The work of both the Council and the Committee has resulted in the recognition of the need to develop SOC throughout the State of Maryland. Recommendations within the HB 1386 report included:

1) development of a plan that will result in a single point of access for parents of identified children with intensive needs in each jurisdiction;
2) utilization of the wraparound model; and,
3) enhancement of respite care and crisis services throughout the State.

**D. Results Accountability Planning Process**

The Children’s Cabinet has adopted the Results Accountability planning process. This process focuses planning, decision-making and budgeting on the results that a community is trying to achieve. These results are the desired conditions of well-being for children and families. In 1996, Maryland established eight child well-being results, which are measured by a set of 25 indicators (see box on the left).

Indicators are measurable data that help to determine if progress
is being made toward achieving the result. The selected measures are ones that communicate well to a broad audience, serve as a proxy\(^1\) for the result, and have available data that is reliable and consistent. These child well-being results and indicators are used by Maryland and the LMBs to develop strategies in each jurisdiction through the process outlined below. (In response to the ITN, LMBs may also select other local jurisdictional indicators that meet these same criteria in addition to the State’s indicators).

Results Accountability planning involves answering a series of questions for population accountability (Friedman, 2005, p. 39-45):

A. What results are we trying to achieve?
B. What do the data tell us? What are the indicators that tell us if we are making progress towards reaching the results we are trying to achieve? Is the indicator getting better or worse?
C. What is the story behind the data and the direction it is heading?
D. Who are the partners who have a role to play in doing better?
E. What strategies work to “turn the curve” and make things better?
F. What is our action plan and budget? (See Appendix I for a more complete description of these questions.) The Results Accountability process is being used to develop Maryland’s SOC, and the format for this ITN is consistent with the Results Accountability questions. Responses to this ITN should also follow this process.

II. Invitation to Negotiate

A. What results are we trying to achieve?
The Children’s Cabinet has established a vision that “all Maryland’s children will be successful in life” and seeks to improve all eight child well-being results. The purpose of this ITN is to take the next step in achieving this vision by improving the following results areas in particular:
- Stable and Economically Independent Families; and,
- Communities Which Support Family Life.

B. What do the data tell us?
The first step in determining what the data tell us is to identify measurable indicators to determine if progress is being made towards the result. Two of the indicators that are of particular importance to the Children’s Cabinet in measuring the result of stable and economically independent families are:

- Number of out-of-home placements and
- Cost of out-of-home placements.

\(^1\) Proxy power (or representative power) means that the indicator says something of central importance about the indicator. It also has to do with the fact that data runs in herds. An indicator with strong proxy power tends to match the direction of other indicators in the herd (Friedman, 2005).
According to the FY2005 State of Maryland Report on Out-of-Home Placements and Family Preservation Services, over the last decade, the total number of children in out-of-home placements statewide has risen by 6.2%, at an average annual increase of 0.6%. However, FY05 marked the fifth year in a row in which the total number of placements declined from the previous year. From a ten-year high of 30,656 in FY00, the total number of placements has declined to 26,884 in FY05. That represents a decrease of 12.3% in the number of placements into out-of-home care since FY00. (See Figure 1).

**Figure 1: Number of Children Served in Out-of-Home Placements, FY95-FY05**

Although the overall number of out-of-home placements has decreased in recent years, the annual cost for these placements has increased steadily over this same time period. Since FY95, over the past ten fiscal years, costs for out-of-home placements increased by 74.3% from $369.0 million in FY95 to $643.1 million in FY05. Even since FY00, when the number of placements began to drop, the annual costs continued to increase by 29.3%. The average annual increase in cost per year since FY95 is 5.7%. This increase in costs is due to the increased number of children requiring high-end services, thus indicating the need for wraparound and other community-based services. Somewhat promising is the fact that the most recent rate of change in cost from FY04 to FY05 (3.4%) was less than the average annual increase per year since FY95 (see Figure 2).

**Figure 2: Costs of Out-of-Home Placements: FY95-FY05**

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2 Children who enter out-of-home placements in a given year may be counted more than once. This number, therefore, more fairly represents the number of placements rather than the number of children in placement.
Although statistical data does not in and of itself present the total picture, on face value it appears as if the total number of placements has begun to show a promising downward trend that needs to be supported through continuing and enhanced efforts to provide community-based care. Data on placement costs indicate, however, that although growth in total cost has slowed by reducing the total number of placements, the cost per placement continues to increase.

Currently there are no state indicators for the result of communities which support family life. Local measures can be developed that will measure, among other indicators, families’ access to services and availability and utilization of effective and efficient community-based services.

C. What is the story behind the data?

It is recognized that families who have difficulty accessing services are often under a great deal of stress.

A fragmented and uncoordinated service delivery system can serve as an additional unnatural source of stress for the very families who are the intended recipients of assistance….In a fragmented service system, families will encounter conflicting regulations and requirements; different expectations and attitudes in the various staff they meet; and even contradictory opinions, advice, and messages as they travel from office to office in their quest for help” (Duchnowski, Kutash, & Friedman, 2002, p.26-27).

The Children’s Cabinet and GOC recognize that some families can experience the current service delivery system for children with intensive needs as not fully responsive to families’ needs and lacking a focus on families’ strengths. Fragmentation can occur with categorical funding for services. While a local SOC may still need to deal with categorical funding, every effort should be made to have families experience the system as seamless and easy to access. Otherwise, many children and families may be unable to access integrated services without progressing to the highest levels of need. The longer that these children and families go without receiving coordinated services, the more debilitating their problems may become and the cost for providing services rises.

D. Who are the partners?

The partners in this process are those individuals who participated in the development of the ITN (Children’s Cabinet Agencies, local child-serving agencies, and the Systems of Care Initiative Committee members3), as well as those who will respond to this invitation and implement local SOC in their communities. This includes LMBs, family members, family advocates, youth, local child-serving agencies and organizations, and the faith-based community, among others. Local Management Boards are in an excellent position to bring the appropriate partners to the table to address these indicators.

E. What works?

This ITN provides information concerning what has worked in other areas of the country and within Maryland to establish SOC and its components. The ITN does not prescribe a certain

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3 See Appendix II for a list of the members of the Children’s Cabinet and the members of the SOCI Committee.
approach. LMBs should select proven or promising practices that are consistent with community
needs, strengths, resources and values.

Based on the knowledge, values and beliefs of the partners listed above, as well as available
research, the Children’s Cabinet has concluded that children belong in the most appropriate, least
restrictive setting possible, and in their own homes and communities when safely possible. The
Children’s Cabinet also believes that most children, even those with intensive needs, can thrive
in a family setting, with proper supports. However, for this to occur, there must be an SOC in
place to support children and families at all points in the continuum of need with a range of
services and residential programs.

The Children’s Cabinet also believes that the most effective SOC are developed as close to the
community as possible. This ITN provides flexibility for LMBs to decide what practice models
best align with the values, strengths, resources and needs of each jurisdiction in supporting
children in their home communities. This section provides what is currently known about best
practices, promising practices and, when available, evidenced-based practices for developing
each of the components of an SOC. However, the adoption of an SOC does not require the
adoption of any particular component, but rather adherence to the guiding principles and values.
In other words, which components are implemented will vary across jurisdictions based on local
needs and resources; however, adherence to the fundamental principles and values of SOC
should guide all local decisions.

1. Integrated Systems of Care

Fundamental Principles
A fragmented service delivery system often presents a significant barrier to children and families
in accessing the coordinated services they require without progressing to the highest level of
need. As previously mentioned, an “uncoordinated service delivery system can serve as an
unnatural source of stress for the very families who are the intended recipients of assistance…”
Duchnowski, Kutash, & Friedman, 2002, p.26). The longer that these children and families go
without receiving services, the more debilitating their problems become and the higher the cost
for providing services rises. Maryland’s Children’s Cabinet believes that a priority strategy for
addressing this is through an integrated SOC. In studying the impact of SOC, there have been a
variety of findings, including reduced rates of out-of-state placements, lower costs, clinical gains,
and reductions in the psychiatric hospitalization of children who received services in an SOC
(Duchnowski et al, 2002).

According to one of the earliest definitions, “A system of care is a comprehensive spectrum of
mental health and other necessary services which are organized into a coordinated network to
meet the multiple and changing needs of children and adolescents …and their families” (Stroul
& Friedman, 1986, p.3). For an SOC to meet this definition, it must be non-categorical and

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4 Among the elements that are flexible in the design of the local SOC are the names of the functions and positions
that are created. See Appendix III for a table of functions and definitions to see how they are termed in the ITN and
elsewhere in the State.
5 See Pires, 2002 for detailed information on the implementation of a system of care.
focused on populations of children and families across service systems. It requires a team approach on every level: state, local and community.

Figure 3 that follows illustrates the different populations of children that can be reached through an SOC. Approximately 2-5% of children have serious emotional disturbances (SED) and need the most intense interventions. Serious emotional disturbances can be defined as “diagnosable mental health disorders with extreme function impairment that limits or interferes with the ability to function in the family, school, and/or community” (Stroul, 2002, p.3). Within this 2-5% may be other children not diagnosed with SED but with other intensive needs. However, there are an additional 15-20% of children who have significant needs that, untreated, may rise to the level of the children with SED. Finally, approximately 80% of children with less complex needs can be addressed at the universal health promotion level. The Children’s Cabinet recognizes that families are on a continuum of coping based on life circumstances and need different types of services, supports and interventions along that continuum.

**Prevention**

Despite the less complex or critical needs of the majority (80%) of children and families, early identification and prevention strategies are important components of a fully developed SOC. The same core values and guiding principles (detailed in the following section) are as important to the success of efforts on the universal health promotion level as the targeted and intense intervention levels of an SOC. Communities should strengthen protective factors and promote resiliency in order to enhance the likelihood of positive outcomes for all children and families throughout the continuum of care.
Core Values and Guiding Principles. It is critical to understand that SOC is not a practice model; rather, it is a philosophy or overarching structure that guides the interventions provided to children and their families. SOC is different from a continuum of care. Stroul and Friedman (1986) observed that

“Continuum of Care” generally connotes a range of services or program components at varying levels of intensity. These are the actual program elements and services needed by children and youth. “System of Care” has a broader connotation. It not only includes the program and service components, but also encompasses mechanisms, arrangements, structures, or processes to insure that the services are provided in a coordinated, cohesive manner. Thus, the system of care is greater than the continuum, containing the components and provisions for service coordination and integration. (p.3)

The three core values at the heart of SOC are:
1. The SOC should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
2. The SOC should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.
3. The SOC should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

(Stroul & Friedman, 1986, p.18)

Child-Centered & Family-Focused. The focus on the individual child is essential to the creation and sustainability of an effective SOC. The individualization of the services and care plans that children receive are hallmarks of SOC, along with the recognition of the child’s strengths and needs in developing these plans. In addition to the focus on the individual child, families themselves are a fundamental element in an SOC. They are partners at all levels of the system—policy, management, and service delivery:

*Effective systems do not simply invite families to be part of the process...they also actively support and engage families in a number of ways, for example, by providing tangible supports such as transportation, translation, and child care assistance; by recognizing and drawing on the knowledge and skills that parents bring to the table...by providing capacity-building support that gives families the information, skills, and confidence to partner* (Pires, 2002, p.73).

Families must be involved throughout the SOC, and family involvement within the SOC must be deliberate, but the shape that it takes may vary by community. At the system level, families can be educators, advocates, and policy-makers. In some communities, family organizations play a significant role in shaping policy, as well as advocating for and supporting families. At the management level, families may identify families to participate in workgroups, conduct family surveys and interviews, and provide information and referral services to other families. Finally, at the service delivery level, families are involved in every stage of the development of their child’s plan, as well as participating in family support groups and providing forms of advocacy and mentoring (Wood, n.d.).
Family advocates and family support partners may be seen at various points in the system, providing support for the families, with families ultimately moving toward empowerment. These individuals may be paid or unpaid, depending on the model chosen by the individual community\(^6\) (Pires, 2002).

*Community-Based.* Consistent with the guiding principles of SOC, the Children’s Cabinet believes that children belong in the most appropriate, least restrictive setting possible, and in their own homes and communities when safely possible. The Children’s Cabinet also believes that most children, even those with conduct disorder, oppositional defiant disorder, and SED, can thrive in a family setting, with proper supports. However, for this to be able to occur, there must be an SOC in place to support children and families at all points in the continuum of need.

*Culturally Competent.* Cultural competence is one of the core values of SOC because it enables children and families of all backgrounds to participate in and receive effective, relevant services. According to the 2000 U.S. Census, 64.0% of Maryland Residents were White or Caucasian, 27.9% of Maryland residents were Black or African-American, 4.8% of Marylanders were of Hispanic or Latino origin, and 4.0% were Asian. An additional 2% of Maryland residents indicated that they were of two or more races (U.S. Census, 2003). Additionally, an average of 16,000 immigrants resettle in Maryland annually (Department of Human Resources, Community Services Administration, Maryland Office for New Americans, 2006).

Given the diversity of families in Maryland, cultural competence becomes critical to building effective SOC:

> Effective systems of care respect and make every effort to understand and be responsive to cultural differences...Effective systems of care also acknowledge and address proactively the disparities in access and treatment that historically have been the experience of diverse families in traditional systems. One would be hard pressed to find a state or locality in the country in which ethnically, racially and linguistically diverse children are not over-represented in the most restrictive, “deep-end” services and under-represented in quality community-based services. (Pires, 2002, p.154).

Cross (1988) defines cultural competence as a:

> Set of congruent behaviors, attitudes and policies that come together in a system, agency or professional and enable that system, agency or professional to work effectively in cross-cultural situations. The word “culture” is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social group. The word “competence” is used because it implies having the capacity to function effectively.

In further work, Cross, Bazron, Dennis, and Isaacs (1989) identified five essential elements that contribute to a system, institution, or agency’s ability to become more culturally competent:

1. Valuing diversity
2. Having the capacity for cultural self-assessment

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\(^6\) The Maryland Coalition of Families for Children’s Mental Health is currently developing training curricula for families in SOC in the role of family support partner (in the care coordination phase) and as family navigators (in the systems navigation phase). Additional information on the Coalition can be obtained from [www.mdcoalition.org](http://www.mdcoalition.org).
3. Being conscious of the dynamics inherent when cultures interact
4. Having institutionalized culture knowledge
5. Having developed adaptations to service delivery reflecting an understanding of cultural diversity.

In order to have a culturally competent SOC, these five elements should be manifested at every tier of an organization, including the policy making, administrative, and practice levels. Further, these elements should be reflected in the attitudes, structures, policies and services of the organization.

Cultural competence requires that the SOC, and the organizations and entities contained within it, have the capacity to value diversity, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the community and incorporate this knowledge and capacity into all aspects of the organization (National Center for Cultural Competence, 2004).

SOC as a framework. An SOC provides structure for treatment: “Systems of care provide a service delivery vehicle for clinical treatment and for support services” (English, 2002, p.307). To develop an SOC that is consistent with the theories and principles espoused above, “a community must focus its service program activities at two distinct levels:
(a) infrastructure to house, organize, and manage the integrated program elements, and,
(b) service delivery to provide services, treatments, and supports that are offered directly to children and families”(Center for Mental Health Services, 2001, n.p.) (emphasis added).

Stroul (2002) emphasizes that the “Systems of Care concept is a framework and a guide, not a prescription”(p.7). The service array contained within an SOC should include a broad range of supports and services that are both traditional and non-traditional and rely on clinical and natural supports (Pires, 2002). These services can include diagnosis and evaluation; case management; outpatient individual, family, and group counseling; medication management; professional consultation; 24-hour emergency/crisis; intensive home-based; intensive day treatment; respite care; treatment foster care; and transition to adult (Center for Mental Health Services, 2001). Examples of natural supports include mentoring, family support, and informal respite care.

It is important to note again that it remains up to each local jurisdiction how the SOC will be structured, and which elements, if any, the LMB wishes to implement in the upcoming year. The information below will provide guidance on the creation of the infrastructure and service delivery elements, as well as recommendations for resource development. However, the adoption of an SOC does not require the adoption of any particular component.

2. Local Access Mechanism (Local Infrastructure)
A Local Access Mechanism (LAM) is an identifiable structure and method that helps families access and coordinate available services and supports, both public and private, to address the full range of needs encountered by families with children. It improves coordination and utilization of

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existing resources and supports, and assists in the identification of needed services. These structures may vary from community to community, but what is most important is that the “stakeholders involved in system building take the time to analyze, acknowledge the strengths and weaknesses of, and plan contingencies in response to the structures that are created (or left standing)” (Pires, 2002, p. 17).

Figure 4 (on the following page) illustrates the organizing structure of the LAM. Not all families and youth will access every element; in fact, many families and youth will not move beyond first contact. The components outlined below represent the functions within a LAM—the particular names of the individuals who perform these functions have not been provided, as that will be a decision left up to the individual jurisdictions. Those components that are bolded are available for funding through this ITN.
Figure 4: Local Access Mechanism (LAM) Organizing Structure
(Components that may be funded through the ITN are bolded)

First Contact:
Information/Referral; Single Point of Access/ No Wrong Door
(phone call, walk-in, internet)

Referral to Specific Agency/Organization
(State and local child-serving agencies, crisis centers, community-based organizations)

- Not all families/youth will move on to this level.
- For child-serving agencies, populations served and services provided will be mandate-specific.
- Services may include case management.

Screening Part 1

May Refer

Screening Part 2

May Refer

Care Coordination
(Can be organized within CMU or CME)

- Not all families/youth will move on to this level.
- Receipt of care planning and other services.
- Utilization of the CANS Comprehensive Assessment

Systems Navigation

- Not all families/youth will move on to this level.
- May occur at the same time as first contact.
- Assist family in identifying strengths & needs (does not constitute clinical evaluation) through the use of the CANS Comprehensive Assessment
- Families requiring clinical evaluation will be referred to appropriate child serving agencies or organizations or appropriately credentialed professionals

Families

Hospitals; Medical Professionals

Courts

Police

State & Local Child-Serving Agencies

Community & faith-based organizations

Youth

Families

Referral to Specific Agency/Organization

- Not all families/youth will move on to this level.
- For child-serving agencies, populations served and services provided will be mandate-specific.
- Services may include case management.

Screening Part 1

May Refer

Screening Part 2

May Refer

Care Coordination
(Can be organized within CMU or CME)

- Not all families/youth will move on to this level.
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Systems Navigation

- Not all families/youth will move on to this level.
- May occur at the same time as first contact.
- Assist family in identifying strengths & needs (does not constitute clinical evaluation) through the use of the CANS Comprehensive Assessment
- Families requiring clinical evaluation will be referred to appropriate child serving agencies or organizations or appropriately credentialed professionals
**Information/Referral:** Information/Referral (I/R) is the first point of contact within the LAM. Maryland has chosen to define it as the “initial interaction of the consumer with the system which is initiated by an individual seeking resource(s) either for a child or family member or whole family.” During that first contact, the I/R specialist will ask preliminary questions and determine if the child or family is in a crisis situation that requires immediate attention by the police, a crisis response unit, or a hospital. There needs to be a mechanism in place that will ensure that the family is connected with the appropriate crisis response system.

There are currently three models that are being used or proposed for use in Maryland:

1) **A Single Point of Access (SPA).** A Single Point of Access is the single point of entry for families who wish to enter the system, regardless of the intensity of the needs of their children. It provides a pathway for families in the navigation of the service delivery system. Some jurisdictions have conceptualized this as a web-based resource guide. Other jurisdictions are interested in utilizing the United Way’s 211 hotline number. Still others are interested in setting up their own hotline within their community. An SPA may be less confusing for families, and allows systems to have better control over who enters the system. However, an SPA may be less accessible for families who are already involved in other segments of the system or who are unaware of the existence of an SPA (Pires, 2002).

2) **“No wrong door” policy.** Under a “no wrong door” policy, families are able to enter the LAM through an array of existing services and agencies. Existing points of access continue to serve children and families, while directing them to the LAM when appropriate. In some jurisdictions, it may be necessary to develop an additional access point for those families not involved with existing organizations and agencies. In a “no wrong door” structure, services are more accessible to families and children, as well as to other agencies. However, there may be a loss of entry control and a loss of quality control for the system overall (Pires, 2002).

3) **Hybrid model.** In the hybrid model, the jurisdiction elects to combine elements of the two models above. Jurisdictions may propose to maximize access to local services by providing both a centralized information and referral source (such as the United Way’s 211 number – principally for families not involved with existing organizations or agencies) and points of access through existing services (for families already involved with or seeking categorical services for the first time). This approach may require a high degree of coordination and cross training across community organizations.

With any structure, pathways should be linked both conceptually and through a management information system to ensure adherence to the “one plan, one family” concept (Pires, 2002).

**Screening.** The first step in assessing a family’s level of need is through a screening process. It is expected that some families will need no more than basic information and referral assistance (Universal Health Promotion Level). Other families, however, will require assistance in obtaining services, including information and referral assistance
across public agencies and/or private providers of service as well as assistance with
coordination of care planning (Targeted Intervention Level). Further along this continuum of
need, it is anticipated that 2-5% of families, those who have children with the most
intensive level of need, will require intensive care coordination services (Intensive
Intervention Level).

Screening is used to identify a family’s needs beyond basic information and referral.
There are two levels to screening, which may be done at the same time or in two distinct
phases.

1) At the first contact: The primary purpose of screening at this contact is to
determine if assistance beyond information and referral is needed, including crisis
intervention.

2) At the start of systems navigation (to be discussed more below): This level is
utilized when it is determined that the caller’s needs exceed simple information
and referral, such as when a specific problem is presented. This screening will
generate more detailed information concerning the families’ strengths, needs,
previous and current use of services, and other information that is needed to best
address the individual or family’s expressed concerns or problems. At this stage,
there is a fuller identification of needs and concerns than at the first contact
(although it is recognized that the screening may occur during the same encounter
as the first contact). However, this level of screening does not constitute clinical
evaluation or diagnosis. Families requiring clinical evaluation will be referred to
appropriate child serving agencies, organizations, or appropriately credentialed
professionals. Some level of intervention may occur here if the individual or
family is not willing to go to the necessary level of service.

_CANS Assessment._ Either at the end of systems navigation or at the beginning of care
coordination, the Child and Adolescent Needs and Strengths (CANS) Comprehensive
Assessment should be administered. The CANS is a functional assessment that is
available for free from the Buddin Praed Foundation (www.buddinpraed.org). It is used
to assist in the planning of non-clinical services for children and adolescents and their
families as well as to provide information for quality assurance monitoring. Additionally,
the CANS can provide information that would lead to appropriate referrals for further
clinical evaluation when needed. The CANS generates dimension scores in a number of
domains (such as functional status, child safety, caregiver needs and strengths), and can
be used with children ages 0-18.

The primary function of CANS as suggested for use in the SOC is to provide information
that will be helpful in care planning and to provide information for outcome measurement
and quality assurance within the System of Care. It is not intended as a tool to determine
level of care or to prescribe treatment.

_Systems Navigation._ For those families who need additional assistance beyond a simple referral,
they may choose to utilize the Systems Navigation function within the LAM. The second part of

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8 For examples of items that may be asked at each level of screening see the appendix.
the screening may occur in systems navigation, with specific questions about current health conditions, recent family stresses, and other more detailed information. This screening is not, however, at the level of a clinical evaluation; families requiring clinical evaluation or diagnosis would be referred to the appropriate child serving agency, organization or an appropriately credentialed professional.

In systems navigation, the family is assisted with identifying strengths and needs and obtaining necessary services. The individuals who provide the systems navigation typically do not carry a caseload, and are available to families as they present themselves. Some families may simply need assistance in systems navigation—identifying specific resources and gaining access to services.

Jurisdictions that choose to implement systems navigation may choose to staff the position with a family member (frequently referred to as a family navigator) or other appropriately trained professional or paraprofessional. If the position is being funded with monies through this ITN, there will be an approved training that will be required for family navigators (see above reference to family navigator training curriculum in partnership with the Maryland Coalition for Families) and other system navigators (non-family). These trainings will prepare family and other system navigators for their role and responsibilities. In addition to learning about system services and access, family members will receive training to prepare them for their unique dual role as family member and family navigator while other system navigators will receive heightened training on family experiences and concerns.

Care Coordination. Care Coordination is most often used for families and children with more intensive needs—those families found within the top 20% of the triangle. Structure, length of time, and caseload size will depend upon the need intensity of the target population, as determined by the local jurisdiction (See Pires (2002) pg 64). Care Coordination funded through this ITN will be limited to children who are Community Medicaid Eligible. The goal of care coordination is to provide families in the top 5% of the triangle with intensive care coordination so that they can “move down the triangle,” and to provide families in the middle 15% to 20% with an intermediate level of care coordination that assists them to “move down in the triangle” and prevents them from “moving up.” Families who receive care coordination typically need someone whose responsibility it is to manage the care plan and services, until the point at which the family is ready and willing to assume this role. The care coordinator supports a single, unified plan across multiple agencies and life domains.

In all of these instances, the position may be filled with a family support person—someone with personal experience in navigating the system. However, the positions can also be filled with professionals who work in a team with a parent support person. Regardless of whether the position is filled with a care coordinator or a family support person, if the positions are funded

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9 The two pilot sites currently funded under Maryland’s Wraparound Initiative are funded to provide care coordination and wraparound services for families with youth in the top 5% who are community Medicaid eligible and meet the criteria for Residential Treatment Center–level of care.

10 For those jurisdictions wishing to operate a Care Management Entity under the Medicaid Waiver, specific requirements exist with regard to the credentials and staffing. Please see the Medicaid Waiver Amendment in the appendix for more information.
through this ITN, there will be approved training required. The training will assist in preparation for the roles, as well as providing guidance on the parent-professional partnership and other elements of the SOC.

**Level of Risk and Responsibility**

LMBs who are planning to provide care coordination through wraparound pilot sites must also consider the level of risk and responsibility that they choose to assume. In the current service delivery system, children with intensive needs are simultaneously the responsibility of many agencies and entities and, therefore, the sole responsibility of no one. In an SOC, a unit, entity, or individual assumes a level of responsibility for the child and family’s outcomes. Several options for the assumption of risk are described below.

In a *Care Management Unit (CMU)*, workers may be pulled from multiple agencies and co-located, or new workers may be hired. However, these workers are designated as members of this Unit, with responsibility for the children whose care they are overseeing. The staff of a CMU have been given both the responsibility and flexibility of being in charge of the child’s plan and outcomes, in conjunction with the family and team members. All agencies involved with the child, as well as the natural supports and family, have authorized this unit to be responsible in leading the work. The CMU has complete flexibility in service planning, but continues to rely on fragmented funding mechanisms. The CMU assumes responsibility for the child’s plan and outcomes, but not the total financial risk that is assumed under the Care Management Entity.

In a *Care Management Entity (CME)*, the entity has assumed both outcome and financial liability. In return, the entity receives a single case rate for the child with whom the entity can flexibly spend money in order to individualize the plan of care. (See the Appendix for a copy of Maryland’s Request to Amend Section 1115 of the Health Care Reform Demonstration, also known as the 1115 Medicaid Waiver.)

Both of these models can be applied to service delivery for any population of families and children, however the funding available for wraparound pilot sites through this ITN is limited to children who are Community Medicaid Eligible. A single CME may have multiple case rates, depending on the intensity of the child’s needs. See the appendix for examples of how jurisdictions in Maryland and elsewhere have structured their CMU and CME.

A CMU enhances the ability to provide wraparound and other services – a CME is even more effective at achieving this. While wraparound and other best practice models can be done without structural changes, the impact of doing so on creating an effective SOC will be minimal. Both research and anecdotal evidence indicate that communities are most likely to implement wraparound without structural change; however, this results in little to no system change. While individual service delivery may still be enhanced without structural change, such an approach leaves the system no easier to navigate for the next family who presents.

Not all jurisdictions are ready to assume full or even partial risk for a child and family’s outcomes. It is at the jurisdiction’s discretion to determine its level of readiness to change and to assume liability in exchange for flexibility.
The Wraparound pilots funded under this ITN should describe the level of risk and responsibility the jurisdiction is assuming for the child and describe the model that will be used to provide care coordination.

3. Service Delivery
How do we take what we are already doing, the services that we are delivering to families and children, and ensure that the values and principles are really being adhered to in practice? What service delivery models exist that are consistent with SOC values and have been demonstrated to be effective when working with families and children? This section provides information on services that are considered to be “best or promising practices” and are consistent with SOC values. The service delivery and practice models detailed below are only a small sampling of some of the most effective community-based interventions for children and youth. Many can be used in combination with one another. See Burns & Hoagwood (2002) and the appendix for additional evidence-based interventions. These services are:

- Wraparound
- Crisis Services and Intervention

Direct funding for service delivery and practice models through this ITN is only available for Wraparound services. Other existing or proposed “best or promising practices” can be integrated into a jurisdiction’s SOC continuum of services with funding from other sources as part of the negotiation process. Discussion about the use of other existing resources or new agency-specific resources that are a part of a jurisdiction’s ongoing efforts to develop a full continuum of services within its System of Care is encouraged.

**Wraparound.** Wraparound is an approach to treatment for children with intensive needs that is a family-centered, community-oriented, strengths-based, highly individualized planning process that relies on a balance of formal and informal or natural supports to help children and families achieve important outcomes while they remain whenever possible in their neighborhoods and homes (Grealish, 2005). Wraparound is “a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes….The philosophy that spawned wraparound is relatively simple: identify the community services and supports that a family needs and provide them as long as they are needed” (Burchard, Bruns, & Burchard, 2002, p.69). In wraparound, a team comprised of the child, family, and natural and formal supports creates a plan for services that will be “wrapped” around the child.

High-fidelity wraparound is a practice model that is appropriate for use with *any* population, regardless of the intensity of their needs. Some families may need fewer services and meetings, but the model remains useful in these instances as well as with the most “deep-end” children. In wraparound, flexible funding and the ability to leverage resources are critical to success. Participants in the process have authorization to use the plan as the single plan for the child and family and to obtain funding as appropriate. **11**

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11 See Appendix: Necessary Conditions for Wraparound
The National Wraparound Initiative, which was partially funded by the State of Maryland, is a collaborative of SOC experts from across the nation\(^\text{12}\). This Initiative articulated the ten principles of wraparound, which are almost identical to those of the SOC and have been adopted by Maryland (Bruns, Walker, Adams, Miles, Osher, Rast, VanDenBerg, & National Wraparound Initiative Advisory Group, 2004).

1. Family voice and choice
2. Team based
3. Natural supports
4. Collaboration
5. Community-Based
6. Culturally competent
7. Individualized
8. Strengths-Based
9. Persistence
10. Outcome based

In articulating these ten principles, the National Wraparound Initiative Advisory Group commented that the overall consensus on the ten principles listed below was strong.

1) **Family Voice and Choice**\(^\text{13}\). Family voice and choice is one of the most critical elements of wraparound, and is defined as occurring when “family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members’ perspectives, and the team strives to provide options and choices such that the plan reflects families’ values and preferences” (Bruns et al, 2004, p.4). Putting the principle of family voice and choice into place requires intentional action on the part of the wraparound team.

Families should have the greatest influence on the process, and decision-making should be structured to allow family members to select the choice that is “most consistent with their own perceptions of how things are, how things should be, and what needs to happen” (Bruns et al, 2004, p.4). However, given the fact that many of the families who chose to utilize wraparound may have involvement with the child welfare or juvenile justice systems, teams must pay special attention to balancing the family’s influence and perspectives with other legal mandates and considerations (Bruns et al).

2) **Team-Based**. In addition to having family on the team, members should be comprised of “individuals agreed upon by the family and committed to them through informal, formal and community support and service relationships” (Bruns et al, p.5). Team members may consist of teachers, neighbors, co-workers, therapists, a care coordinator, family support person, and other natural and formal supports. Practical and legal considerations may shape the decisions for who is a member of the team.

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\(^{12}\) See the National Wraparound Initiative for additional resources and information on wraparound: http://www.rtc.pdx.edu/nwi/

\(^{13}\) See Bruns et al, 2004 for detailed information on each of the principles.
3) Natural Supports. The principle of natural supports is defined as when “the team actively seeks out and encourages the full participation of team members drawn from family members’ networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support” (Bruns et al, p.6). Bruns et al note that natural supports (i.e. colleagues, teammates, neighbors, family members) are more sustainable than professional support, which may dwindle or cease after the case is closed. Team facilitators will need to act intentionally to increase the natural supports, as this can be one of the most difficult elements of wraparound for providers to access: “People who have a long-term, ongoing relationship with a child or youth have a unique stake in and commitment to the wraparound process and its outcomes...a young person who is receiving wraparound also has a unique stake in the process and outcomes”(Bruns et al, p.4).

4) Collaboration. Collaboration occurs when “team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound team. The plan reflects a blending of team members’ perspectives, mandates, and resources. The plan guides and coordinates each team member’s work towards meeting the team’s goals” (Bruns et al, p.7). Team members are expected to be committed to the team and to the work being done. Team cohesiveness and high quality planning are two characteristics of wraparound teamwork that is most likely to achieve the desired outcomes (Bruns et al).

5) Community-Based. In wraparound, the team implements “services and strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life”(Bruns et al, 2004, p.8). This principle recognizes the importance of families participating in activities within their own communities, and of having the greatest possible access to the services and supports available to families in their communities.

6) Culturally Competent. Consistent with the discussion above about cultural competence as a core value of SOC, “the wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community” (Bruns et al, p.8). Team members should recognize the potential of a family’s heritage as a strength upon which they can draw. Team members with a shared cultural identity can help to achieve a longer lasting relationship and source of support (Bruns et al).

7) Individualized. It is critical that the plan be individualized so that it is uniquely tailored to the child and family: “To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services” (Bruns et al, p.9). There are several theories that underlie wraparound, including social-ecological, systems, family-centered, social learning, and strengths-based (Research and Training Center on Family Support and Children’s Mental Health (RTC), 2004; Burchard Bruns, & Burchard, 2002): “The developmental
process occurs within the unique ecological environment of each child and family. Therefore, behavior change or adjustment needs to take place within the normative roles, expectations, and opportunities of these settings, and in interaction with those systems or contexts” (Burchard et al, p.70).

According to Bandura’s social learning theory, behavior is “shaped by the interaction of...biological characteristics and the many reciprocal relationships that occur within the child’s environment over time” (Burchard et al, 2002, p.71). Therefore, wraparound must be extremely individualized to reshape “the environment so the child can learn to behave in a more adaptive manner” (Burchard et al, 2002, p.71).

8) **Strengths-Based.** As is consistent with the core values of SOC, the wraparound process and plan should be strengths-based: “The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members” (Bruns et al, p.9). The team should focus on validating, building on, and expanding the “family members’ psychological assets...interpersonal assets...and their expertise, skill, and knowledge” as well as capitalizing on the strengths of other team members (Bruns et al, p. 10).

9) **Persistence.** In a wraparound model, the plan and support are not terminated simply because services are not available: “This principle emphasizes that the team’s commitment to achieving its goals persists regardless of the child’s behavior or placement setting, the family’s circumstances, or the availability of services in the community” (Bruns et. al. p. 10). Instead, there is a commitment to the child and to the family to continue to work toward the best possible outcome for that child: “Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches the agreement that a formal wraparound process is no longer required” (Bruns et al, 2004, p.10). Wraparound models adhere to a no reject/no eject policy of serving families in need—not just families who are a match with the services currently available. Adverse events or outcomes during the wraparound process are indicative of the need to revise the plan—not of failure (Bruns et al).

10) **Outcome Based.** In wraparound, there is a focus on outcomes throughout the process: “The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly” (Bruns et al, p.10). This principle is in keeping with the Results Accountability framework, and can be accomplished by using the four quadrants of performance accountability: quantity of effort, quality of effort, quantity of effect, and quality of effect. These four quadrants can be more simply stated by three questions: How much did we do? How well did we do it? Is anyone better off?

By utilizing all of the principles listed above, the wraparound team ends up with a plan that is uniquely tailored to the family. The child is not forced to fit into the standard service plan but
rather the necessary services are wrapped around the child and family’s needs and desires: “Individualization necessarily results as team members collaboratively craft a plan that capitalizes on their collective strengths, creativity, and knowledge of possible strategies and available resources” (Bruns et al, p.9).

The wraparound team is accountable to the family, team members, participants, and the public for achieving the goals of the plan. Tracking data and outcomes helps the team to “maintain hope, cohesiveness, and efficacy” (Bruns et al, p.11). For children with intensive needs, high-fidelity wraparound is a highly effective tool that has resulted in significant and positive customer results. Nine pre-post studies that were completed on sites that used high-fidelity wraparound found a correlation between the program model and positive outcomes. A majority of the children studied were able to maintain a stable adjustment in the community, and almost all of the children were able to remain in the community months and even years after entering wraparound programs (Burchard et al, 2002).

Organizations must monitor adherence to the wraparound practice model if they purport to use high-fidelity wraparound. This can be achieved in a number of ways, including reviewing wraparound plans for consistency with the model and observing meetings (Walker, 2004). The Wraparound Fidelity Index (WFI)\(^\text{14}\) is also available as a tool for measuring fidelity: “The Wraparound Fidelity Index is an interview process that measures the implementation of wraparound on a family-by-family basis” (Rast & Bruns, 2003, p.22). The forms are used with caregivers, youth (ages 11 and older) and care coordinators.

The fidelity measurement has been found to be an important part of the quality assurance process. It can enhance the communication of expectations, and be useful in training. It also ensures adherence to the practice model and can be helpful in making changes to the program (Rast & Bruns). This tool can serve as an excellent measure of the quality of effort: How well are we implementing wraparound? For those jurisdictions wishing to implement wraparound, training and technical assistance will be provided through the Innovations Institute. The Innovations Institute will also be assisting with the administration of the WFI and the aggregation and analysis of the data.

“Wraparound is more than a technology for improving clinical and functional outcomes: it is also an expression of a philosophical commitment to protecting certain fundamental rights of children with mental health needs and their families”(RTC, 2004, p.4).

**Crisis Services & Intervention.** Crisis intervention is defined in COMAR 10.21.17.02 B as “the therapeutic response that provides immediate care or referral for an individual with urgent mental health need.” Maryland’s Blueprint Committee on Children’s Mental Health expands this definition to describe crisis intervention as a service that is “brief, short-term and intensive and is designed to provide an immediate clinical response to support an individual remaining in the least restrictive setting”(p.25-26). The Blueprint Committee observes that crisis intervention services can include a 24-hour crisis hotline, intervention and stabilization, crisis assessment and evaluation, mobile crisis services, and residential crisis beds.

\(^{14}\) More information on the WFI can be obtained by going to [http://depts.washington.edu/wrapeval/WFI.html](http://depts.washington.edu/wrapeval/WFI.html)
In the 1999 report, *Mental health: A report of the Surgeon General*, it was observed that there have been limited studies on the effects of crisis intervention. However, one study of a mobile crisis team found that it was able to prevent emergency department visits and out-of-home placements. Another study of a short-term residential service crisis intervention found fewer inpatient admissions to psychiatric hospitalizations (U.S. Dept. of Health & Human Services (HHS), Office of the Surgeon General, 1999).

4. Resource Development for Community-Based Residential Placement Capacity

There is a significant need for additional resources throughout the state to support an SOC. LMBs should refer to the *State Resource Plan* that further articulates the state’s community-based placement needs by jurisdiction and region (located at www.goc.state.md.us). Therapeutic group homes, regular group homes, and treatment foster care are resources that are in short supply yet are necessary to create a continuum of care when out-of-home placement is necessary. The Children’s Cabinet has identified, in the State Resource Plan, the following resource priorities based upon current data on out-of-home placements and utilization, as well as surveys of local departments of social services and the Department of Juvenile Services (DJS).

In Maryland, there are three predominantly under-served regions in terms of availability of community-based placements. These regions will be given priority in funding new placement capacity. These regions are:

1. Baltimore City
2. Eastern Shore
3. Prince George’s County and Montgomery County (D.C. Metro Area)

However, it is recognized that all regions of the State have identified resource needs and consideration will be given to all proposals. The information detailed below is a sample of the most pressing needs in the State.

**Group Homes.** The Children’s Cabinet has articulated three categories of group homes in the State of Maryland—general service group homes, general service group homes serving children with special characteristics, and group homes with specialized licenses.

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15 n.b. Residential Child Care Facilities are regulated by COMAR 14.31, in addition to any particular regulations for specialized placements. All parties interested in opening a new residential child care facility must go through the Single Point of Entry at the Governor’s Office for Children. More information can be obtained at www.goc.state.md.us.

16 See the State Resource Plan (2006) for additional information on out-of-home placement resources needed (available from the Governor’s Office for Children). Much of this information is based on a survey of local departments of social services conducted by the DHR Office of Planning in January 2006. Because of the limited time available to prepare for and conduct the survey, the above data should be considered as very rough estimates of need.

17 Funding will not be made available through this ITN for the development of additional group homes in Baltimore County, due to the disproportionate number of group homes already in existence in Baltimore County. Therefore, any references to the Baltimore Metro Area in the following sections exclude Baltimore County.
**General Service Group Home:**
A general service group home has been defined as a facility licensed by the Department of Human Resources (DHR), DJS, or the Department of Health and Mental Hygiene/Mental Hygiene Administration (DHMH/MHA) to provide out-of-home care for four or more children, depending on licensing agency, who need more structure and supervision than a relative, foster parent, or treatment foster parent could offer, with a formal program of basic care, social work and health care services.

The geographic areas that have been identified for this type of group home are:

- Lower Eastern Shore Region: 10-16 beds for adolescents
- Southern Maryland Region: 3-5 beds to serve girls

**General Service Group Home Serving Youth with Special Characteristics:**
There is an identified need for general service group homes serving youth with special characteristics. This category has been defined as a facility licensed by DHMH/DDA, DHMH/MHA, DHR, or DJS, to provide out-of-home care for four or more children, depending on licensing agency, who need more structure and supervision than a relative, foster parent, or treatment foster parent could offer, with a formal program of basic care, social work and health care services. The facilities specifically provide services for the following characteristics:

1. Aggressiveness
2. Sex Offending
3. Fire Starting
4. Runaway
5. Medically Fragile
6. Teen Mother/Pregnant/Mother-Infant
7. Addictions

The geographic areas that have been identified for Group Homes Serving Youth with Special Characteristics are:

- Baltimore Metropolitan Region: 55-65 beds for a variety of special characteristics including: 17-21 year olds; adolescent girls with challenging behaviors; children with a history of running away; children with mental health problems and any adolescents.
- D.C. Metropolitan Region: 15-30 beds for youth with substance abuse problems; children with developmental delays and/or disabilities; children with mental health problems and children and youth with a need for alternative schooling.

**Therapeutic Group Homes (TGH):**
Therapeutic group homes (TGH) are group homes with specialized licenses. They are facilities for children in out-of-home care that are licensed by DHMH/MHA, and must be a non-profit organization. A TGH provides residential care, as well as access to a range of diagnostic and therapeutic mental health services for children and adolescents who have a diagnosed psychiatric disorder.

The geographic areas that have been identified as needing TGH are:
- Baltimore Metropolitan Region: 35-40 beds for youth with mental retardation, sexual acting out behaviors, aggression, delinquency, dual diagnoses, medically fragile, autism, and youth who require drug treatment and a full range of services.
- DC Metropolitan Region: 10-20 beds for youth with a dual diagnosis; youth with sexual offenses; girls and a need for highly trained staff.
- Lower Shore Region: 6-8 beds for adolescents
- Southern Maryland Region: 10-12 beds for pregnant teens; children with developmental disabilities; children and youth with significant mental retardation; youth at risk for running away; and children and youth with a dual diagnosis.
- Upper Shore Region: 3-5 beds capable of providing one-to-one components and educational components.

It should be noted that the Developmental Disabilities Administration must license all programs that serve children with developmental disabilities. A program for children with developmental disabilities has been defined as a facility licensed by DDA to provide 24-hour supervision, and provide residential services for children who, because of a developmental disability, require specialized living arrangements.

Other Community-Based Placements.

Treatment Foster Care. Treatment foster care (TFC), sometimes referred to as therapeutic foster care, is “considered the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders” (HHS, 1999, n.p.). Treatment foster care parents are specially trained to work with children with serious emotional and behavioral problems in a family setting.

TFC is tailored to meet the needs of the individual child and, therefore, the plan changes over time as the youth needs less supervision and different services (Chamberlain, 2002). TFC uses a team model, with the case manager, TFC parents, youth, therapist, and others involved in the decision-making process. The key principles of TFC are 1) a proactive approach to dealing with antisocial behavior and teaching pro-social behavior, 2) staff and parent roles are stratified for flexibility and impact, and 3) a consistent positive environment for the youth (Chamberlain).

The Foster Family Treatment Association of America (FFTA) has set national standards for TFC. The Oregon Science Learning Center model of TFC has been found to produce superior outcomes for children. This model includes higher treatment parent stipends, intensive training and in-vivo training, active support to implement a behavior plan, daily telephone contact from the program staff and 24-7 access to the program staff, and planned respite for treatment parents on a regular basis (Bruns, Zachik, Brylske, Walker, Kiser, & Tomlin, 2005). In Maryland, there is inconsistent application of these features across TFC providers (Bruns et al, 2005).

The geographic regions identified as needing TFC are:

- Baltimore Metropolitan Region: 100-120 beds serving sibling groups; adolescents; mothers with infants; children with dual diagnoses; children with a low IQ; and children who demonstrate sexual acting out behaviors.
- D.C. Metropolitan Region: 25-35 beds providing specialized treatment services and drug screening and treatment.
- Lower Shore Region: 3-5 beds serving adolescents and sexualized youth.
- Upper Shore Region: 5-8 beds serving children and youth with severe mental health problems; medically fragile infants; and drug-affected infants.
- Southern Maryland Region: 25-35 beds serving youth with sex offenses; teen parents/pregnant teens; children with significant behavioral problems and runaways.
- Western Maryland Region: 15 beds serving children with special needs; willing to serve and adopt medically fragile children and children with severe behavioral/emotional problems.

**Respite Care**

The Blueprint Committee on Children’s Mental Health provides the following description of in-home and out-of-home respite: “Respite services involve the provision of short-term temporary care in or out of the home by qualified care workers with the primary purpose of offering relief to the family or caregiver of a child or adolescent with a DSM IV mental health diagnosis. Services are designed to support the child remaining in their home” (p.7).\(^{18}\)

The Children’s Cabinet has defined out-of-home respite as “temporary care (up to 30 days) provided in a facility licensed with the purpose of providing relief to the caregiver, regulating or changing a child’s medication or treatment.” Respite care is typically provided for a partial day or weekend in order to give the caregiver a break from his or her responsibilities.

Jivanjee & Simpson (2001) observe that, when respite care is part of an SOC, a wide range of options should be available:

Within the two broad categories of respite services (in-home care and out-of-home care) there are variations depending on: the respite care setting (provider’s home, foster home, group home, camp, or community recreational facility); whether respite is regular, planned or provided on an emergency basis; and whether respite care is overnight or only during the day. There are also variations depending on the type and level of training of respite providers, the kinds of activities planned for the child, and the payment system”(n.p.).

In one of the few studies on the impact of respite care, Bruns & Burchard (2000) found that the families caring for a child with emotional and behavioral problems “who received respite care experienced significantly better outcomes overall than did 28 families in a wait-list comparison group, including fewer incidents of out-of-home placement, greater optimism about caring for the child at home, reductions in some areas of caregiving stress, and lower incidence of negative behaviors expressed in the community” (abstract).

**The geographic regions identified as needing respite care are:**

- Baltimore Metro Region 10-12 beds serving foster parent families, available 24/7, serving children with low IQ, aggression, and mental health problems
DC Metro Region: 50-55 beds serving children ages 8-21 that are available on weekends; have psychiatric staff and are available as an interim placement before moving a child to more intensive care.

Lower Shore Region: 15-20 beds serving young children; and children in public treatment foster care programs.

Southern Maryland Region: 12-17 beds serving sibling groups; teens; infants; children with autism; children with intensive behavioral and/or mental health issues; medically fragile children; children awaiting RTC placement or discharge from a hospital.

Western Maryland Region: 5-7 beds for vacation assistance or regular respite.

III. Response to the Invitation to Negotiate

A. Action Plan and Budget

Continuing with the Results Accountability process, the Children’s Cabinet has determined that the best action plan for implementing statewide SOC is to:

- Ask each LMB to utilize the same Results Accountability planning process in each local jurisdiction to determine the infrastructure, values, principles and service delivery practice models that best align with the values, strengths, resources and needs of its jurisdiction;
- Communicate the design of the local SOC to the Children’s Cabinet in the form of a concept paper; and,
- Utilize a mutual gains negotiation process between state and local partners to make final determinations on each local plan and budget.

The new FY07 budget available from the State for the various components of the SOC is:

- Local Access Mechanisms: $1.8 million
  - Single Point of Access/No Wrong Door
  - Systems Navigation
- New Wraparound pilot sites: $500,000
  - Wraparound Pilot Sites that provide accountable care coordination for Community Medicaid Eligible children through designated care management units or care management entities.
  - Funding priority for new Wraparound pilot sites will be given to rural jurisdictions or regions with at least one rural partner.
- Resource Development for Community-Based Residential Placements: $1 million
  - Priority will be given to proposals for group homes in Baltimore City, the Eastern Shore and Prince George’s and Montgomery Counties (D.C. Metro Region).

It is recognized that service capacity needs may exceed these funding categories. Therefore, discussion about use of other existing resources or new agency-specific resources that are a part of a jurisdiction’s ongoing efforts to develop a full continuum of services within its System of Care is encouraged. Additionally, throughout these areas, the State is urging the development of family and youth partnership capacity at both the case plan and policy levels.
B. LMB Responses:

- LMB responses MUST be submitted with a signed cover sheet which includes the signatures of all members of the Local Management Board.

Each response should follow the Results Accountability process by answering a series of questions for each component. These responses can be built on the jurisdiction’s previous work in developing a Local Access Plan.

Population Accountability. This ITN provides an opportunity for local jurisdictions to think about the entire System of Care (SOC) for their jurisdiction and the specific results and indicators that this SOC will address. While funding is only being provided for portions of the SOC this year, it is important for the LMB to think about what is needed for a comprehensive SOC. For the overall SOC, the following population accountability questions should be answered:

1. Who is your target population for your SOC?
   a. Demographic information
      i. Population
      ii. Socioeconomic factors
   b. Utilization of service system at various sections of the “triangle” (based on data developed during the Local Access Plan process)

2. What are the results your community is trying to achieve through this ITN? The State is particularly interested in addressing two specific results as described previously and listed below. LMBs may also address other results through their SOC:
   a. Stable and economically independent families
   b. Communities which support family life
   c. Other results you are trying to achieve

3. What do the data tell us?
   a. Which indicators will you use to measure each of these results?
      i. Provide local data (if available) for the following indicators:
         1. Number of out-of-home placements, by placement type
         2. Cost of out-of-home placements
         3. Number and cost of voluntary placements
      ii. Provide data for other indicators that your jurisdiction will use to measure the additional results listed in #2 above
   b. What is the historical baseline and future forecast (and/or trendline) for these data?
   c. For each indicator, is the indicator heading in the right direction?

4. What is the story behind the data and the direction it is heading? If the data are trending in the wrong direction, what are the causes and forces at work that are contributing to this direction?
5. Who are the partners who have a role to play in doing better? What partners have been involved in your planning process? Key partners on the Planning Team should include representatives of the following (at a minimum):
   - Department of Social Services
   - Department of Juvenile Services
   - Local School System
   - Developmental Disability Administration
   - Core Service Agency
   - Health Department
   - Chairperson of the Local Management Board
   - Family Member/Caregiver/Youth

   a. How have families been involved in the development and policies of your SOC, and how will you ensure their ongoing engagement?
   b. Who will continue to be involved in the SOC?
   c. How have you insured that cultural competency has been addressed throughout the process?

6. What strategies work to “turn the curve” and make things better?
   a. What are the strategies that are currently working and should be included in the SOC negotiations as the local contribution?
   b. What else is needed in the community? (Research and information concerning best practices, promising practices and evidenced-based practices that have been provided in this ITN can be very helpful in this step).
   c. What are some of the low cost/no cost ideas that you will implement?

7. Action plan: What are your prioritized strategies? (utilize the specificity, leverage, values, reach criteria defined in the appendix to prioritize strategies) How will cultural competency be addressed in each strategy? Utilize the format that follows (Performance Accountability) to describe each of the state-funded strategies in a more detailed manner.

   Budget: Provide a detailed budget and budget narrative using the forms provided. These forms provide columns for identifying the use of local funding, other state funding and requested Children’s Cabinet funding. **Note:** At this time, new FY07 Children’s Cabinet funding is only being provided for:

   - Local Access Mechanisms: $1.8 million
     - Single Point of Access/No Wrong Door
     - Systems Navigation
   - New Wraparound pilot sites: $500,000
     - Wraparound Pilot Sites that provide accountable care coordination for Community Medicaid Eligible children through designated care management units or care management entities.
     - Funding priority for new Wraparound pilot sites will be given to rural jurisdictions or regions with at least one rural partner.
   - Resource Development for Community-Based Residential Placements: $1 million
     - Priority will be given to proposals for group homes in Baltimore City, the Eastern Shore and Prince George’s and Montgomery Counties (D.C. Metro Region).
Performance Accountability. For each SOC component that your jurisdiction is proposing creating or modifying (Local Access Mechanism, Systems Navigation, wraparound services, and resource development), answer the questions below. Please begin each set of answers (by component) by briefly describing the component that you are proposing for your SOC and identifying whether you will be partnering with any other LMB on that particular component.

Local Access Mechanism (Single Point of Access, No Wrong Door or Hybrid Model)

If your LMB is proposing the Local Access Mechanism Component, briefly describe this component and answer the following questions in reference to it:

1. Who are your customers?
   a. Describe the children and families that you anticipate accessing your Local Access Mechanism.
   b. Provide demographic information
2. How can we measure if our customers are better off?
   a. What measures will you use to determine if these customers will be better off by using your Local Access mechanism? Possible examples are:
      i. Percentage of customers reporting access to information requested
      ii. Percentage of customers reporting resolution of problem
   b. If you have current measures of customer results, how are you doing on these measures?
   c. What other measures do you need? What is your Data Development Agenda?
3. What are our current measures in regard to service delivery?
   a. What headline measures will you use to determine how well you are delivering services? Examples are:
      i. Percentage of parents satisfied with services, cultural competence and family-centeredness
      ii. Timeliness of referrals and information received
   b. If you have current measures, what does this data tell you in regard to how well we deliver services?
4. What partners have we included in our planning process?
   a. How have you obtained family input into the planning of your Local Access Mechanism?
   b. How have other members of the community been involved in your planning process for the Local Access Mechanism?
   c. How have the various child-serving agencies and partners been involved in the planning process?
5. What is the story behind our measures?
   a. Provide information on the measures listed above.
   b. What are the causes and effects contributing to the data?
6. What works to improve these measures?
   a. What is currently being done to improve families’ access to services and the efficiency and effectiveness of services?
   b. What do we propose to do to begin and/or improve our Local Access Mechanism?
i. How will families access the system?
ii. How will the system be staffed?
iii. How will you ensure cultural competency?
iv. What barriers need to be addressed with the state?
c. What are our no cost/low cost ideas to improve access to services?

7. Action plan with timeline
8. Budget: Provide the budget and the budget narrative on the forms provided.

Local Access Mechanism: Systems Navigation

If your LMB is proposing to implement Systems Navigation, briefly describe this component and answer the following questions in reference to it:

1) Who are your customers?
   a) Describe the children and families that you anticipate receiving systems navigation services.
   b) How many families do you envision serving in a year?
   c) Provide demographic information

2) How will you measure if your customers are better off?
   a) What measures will you use to determine if these customers will be better off by using systems navigation? Possible examples are:
      i) Percentage of families reporting access to services
      ii) Percentage of families reporting resolution of problem
      iii) Improvement in a child’s school behavior (or other measures related to the child’s plan).
   b) If you have current measures of customer results, how are you doing on these measures?
   c) What other measures do you need? What is your Data Development Agenda?

3) What are your current measures in regard to service delivery?
   a) What headline measures will you use to determine how well you are delivering systems navigation services? Examples are:
      i) Percentage of parents satisfied with services.
      ii) Percentage of children/youth satisfied with services
      iii) Decrease in barriers to receiving services.
   b) If you have current measures, what does this data tell you in regard to how well you deliver services?

4) What partners have you included in your planning process?
   a) How have you obtained family input into the planning of your systems navigation system?
   b) How have other members of the community been involved in your planning process for systems navigation?
   c) How have the various child-serving agencies and partners been involved in the planning process?

5) What is the story behind your measures?
   a) Provide information on the measures listed above.
   b) What are the causes and effects contributing to the data?

6) What works to improve these measures?
a) What is currently being done to improve families’ access to services and the efficiency and effectiveness of services?
b) What do you propose to do to begin and/or improve your systems navigation?
   i. How will families access the system?
   ii. How will the systems navigation be staffed?
   iii. How will families be involved in all levels of systems navigation?
   iv. How will you ensure cultural competency?
c) What are your low cost/no cost strategies to improve systems navigation?

7) Action Plan and Timeline
8) Budget: provide the budget and budget narrative on the forms provided.

**Wraparound**

This ITN will provide funding for wraparound pilot sites that provide accountable care coordination for Community Medicaid Eligible children through designated care management units or care management entities. Funding priority for new Wraparound pilot sites will be given to rural jurisdictions or regions with at least one rural partner. Describe your proposed wraparound pilot including whether you will be using a Care Management Unit or Care Management Entity and answer the following questions:

1. Who are your customers?
   a. Describe the children and families that you anticipate accessing your Wraparound program.
   b. What is the number of children that you anticipate providing wraparound services to in FY07?
   c. Provide demographic information

2. How can we measure if your customers are better off?
   a. What measures will you use to determine if these customers will be better off by using your Wraparound program. Possible examples are:
      i. Increase in school attendance
      ii. Increase in strengths as measured on a functional assessment
   b. If you have current measures of customer results, how are you doing on these measures?
   c. What other measures do you need? What is your Data Development Agenda?

3. What are our current measures in regard to service delivery?
   a. What headline measures will you use to determine how well you are delivering services? An example is:
      i. Wraparound Fidelity Index (WFI): A wraparound program that scores 75% or better on this index has been proposed as having “adequate” fidelity. A score of 85% or better on this index has been proposed as a “high fidelity” wraparound model.
   b. If you have current measures, what does this data tell you in regard to how well you deliver services?

4. What partners have you included in your planning process?
   a. How have you obtained family input into the planning of your Wraparound program?
b. How have other members of the community been involved in your planning process for Wraparound?

c. How have the various child-serving agencies and partners been involved in the planning process?

5. What is the story behind your measures?
   a. Provide information on the measures listed above.
   b. What are the causes and effects contributing to the data?

6. What works to improve these measures?
   a. What is currently being done (if anything) to provide wraparound services to children and families with intensive needs?
   b. What do we propose to do to begin and/or improve your Wraparound Program?
      i. How will families access Wraparound Services?
      ii. How will the Wraparound Program be staffed?
      iii. How will families be involved in all levels of the Wraparound process?
      iv. How will you ensure that all ten elements of the wraparound approach are present in your program?
      v. What type of care management system are you proposing and how will it work?
         1. Care Management Unit
         2. Care Management Entity
   c. What are your no cost/low cost ideas?

7. Action plan with timeline

8. Budget: Provide the budget and the budget narrative on the forms provided.

Resource Development: Community Based Residential Placements

1. Who are your customers?
   a. Describe the children and families that are in need of community based residential placement.
   b. Provide information on the number of children that are placed far away from their communities due to a lack of community based residential placements near children’s homes.
   c. Provide demographic information

2. How can you measure if your customers are better off?
   a. If community based residential placement is effective, how will your customers’ lives be better? What 2-3 headline measures will you use to determine if these customers will be better off by using this component?
   b. If you have current measures of customer results, how are you doing on these measures?
   c. What other measures do you need? What is your Data Development Agenda?

3. What are your current measures with regard to service delivery?
   a. What 2-3 headline measures will you use to determine how well you are delivering services? Example:
      i. Number of children placed further than 50 miles from home.
   b. If you have current measures, what does this data tell you in regard to how well we deliver services?
   c. What other measures do you need? What is your Data Development Agenda?
4. What partners have you included in our planning process?
   a. How have you obtained family input into the planning of community based residential placements?
   b. How have the various child-serving agencies and partners been involved in the planning process?
   c. How have other members of the community been involved in your planning process for this community based residential placement?
   d. Will you be partnering with LMBs in other jurisdictions? If so, how will you partner with them? What type of agreement will you have to work together?

5. What is the story behind your measures?
   a. Provide information on the measures listed above.
   b. For each measure, create a baseline that shows the history of performance and a forecast of where you are heading if you don’t do anything differently.
   c. Why are things getting better or worse? What are the causes and forces contributing to the data?

6. What works to improve these measures?
   a. What is currently being done to improve provide community based residential placements for children?
   b. What do you propose to do to begin and/or improve community based residential placements?
      i. How will families access the system?
      ii. How will the system be staffed?
      iii. How will families be involved in all levels of the planning and service delivery?
      iv. How will you ensure cultural competency?
      v. What barriers exist to providing community based residential placements?
   c. What are your no cost/low cost ideas?

7. Action plan with timeline
8. Budget: Provide a budget and budget narrative on the forms provided.

C. Submission
The Responses should not exceed 20 12-point font pages, excluding appendices. One hard copy of each response must be submitted, along with a single electronic version. Responses should be indicative of broad stakeholder input and a commitment to the principles of an SOC. Terms (i.e. “care coordination” and “family support”), if used, should be clearly defined for each local jurisdiction.

Responses must be e-mailed (for electronic version) and postmarked (for hard copies) by 5PM on Friday, June 23, 2006. They should be submitted to:
Deborah S. Harburger
Systems of Care Initiative Manager
Governor’s Office for Children
301 W. Preston St, 15th Floor
Baltimore, MD 21201
dharburger@goc.state.md.us
If you have questions, please contact Deborah Harburger at the Governor’s Office for Children, at 410-767-3539 or dharburger@goct.state.md.us. All questions will be responded to in writing and distributed to all LMBs.

D. Technical Assistance
Technical Assistance (TA) will be provided by GOC and The Innovations Institute at the University of Maryland. TA will consist of three regional sessions lasting one and a half days, as well as ongoing TA via a listserv. National experts will be brought in to provide some elements of the TA.

Day 1 (4 hours):
Overview of the ITN
Results and Performance Accountability Process
Explanation of the negotiation process
Expectations for this ITN and negotiations
Questions & Answers

Day 2 (8 hours):
Systems of Care—Components & Best Practices
Financing
Care Management Units & Care Management Entities
Questions & Answers

Information on registering for the TA days will be provided by GOC.

Library resources on SOC and best practices will be made available to the LMBs through the Innovations Institute.

Upon the successful negotiation between the State and LMB(s), additional TA will be provided. For those LMBs who are implementing wraparound and/or a care management structure, the Innovations Institute will be providing 3-4 days of planning and TA, as well as 6 one-day trainings for the purpose of orienting community stakeholders, lead agencies, and providers to SOC and high fidelity wraparound. GOC-approved module-based training will be provided to wraparound facilitators and wraparound supervisors. Twelve days of on-site coaching will be provided for the purpose of providing TA to wraparound facilitators, supervisors, and teams.

For those LMBs who are utilizing family support partners and/or family navigators, GOC-approved module-based training will be provided to the family support partners and family navigators.
Works Cited


H.B. 1386, 2002 Session (enrolled).


Appendices

Appendix I: Results Accountability

Appendix II: Children’s Cabinet, CCRT, and SOCI Committee Members

Appendix III: SOC Terminology Crosswalk

Appendix IV: Other Best/Promising Practices

Appendix V: 1115 Medicaid Waiver

Appendix VI: Examples of CMUs and CMEs

Appendix VII: Examples of things you might want to ask people who contact the LAM

Appendix VIII: Necessary Conditions for Wraparound

Appendix IX: Cover Sheet & Budget Forms
Appendix I: Results and Performance Accountability

Definitions:

Result: A condition of well-being for children, adults, families or communities.

Indicator: A measure which helps quantify the achievement of a result.

Performance Measure: A measure of how well a program, agency or service system is working. There are three types:
- How much did we do?
- How well did we do it?
- Is anyone better off?

Headline Measure: A measure that has timely and reliable data and is one you would choose to present your program’s performance in a public setting.

Data Development Agenda: A prioritized list of where we need new or improved data.

Questions for Population Accountability:

A. What results are we trying to achieve?
   a. What are the indicators that tell us if we are making progress towards reaching the results we are trying to achieve?

B. What does the data tell us?
   a. For each identified indicator, establish the baseline and a forecast
   b. Is the indicator heading in the right direction?

C. What is the story behind the data and the direction it is heading?
   a. Is the data getting better or worse? What are the causes and forces at work behind the direction of the data?
   b. Understanding the story behind the data helps to decide the appropriate actions to take to improve the indicators and the results and “turn the curve” in the right direction.

D. Who are the partners who have a role to play in doing better? No one program or agency can improve results and indicators alone. Improving child well-being and developing an integrated community-focused, family-focused system of care requires contributions from a wide array of community and family members as well as public and private agencies.

E. What strategies “work” to “turn the curve” and make things better?
   a. This step involves brainstorming possible approaches to improve the indicator by utilizing:
      i. The knowledge of the partners to determine:
         1. What strategies are currently working?
         2. What else is needed in our community?

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19 Friedman, 2005.
3. What are some no cost/low cost ideas?
   ii. Research concerning best practices, promising practices and evidenced-based practices can be very helpful in this step.
   b. Once all possible strategies have been identified, specific strategies must be selected based on the following:
      i. Specificity: Is the strategy specific enough to implement?
      ii. Leverage: Does the strategy have enough leverage to “turn the curve”?
      iii. Values: Does the strategy fit in with the values of our community?
      iv. Reach: Is the strategy feasible and affordable? Can it actually be done and when? Who will take lead responsibility for implementing the strategy?

F. What is your action plan and budget?
   a. What are your prioritized strategies? Who will implement them? What is the timetable?
   b. How much will it cost? What are the sources of revenue to implement the strategies?

Questions for Performance Accountability:

A. Who are your customers?
B. How can you measure if your customers are better off?
C. What are your current measures with regard to service delivery?
D. What partners have a role to play in doing better?
E. What is the story behind the measures?
F. What works to improve these measures?
G. What is your action plan and timeline?
Appendix II: Members of the Children’s Cabinet, Children’s Cabinet Results Team and SOCI Committee

The Children’s Cabinet:

- Arlene Lee, Executive Director (Chair)
  Governor’s Office for Children
- Cecilia Januszkiewicz, Secretary
  Department of Budget & Management
- Kristen Cox, Secretary
  Department of Disabilities
- S. Anthony McCann, Secretary
  Department of Health and Mental Hygiene
- Christopher McCabe, Secretary
  Department of Human Resources
- Kenneth C. Montague, Jr., Secretary
  Department of Juvenile Services
- Nancy Grasmick, Ph.D., State Superintendent of Schools
  Maryland State Department of Education

Children’s Cabinet Results Team:

- Department of Disabilities
  o Lynell Otto (Voting Member)
  o Tom Merrick (Alternate)
- Department of Budget and Management
  o Cheri Gerard (Voting Member)
  o Carl DeLorenzo (Alternate)
- Department of Health and Mental Hygiene
  o Barbara DiPietro (Voting Member)
  o Dr. Al Zachik (Alternate)
- Department of Human Resources
  o Peggy DeCarlis (Voting Member)
  o Jack Altfather (Alternate)
- Department of Juvenile Services
  o Steve Moyer (Voting Member)
- Governor’s Office for Children
  o Arlene Lee (Chair)
  o Karen Finn
- Maryland State Department of Education
  o Carol Ann Baglin (Voting Member)
  o Rosemary King Johnston (Alternate)

Invited Members of the SOC Initiative Committee

- Mary Abraham, DJS
- Andrea Alexander, DJS
- Jim Antal, GOCCP
- Jack Altfather, DHR/SSA
- Marcia Andersen, DHMH/MHA
- David Ayer, GOC
- Steve Baron, BMHS
- Steve Berry, DHR/SSA
- Diane Bolger, DHMH
- Diane Cabot, DHMH/MHA
- Brenda Corsi, Anne Arundel County
- Jenny Crawford, Community Kids (Montgomery County)
- Roe Davis, Baltimore County LMB
- Kiran Dixit, Montgomery County Collaboration Council
- Scott Finkelsen, GOC
- Karen Finn, GOC
- Mike Franch, DHMH
- Gerry Grimm, Family League of Baltimore City
- Deborah Harburger, GOC
• Linda Hardman, Wicomico County LMB
• Donna Hornsby, DHR/SSA
• Rosemary King Johnston, MSDE
• David Jones, Montgomery County CSA
• Deana Krizan, DHMH/MHA
• Kathy Lally, Montgomery County Collaboration Council
• Kim Malat, GOC
• Jim McComb, MARFY
• John McGinnis, MSDE
• Mark Mittelman, Baltimore County CSA
• Madeline Morey, Frederick County LMB
• Kitty Nelson, GOC
• Marc Nicole, DBM
• Lynell Otto, MDOD
• Mary Louise Orth, DJS
• Valarie Oulds-Dunbar, Family League of Baltimore City
• Robert Pitcher, Mental Health Mgmt. Frederick County (Co-Chair)
• David Putsche, DHMH/ADAA

• Heidi Rochon, MD Coalition for Children’s Mental Health
• Celia Serkin, MD Coalition for Children’s Mental Health
• Velva Spriggs, DJS
• Mary Beth Stapelton, GOCCP
• Alycia Steinberg, DHMH/Medicaid
• Stephanie Stone, Washington Co. LMB
• Denise Sulzbach, DHMH/MHA (Co-Chair)
• Cathy Surace, Maryland Disability Law Center
• Kaya Swann, Prince George’s County LMB
• Mary Beth Tierney, Family Representative
• Connie Uruhart, DHMH/DDA
• Jane Walker, MD Coalition for Children’s Mental Health
• Susan Russell Walters, DHMH/MHA
• Michelle Zabel, Innovations Institute/UM
• Al Zachik, DHMH/MHA
## Appendix III: System of Care Terminology Crosswalk

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<tr>
<th>Function/Definition</th>
<th>Terms Often Used</th>
<th>Term used in ITN for concept</th>
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| Initial interaction of the consumer with the system which is initiated by an individual seeking resource(s) either for a child or family member or whole family | • First Contact  
• Intake  
• System Entry/Access  
• Information and Referral  
• Local Access  | First Contact; Information and referral |
| Assistance provided to families to help them identify strengths and needs and to obtain necessary services (does not constitute clinical evaluation). The individuals who provide this assistance do not carry a caseload, and are available to families as they present themselves. - Families requiring clinical evaluation will be referred to appropriate child-serving agencies, organizations, or appropriately credentialed professionals. | • Family Navigation  
• Systems Navigation  
• Family Advocacy  
• Legacy Family Member  | Systems Navigation |
| Assistance provided to families and children with more intensive needs-those families found within the top 20% of the triangle. These families may initially need someone whose responsibility is to manage the care plan and services until the point at which the family is ready and willing to assume this role. The care coordinator supports a single, common, unified plan across multiple agencies and life domains. | • Care Management  
• Case Management  
• Care Coordination  
• Wraparound  | Care Coordination |

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<tr>
<th>Local Access Mechanism Component</th>
<th>DEFINITION</th>
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| SCREENING                        | First Step  
|                                  | Triage  
|                                  | Identify Children at High Risk  
|                                  | Link to appropriate assessments  |
| ASSESSMENT                       | Based on data from multiple sources  
|                                  | Comprehensive  
|                                  | Identify Strengths, Resources and Needs  
|                                  | Leads to Care Planning  |
| EVALUATION                       | Discipline Specific (e.g.: neurological exam)  
|                                  | Closer, more intensive study of a particular or suspected clinical issue  
|                                  | Provides data to assessment process  |

Appendix IV: Other Best/Promising Practices

Multi-Systemic Therapy (MST). MST is “an intensive, short-term, home- and family-focused treatment approach for youth with severe emotional disturbances…MST intervenes directly in the youth’s family, peer group, school, and neighborhood by identifying and targeting factors that contribute to the youth’s problem behaviors” (HHS, 1999, n.p.). MST targets chronic, violent or substance-abusing juvenile offenders who are at high-risk of out-of-home placement. Evaluations of MST for serious juvenile offenders have found reductions of out-of-home placements by 47-64%, reductions in long-term re-arrest rates of 25-70%, extensive improvements in family functioning, and decreased mental health problems (Henggeler, 1998).

Functional Family Therapy (FFT). FFT is a short-term intervention used with youth ages 11-18 who are at-risk for or are presenting with delinquency, violence, substance abuse, Conduct Disorder, Oppositional Defiant Disorder, or Disruptive Behavior Disorder. The intervention is short-term, with an average of 8 to 12 one-hour sessions for mild cases and up to 26 to 30 hours of direct service for more difficult situations. The therapy usually occurs over a three-month period of time, and services can be provided in-home or in an outpatient setting. Research has shown FFT to be successful in preventing adolescents with these disorders from being placed in more restrictive services, as well as in preventing further incidence of the presenting problem and preventing younger siblings from entering the system of care (Center for the Study and Prevention of Violence, University of Colorado, 2004).

Additional evidence-based and model programs can be found on the Substance Abuse and Mental Health Services Administration’s website (www.samhsa.gov).
Appendix V: 1115 Medicaid Waiver

Maryland Wraparound Model

Request to Amend Section 1115 Health Care Reform Demonstration
(Project No. 11-W-00099/3)

February 13, 2006
Introduction

Maryland Medicaid seeks to amend its Medicaid section 1115 health care reform demonstration, HealthChoice (project No. 11-W-00099/3), to pilot a “wraparound” model of community-based service delivery for children with serious emotional disturbance (SED). The wraparound model is a family-driven, community-based, inter-agency cooperative model. Each child’s plan of care is tailored to that child and family's individual needs. Under this model, a care managing entity (CME) will receive a set payment rate in exchange for delivering a specific package of specialty mental health services (i.e., “partial” capitation) to children and youth who voluntarily elect this service delivery option.

This program would serve children and youth who are determined community eligible for Medicaid or the Maryland Children’s Health Program (MCHP). This program would not expand Medicaid or MCHP eligibility. Capitation rates will be based on historical fee-for-service cost data for Medicaid-covered services. Because this population is already covered under Medicaid or MCHP, and because the capitation rates will be based on the existing benefit package, this program will be budget neutral. The population that is eligible for and elects this option would no longer access most specialty mental health services in the fee-for-service specialty mental health system, but would receive most of this care through the CME.

In addition to providing the specified package of specialty mental health services, the CME(s) may use the rate to provide non-Medicaid covered services, with the goal of preventing the need for more intensive services. The CME(s) will individualize the package of benefits to the needs of the child and to build on the strengths of the child’s family and community. The goal is to serve children in the community as opposed to institutions such as residential treatment centers (RTCs), and regional institutes for children and adolescents, (RICAs), the State-run equivalent of RTCs. Currently, lengths of stay in RTCs and RICAs are long and the costs of these settings are high.

Some of the wraparound community support services that would prevent the need for an institutional placement or facilitate a child’s transition home cannot be covered under the Medicaid State Plan. Paying the CME(s) a capitation rate to meet the mental health needs of the child will: 1) introduce flexibility to enable provision of wraparound community support services and 2) provide an incentive to the CME(s) to serve the child efficiently.

Much of the groundwork for the pilot has already been completed through a Real Choices Systems Change grant from CMS. The Mental Hygiene Administration (MHA) within the Department of Health and Mental Hygiene (DHMH) has led a steering committee composed of agency staff, provider and consumer representatives, and advocates to explore the development of this model. MHA subcontracted with the Center for Health Program Management and Development at the University of Maryland, Baltimore County (UMBC) to analyze data and design a rate system for the project.
DHMH anticipates that the CME(s) will be defined as a Prepaid Inpatient Health Plan (PIHP) according to federal rules and regulations. The State and the CME will meet all federal rules and regulations for PIHPs.

Experience in Other State

Wraparound Milwaukee
Wraparound Milwaukee is a unique system of care for children with serious emotional, behavioral, and mental health needs and their families. It utilizes a wraparound philosophy and approach that focus on strength-based, individualized care. Combined with a unique organizational structure, Wraparound Milwaukee delivers a comprehensive and flexible array of services to youth and their families.

Wraparound Milwaukee has been in existence since 1995. It was designed to reduce the use of institutional-based care such as RTCs and inpatient psychiatric hospitals while providing more services in the community and in the child’s home. The program also promotes more family inclusion in treatment programs along with collaboration among child welfare education, juvenile justice and mental health in the delivery of services.

A combination of several state and county agencies, including the Bureau of Milwaukee Child Welfare, the County’s Delinquency and Court Services, Behavioral Health Division, and the State Division of Heath Care Financing which operates Medicaid, provide funding for the system. Funds from the four agencies are pooled to create maximum flexibility and a sufficient funding source to meet the comprehensive needs of the families served. Part of the County’s Behavioral Health Division, Wraparound Milwaukee oversees the management and disbursements of those funds acting as a public care management entity.

Program Participation
Initially the pilot program would operate in two jurisdictions (Baltimore City and Montgomery County). DHMH anticipates that in the future the program will expand to additional jurisdictions. Individuals eligible for program participation are described as follows:

- **Population:** The target population is children in certain jurisdictions who have SED and meet RTC medical necessity criteria, as determined by MHA’s administrative services organization, MAPS-MD. A standardized instrument will be used to determine level of care. Participation in the pilot program will be voluntary on the part of the child or youth’s parent or legal guardian, and will be offered as an alternative to RTC placement for children who have not yet entered an RTC or have had only a short RTC stay. The child will be able to opt out of the pilot program if the parent or guardian chooses to have him/her enter the RTC instead. Initially the pilot will operate in Baltimore City and Montgomery County.

- **Financial Eligibility:** Children must already be community-eligible for Medicaid or MCHP.

- **Population Size:** The number of program slots will be limited to 750 prior to an evaluation of program efficiency.
Benefits

All Medicaid-reimbursable specialty mental health services will be included in the capitated rate and will be the responsibility of the CME to provide, except for mental health prescription drugs and mental health laboratory tests and diagnostic services, which will be carved out and will continue to be paid fee-for-service.

CME specialty mental health services include:

- Inpatient and outpatient hospital services, including emergency room services, under COMAR 10.09.06
- Residential treatment centers under COMAR 10.07.04, 10.09.29, and 10.21.06
- Partial hospitalization or psychiatric day treatment under COMAR 10.210.02
- Freestanding clinic services under COMAR 10.09.09
- Psychiatrist services under COMAR 10.09.02
- Services provided by individual mental health professionals, as authorized under Health Occupations Article, Annotated Code of Maryland, including occupational therapists, social workers, psychologists, nurse psychotherapists, and professional counselors with the appropriate expertise to provide the services;
- EPSDT under COMAR 10.09.23 and 10.09.37 including therapeutic nursery programs under COMAR 10.21.18
- Mental health targeted case management under COMAR 10.09.09
- The following rehabilitation and other mental health services, under COMAR 10.09.59:
  - Mobile treatment services, under COMAR 10.21.19,
  - Outpatient mental health clinic services, under COMAR 10.21.20, and
  - Psychiatric rehabilitation programs, under COMAR 10.21.21.

Physical health services and substance abuse screening and treatment will continue to be provided through HealthChoice managed care organizations (MCOs).

Some children may require out of home placements during their period of enrollment in the program. The CME will be responsible for the length of stay in group homes or treatment foster care, equivalent to the average RTC length of stay. The capitated rate will include costs for RTC stays, and the CME will be responsible for costs of RTC care. RTC payments include a room and board component, which the CME can redirect to pay for group home or treatment foster care placements as a substitute for RTCs. This advances the goal of serving children in the community.

The CME will provide additional services to an enrollee to promote health and well-being, to help an enrollee transition from an institutional or out-of-home placement to the community, or to prevent the need for an institutional or out-of-home placement.

The CME will develop a care plan for each enrollee. The care plan will address the specialty mental health needs of the child, including a plan for responding to psychiatric emergencies.
The care plan is to be shared with the enrollee’s parent or legal guardian and providers and is to be reviewed and updated on a regular basis.

Program Administration

DHMH Structure
DHMH is the single state Medicaid agency. The Mental Hygiene Administration (MHA) is a component of DHMH that reports to the Deputy Secretary for Public Health Services. MHA is responsible for overseeing the system for delivering specialty mental health services to Medicaid recipients.

Components of MHA include the following.

- **Core Service Agencies (CSAs)**
  The CSAs are the local mental health authorities responsible for planning, managing, and monitoring public mental health services at the local level. CSAs exist under the authority of the Secretary of the Department of Health and Mental Hygiene and also are agents of the county government, which approve their organizational structure. The functions of core service agencies are to plan, develop, and manage a full range of treatment and rehabilitation services for persons with serious mental illness in their jurisdiction as stipulated by the Health General Article, 10-10-1203, Annotated Code of Maryland.

- **MAPS-MD Administrative Services Organization**
  - MAPS-MD assists the Mental Hygiene Administration and the CSAs with administering the Public Mental Health System (PMHS). As agents of MHA and the CSAs, MAPS-MD supports MHA and the CSAs by:
    - Determining whether an individual is part of the public mental health system
    - Referring the individual to qualified providers of public mental health services
    - Preauthorizing non-emergency care
    - With MHA and the CSAs, concurrently managing the care and cost of care in the public mental health system according to established protocols
    - Conducting utilization review of services to ensure quality, appropriateness, and effectiveness
    - Collecting data and submitting reports
    - Processing billing claims and remitting payments
    - Evaluating the public mental health system

The Deputy Secretary for Health Care Financing is another component of DHMH. The Deputy Secretary for Health Care Financing, along with three administrations--the Office of Health Services, the Office of Operations, Eligibility and Pharmacy, and the Office of Planning and Finance--oversees the Medicaid program.
Administrative Functions Under the Waiver Amendment

Relationships with Other State Agencies
The target population often has a variety of needs and access services from multiple state agencies in addition to DHMH. Therefore it is especially important to collaborate and coordinate the efforts of state agencies, including the Department of Human Resources (DHR), the Department of Juvenile Services (DJS), the Maryland State Department of Education, (MSDE), the Maryland Department of Disabilities (MDoD), and the Governor’ Office for Children (GOC). The State of Maryland has created a Local Management Board (LMB) in each jurisdiction to coordinate the delivery of State-funded services to children, youth, and families. The LMBs operate under GOC. The LMBs will be active in working with children, youth, their families, and the CME(s).

CME Review and Selection
MHA with the CSAs and LMBs will select one or more CMEs to provide specialty mental health and wraparound services to the target population. The CME(s) will be selected through a competitive bidding process. Proposals responding to the RFP will be reviewed for the following.

- CME capacity and network adequacy
- Data systems
- Clinical and care coordination expertise
- Expertise in the principles of wraparound
- Human resource expertise
- Financial and administrative systems
- Quality assurance systems
- Compliance with federal requirements

CME Quality Oversight
Oversight of the quality of care provided by the CME(s) will be the responsibility of MHA in partnership with the CSAs and LMBs. Specific quality oversight activities include the following.

- Establish and regularly update clinical standards
- Analyze encounter data and assess CME clinical performance
- Perform focused studies to assess performance in areas that cannot be evaluated using encounter data, or to assess performance at the beginning of the program before encounter data are available
- Operate an enrollee hotline, and oversee appeals process
- Conduct enrollee satisfaction surveys
- Operate a provider hotline

Administrative and Financial Monitoring of CMEs
Monitoring the administrative and financial functioning of the CME(s) will be the responsibility of MHA, with support from the CSAs and LMBS as well as Medicaid. Specific activities include:
• Rate setting. Initial CME rates will be set as a percentage of current Medicaid fee for service payments (the fee for service equivalency). UMBC is developing the risk adjustment methodology and capitation rates for the waiver. UMBC will procure the services of an actuary for consulting services to assure actuarially sound rates. UMBC will also work with DHMH to update rates annually.
• Solvency standards. MHA will monitor the financial performance of the CME.
• Financial Reports. The CME(s) will submit periodic financial reports, e.g., quarterly, on their financial expenses. These reports should provide enough detail to assist with future rate setting calculations as well as to provide DHMH with timely data regarding what is driving certain expenditure trends by service type, eligibility group, or geographical area

Eligibility, Outreach, and Enrollment
MHA, Medicaid OOEP, and DHR will share responsibility for this function.
• Eligibility determinations. DHMH and the Department of Human Resources currently share responsibilities for determining eligibility for Medicaid and MCHP. MHA will be responsible for determining whether a Medicaid or MCHP eligible individual meets RTC level of care and can therefore elect to enroll with the CME program.
• Recipient Education and Outreach. The CSAs and LMBs will provide recipient education and outreach to the target population.
• Recipient enrollment. BMHS or MHA will enroll individuals, load enrollment data into their information systems, and notify CME within several business days. BMHS will enter individual’s information into the MAPS-MD Care Connections or another information system, which will flag enrollees.

Management Information and Data Systems
The successful implementation and management of the waiver requires sophisticated data and systems support. MAPS-MD will:
• Make monthly capitation payments to the CME.
• Process capitation payments through MMIS.
• Edit their information systems to block fee-for-service payments for the enrolled population.
• Process CME encounter data.
• Validate CME encounter data submissions on an ongoing basis.

Data will be warehoused and analyzed. The encounter data that will be submitted will be used for various functions, such as analysis of program performance, and future development of capitation rates. To assure that these activities are done in a timely manner, using consistent and reliable data, a central data warehouse with analytic capacity will be developed.

Delivery System

Organizations Qualifying as CMEs
Organizations that can qualify as CMEs must be health maintenance organizations that hold a certificate of authority from the Maryland Insurance Administration (MIA) or managed care systems that are authorized to receive medical assistance pre-paid capitation payments and enroll
only Medicaid recipients. Both types of organizations must meet the same standards relating to quality, access, and data in order to qualify as CMEs.

Non-HMO CMEs will still be required to meet solvency requirements for MCOs established jointly by DHMH and MIA. Any regulations established by MIA that apply to MCOs will also apply to the CME.

Federal Definition—PIHP
From a federal perspective, DHMH anticipates that the CME(s) will be defined as a Prepaid Inpatient Health Plan (PIHP) according to federal rules and regulations. The CME will assume risk for the cost of services covered and incur loss if the cost of furnishing services exceeds capitated payments. Consistent with federal rules, the CMS Regional Office will review and approve CME contracts.

CME Youth and Family Advisory Board
MHA and GOC will establish an advisory committee that will meet on a regular basis to monitor the care provided by the CME(s). In addition to youth and families, the committee will include representatives from the CME(s), DHMH and the CSAs representative, providers, and other state agencies.

Enrollment and Disenrollment Processes

Enrollment
Enrollment will operate as follows:

- A child/youth will be referred to MHA or its designee to determine if they satisfy the clinical criteria for RTC level of care.
- All children/youth that satisfy the medical necessity criteria will be given the option of participating in the program or placement in an RTC. These enrollment choices will be explained to the child by MHA or its designee.
- All children that choose the program will get enrollment brochures for the provider(s) in their jurisdiction. The child may select the CME. Each CME must accept all children/youth selecting them. CMEs will not discriminate for any reason (e.g., health status, need, demographics) and will accept all applicants who are eligible for Medicaid and the wraparound program, up to the capped number of slots.
- The selected provider will enroll the child/youth within a reasonable timeframe and contact the child/youth within a reasonable timeframe to begin delivering specialty mental health care. The CME’s capitation payment will be effective the date of enrollment.

Children and youth will enroll in the pilot program for no longer than 18 to 24 months. After 18 to 24 months they will disenroll to receive specialty mental health services on a fee-for-service basis. Analysis of claims data shows that in the years after the RTC stay, children’s average service costs decrease. DHMH interprets this to mean that in many cases the need for intensive services reduces dramatically over time.
Enrollees will remain in the program even if they require placement in an RTC. The CME will be responsible for paying the costs of the RTC from the capitation payments. This will provide the maximum incentive for the CME to serve the child or youth in the community when possible.

**Disenrollment and Transition Planning**

Reasons for disenrollment include end of 24 months of enrollment, loss of Medicaid or MCHP eligibility, change of residence outside of the service area, or voluntary disenrollment by the child or youth’s parent or legal guardian.

Prior to disenrollment at 24 months, the CME will develop a transition plan for the child/youth. The child/youth may be placed in an after care program if offered by the program or other community mental and social programs that serve their area. This transition planning process should be part of the plan of care development throughout the course of the child’s enrollment.

**Enrollee Rights**

The State and the CME will comply with all federal and state rules and regulations to protect the rights of enrollees of prepaid inpatient health plans (PIHPS).

**Access Standards**

Each CME must meet DHMH’s standards for the following:

- Appropriate range of qualified providers in network
- Adequate ratios of providers to enrollees
- Geographic access to providers (i.e., time/distance to providers)
- Clear policies and procedures regarding referrals and prior authorization
- Availability of medically necessary emergency care 24 hours a day, seven days a week.

**Quality**

MHA will monitor the quality of care delivered by CMEs, and each CME will have a written quality assurance and performance improvement program. These activities will ensure:

- Delivery of medically necessary services to enrollees
- Quality of health care service rendered meets professionally recognized standards
- Performance improvement over time
- Compliance with federal and State law and regulation

Through a systematic process of periodic reviews of managed care organizations’ operations and provider services, MHA will monitor and identify problems and trends in service delivery on a timely basis. Monitoring efforts will include:
• Review of CME application and qualifications, including an on-site review
• Conducting an annual quality of care audit conducted by an external quality review organization (EQRO)
• Assessing CME infrastructure, including complaint and appeal processes
• Collecting and evaluating certain standardized performance measures
• Conducting performance improvement projects focusing on clinical or non-clinical areas as determined by the Department
• Administering provider and enrollee satisfaction surveys
• Conducting annual financial audits by an independent external auditor
• Initiating ad hoc performance reports using encounter data
• Oversight by a quality improvement committee

Complaints and Appeals
Enrollees and providers will have access to hotlines at the CME as well as at MHA or its designee, and will be able to file complaints and appeals with the CME as will as with MHA. Each CME will have written complaint policies, and procedures for appealing denials, reductions, or terminations of service. These policies and procedures will include standards for timely handling of complaints and appeals. An enrollee does not have to exhaust the CME procedures, but can file an appeal with MHA at any time.

Financing

Capitation Rate
Financial risk will reside with the CME. The federal government will match the State’s contribution to the capitated rate at the usual 50% or 65% FFP level, depending on whether the child/youth is eligible for Medicaid or MCHP.

As noted above, initial CME rates will be set as a percentage of current Medicaid fee for service payments (the fee for service equivalency). UMBC is developing the risk adjustment methodology and capitation rates for the waiver. UMBC will procure the services of an actuary for consulting services to assure actuarially sound rates. UMBC will also work with DHMH to update rates annually.

CME Claims Processing System
The CMEs must have a HIPAA compliant claims processing systems in place to make payments to their provider networks. The system must be able to identify those claims that qualify for payment and determine the correct payment amount. The system must also contain a reporting module that will permit the CME to monitor and report on the payments that they have made. Clean Claims that do not involve other insurers must be paid within 30 days of receipt.

The system must contain a series of edits to ensure that accurate payments are made. The system must be able to identify those services that are covered in the benefit package and those services that are excluded. The editing procedure must also be able to identify the recipients that are enrolled in the CME and the periods of time when they were enrolled. In order to qualify for participation in the program, the CME must include an explanation of the features of their claims
processing system, including a description of the editing procedures and examples of the management reports generated by the system.

**Encounter Data**

The provider must submit an encounter for each service provided to each child/youth. The provider must submit the encounters to MAPS-MD or the Maryland MMIS, to be determined. Encounters must be submitted electronically and in a HIPAA compliant format.

The encounter must include the following information:

- Medicaid ID for the recipient
- Provider ID for the provider of service
- Date the service was received
- Diagnosis codes describing the recipient’s condition
- Procedure codes describing the services that were rendered

Encounters should be submitted within two weeks following the payment of the claim for the service. The CME must monitor the volume of encounters submitted to the MMIS system and the volume of encounters accepted by the system. The CME system must have the ability to receive encounters rejected by the MMIS system, correct deficiencies identified by the MMIS system, and resubmit corrected encounters.

The CME must reconcile their encounter data with their financial reports on a quarterly basis to ensure that the volume of accepted encounters is consistent with the volume of paid claims.

**Payments and Funding**

The CME must submit quarterly and annual reports so that the State can monitor their financial position. The financial reports will also serve to evaluate the adequacy of the capitation rates. Timely and accurate financial reporting is essential in order for a provider to participate in the program.

The CME must submit financial reports on a quarterly basis stating their revenues and expenditures for the previous quarter. Quarterly reports must be submitted within three months following the end of each quarter. The quarterly report will detail the premium payments received by the provider during the quarter and the total value of claims paid by the provider during the quarter. The provider will report claims separately for the major category of services included in the benefit package. The provider will report the value of claims paid for services rendered during the current service year, and the value of claims for services provided during prior service periods.

On an annual basis the provider will submit a complete financial report detailing all of their revenues, expenditures for the service year. The annual report must be submitted within six months following the end of the service year. The financial report must detail paid claims, claims received but not paid, and services incurred for which a claim has not been received. An independent auditor must certify this report.
**Budget Neutrality**

The wraparound program will be budget neutral. Children and youth who will be eligible to participate in this program are already eligible for Medicaid or MCHP in the community; this waiver is not an expansion of Medicaid or MCHP eligibility. Moreover, the CME will be paid a capitation rate that is slightly less than the fee-for-service rate of specialty mental health services that are covered under the Medicaid State Plan. Therefore we expect no budgetary impact from this program.

**Program Evaluation**

DHMH will evaluate how the pilot programs affect clinical outcomes and costs. This program may be cost-effective in the long term by providing an individualized package of community-based services to children to prevent them from entering institutions.

The types of indicators to be included in the evaluation include:
- Restrictiveness of service settings;
- Improvements in functioning;
- School attendance, performance, and/or participation in vocational activities;
- Adjudication of offenses;
- Child/youth, family, and caregiver satisfaction with services; and
- Access to appropriate health care services.

**Waivers**

DHMH requests that CMS waive the federal requirement for statewideness and allow the State to serve a limited number of children who have serious emotional disturbance.
Appendix VI: Examples of CMUs and CMEs

Examples of variations in the structure and degree of liability in CMUs and CMEs:

Wraparound Milwaukee: A combination of several state and county agencies, including the Bureau of Milwaukee Child Welfare, the County’s Delinquency and Court Services, Behavioral Health Division, and the State Division of Health Care Financing which operates Medicaid, provide funding for the system. Funds from the four agencies are pooled to create maximum flexibility and a sufficient funding source to meet the comprehensive needs of the families served. Part of the County’s Behavioral Health Division, Wraparound Milwaukee oversees the management and disbursements of those funds acting as a public care management entity.

Baltimore City and Montgomery County LMBs: Under the proposed Medicaid waiver, children and youth will enroll in the pilot program for no longer than 18 to 24 months. After 18 to 24 months they will disenroll to receive specialty mental health services on a fee-for-service basis. Enrollees will remain in the program even if they require placement in an Residential Treatment Center (RTC). The CME will be responsible for paying the costs of the RTC from the capitation payments. This will provide the maximum incentive for the CME to serve the child or youth in the community when possible.

St. Mary’s County LMB: St. Mary’s County LMB has developed a Care Management Unit with pooled staff from multiple agencies. This Unit has been authorized as the Unit responsible for the child’s outcomes. However, the Unit does not assume financial risk, and still utilizes funding from multiple sources.

Wicomico County LMB: In Wicomico County, the care coordination is done by a vendor who receives referrals from the Local Coordinating Council. Services are then provided through pooled dollars. In this example, new staff was hired and funding is pooled to allow enhanced flexibility without assuming financial risk.

New Jersey: In New Jersey, the Care Management Entity obtains a monthly rate for care coordination. However, the CME utilizes a fee-for-service mechanism for all other deliverables. In this instance, there is partial financial liability assumed.
Appendix VII: Examples of things we might want to ask people who contact the LAM:

First Contact: (Single Point of Access/No Wrong Door/ Hybrid Model):
- Date of call/walk-in
- Time of call/walk-in
- Unique identifier
- Screener’s name/ID
- Need for communication assistance
- Jurisdiction
- Office/Site Location
- Race/tribe
- Reason for calling (nature of the services/support caller is looking for)
- How did you hear about us?
- Disposition of call. If referral, to whom?

Screening Part 1:
- Call back number
- Caller’s name & relationship to the child
- Demographics:
  - Age of person being called about
  - Child’s living arrangement
  - Child’s residence—describe type
  - Child’s date of birth
  - Gender of the child
- School/education:
  - Child’s grade level
  - Is the child going to school? If so, where?
  - Individual Education Plan (IEP) information or is otherwise receiving special education classes?
- Court involved?
- Diagnosis information (menu)
- Do you and/or your child have Medicaid? (may want to ask about other health insurance)
- Who else have you called?
- What agencies/services are you currently involved with?

Screening Part 2:
- Current medications
- Health Condition
- Is there a recent stress (es) on the family or the child? (Menu from EPSDT MH form)
- Mental Health Provider
- Primary Care Physician
- What services have you tried to access but have been unable to do so?
- What were the barriers to receiving these services?
Appendix VIII: Necessary Conditions for Wraparound

Figure 5: Necessary Conditions for Wraparound

<table>
<thead>
<tr>
<th>Team Level</th>
<th>Organizational Level</th>
<th>Policy &amp; Funding Context (System Level)</th>
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<tbody>
<tr>
<td><strong>Practice Model</strong>&lt;br&gt;i. Team adheres to a practice model that promotes team cohesiveness and effective planning in a manner consistent with the value base of ISP.</td>
<td><strong>Practice model</strong>&lt;br&gt;i. Lead agency provides training, supervision, and support for a clearly defined practice model.&lt;br&gt;ii. Lead agency demonstrates its commitments to the values of ISP.&lt;br&gt;iii. Partner agencies support the core values underlying the team ISP process.</td>
<td><strong>Practice model</strong>&lt;br&gt;i. Leaders in the policy and funding context actively support the ISP practice model.</td>
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<td><strong>Collaboration/partnerships</strong>&lt;br&gt;i. Appropriate people, prepared to make decisions and commitments, attend meetings and participate collaboratively.</td>
<td><strong>Collaboration/partnerships</strong>&lt;br&gt;i. Lead and partner agencies collaborate around the plan and the team.&lt;br&gt;ii. Lead agency supports team efforts to get necessary members to attend meetings and participate collaboratively.&lt;br&gt;iii. Partner agencies support their workers as team members and empower them to make decisions.</td>
<td><strong>Collaboration/partnerships</strong>&lt;br&gt;i. Policy and funding context encourages interagency cooperation around the team and the plan.&lt;br&gt;ii. Leaders in the policy and funding context play a problem-solving role across service boundaries.</td>
</tr>
<tr>
<td><strong>Capacity building/staffing</strong>&lt;br&gt;i. Team members capably perform their roles on the team.</td>
<td><strong>Capacity building/staffing</strong>&lt;br&gt;i. Lead and partner agencies provide working conditions that enable high-quality work and reduce burnout.</td>
<td><strong>Capacity building/staffing</strong>&lt;br&gt;i. Policy and funding context supports development of the special skills needed for key roles on ISP teams.</td>
</tr>
<tr>
<td><strong>Acquiring services/supports</strong>&lt;br&gt;i. Team is aware of a wide array of services and supports and their effectiveness.&lt;br&gt;ii. Team identifies and develops family-specific natural supports.&lt;br&gt;iii. Team designs and tailors services based on families’ expressed needs.</td>
<td><strong>Acquiring services/supports</strong>&lt;br&gt;i. Lead agency has clear policies and makes timely decisions regarding funding for costs required to meet families’ unique needs.&lt;br&gt;ii. Lead agency encourages teams to develop plans based on child/family needs and strengths, rather than service fads or financial pressures.&lt;br&gt;iii. Lead agency demonstrate its commitment to developing culturally competent community and natural services and supports.&lt;br&gt;iv. Lead agency supports teams in effectively including community and natural supports.&lt;br&gt;v. Lead agency demonstrates its commitment to developing an array of effective providers.</td>
<td><strong>Acquiring services/supports</strong>&lt;br&gt;i. Policy and funding context grants autonomy and incentives to develop effective services and supports consistent with ISP practice model.&lt;br&gt;ii. Policy and funding context supports fiscal policies that allow the flexibility needed by ISP teams.&lt;br&gt;iii. Policy and funding context actively supports family and youth involvement in decision making.</td>
</tr>
<tr>
<td><strong>Accountability</strong>&lt;br&gt;i. Team maintains documentation for continuous improvement and mutual accountability.</td>
<td><strong>Accountability</strong>&lt;br&gt;i. Lead agency monitors adherence to the practice model, implementation of plans, and cost and effectiveness.</td>
<td><strong>Accountability</strong>&lt;br&gt;i. Documentation requirements meet the needs of policy makers, funders, and other stakeholders.</td>
</tr>
</tbody>
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Koroloff, Schutte, & Walker, 2003, p.2
Appendix VIII: Cover Sheet & Budget Forms

- Cover Sheet: See next page
- Budgets: See separate excel spreadsheet file for budget forms
NAME OF APPLICANT: 
________________________________________________________________________

NAME OF AUTHORIZED OFFICIAL: 
________________________________________________________________________

ADDRESS OF APPLICANT: 
________________________________________________________________________

APPLICATION AREAS:
___ SINGLE POINT OF ACCESS 
___ SYSTEMS NAVIGATION 
___ WRAPAROUND 
___ RESOURCE DEVELOPMENT 
___ NOT APPLYING 

FUNDING SUMMARY:
REQUESTED FUNDS  $ _______________
STATE FUNDS  $ _______________
STATE CASH MATCH  $ _______________
LOCAL CASH MATCH  $ _______________
PRIVATE CASH MATCH  $ _______________
IN-KIND MATCH  $ _______________
TOTAL PROJECT FUNDS  $ _______________

THIS SUBMISSION IS ON BEHALF OF THE LOCAL MANAGEMENT BOARD AS EVIDENCED BY SIGNATURE BELOW (all LMB members must sign):

Name 
Title 

Name 
Title 

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Note: 1. Enter LMB information and Date on SPA sheet only.
2. If your FY07 operating start date is not 10/01/07 please enter correct operating start date in cell F10
3. Please show annualized operating cost for FY08.
4. Please ensure that Budget and Revenue are in balance (match).
5. Do not enter data in shaded cells or cells containing red numbers.
6. GOF-ITN (04/06)
## Invitation to Negotiate

Proposed Budget for Systems Navigation

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### Notes:
1. Enter LMB information and Date on SPA sheet only.
2. If your FY07 operating start date is not 10/01/07 please enter correct operating start date in cell F103.
3. Please show annualized operating cost for FY08.
4. Please ensure that Budget and Revenue are in balance (match).
5. Do not enter data in shaded cells or cells containing red numbers.
### Invitation to Negotiate

Proposed Budget for wrap Pilot

**Notes:**
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#### Children's Cabinet Interagency Fund Request (CCIF)

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**Note:**
1. Enter LMB information and Date on SPA sheet only.
2. If your FY07 operating start date is not 10/01/07 please enter correct operating start date in cell F10.
3. Please show annualized operating cost for FY08.
4. Please ensure that Budget and Revenue are in balance (match).
5. Do not enter data in shaded cells or cells containing red numbers.
## Invitation to Negotiate

**Proposed Budget for Resource Development**

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<th>Budget Category</th>
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<th>2008</th>
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<td><strong>Children's Cabinet Interagency Fund Request (CCIF)</strong></td>
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<td>One-time only Start-up costs</td>
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### Budget Category Details

#### Children's Cabinet Interagency Fund Request (CCIF)

- **B1**: Salaries
- **B2**: Fringe Costs
- **B3**: Communications
- **B4**: Postage
- **B5**: Business Travel
- **B6**: Training
- **B7**: Conferences/Conventions
- **B8**: Advertising
- **B9**: Supplies
- **B10**: Equipment
- **B11**: Printing/Duplication
- **B12**: Indirect Costs

#### Local Funding

- **B13**: Other (list)

#### State Agency Funding

- **B13**: Other (list)

### Revenue Category

#### R1: CCIF

- **R2**: Local Government

#### R3: Reinvestment

- **R4: Agency**
  - **a**: DHMH
  - **b**: DHR
  - **c**: DJS
  - **d**: MSDE

### Total Revenue

- **Total Budget**

### Notes

1. Enter LMB Information and Date on SPA sheet only.
2. If your FY07 operating start date is not 10/01/07 please enter correct operating start date in cell F10.
3. Please show unamortized operating cost for FY08.
4. Please ensure that Budget and Revenue are in balance (match).
5. Do not enter data in shaded cells or cells containing red numbers.

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**GOC-ITN (04/06)**

---

**Go to sheet SPA**
### Invitation to Negotiate

#### Proposed Budget for Total Invitation to Negotiate

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<th>Budget Category</th>
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<th>State Agency Funding (please provide agency, program name and PCA in other budget items B13-a-thru-m not being used for CCIF or Local Funding)</th>
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#### Revenue Category

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GOC-470 (04/06)