HAMILTON COUNTY
FAMILY AND CHILDREN FIRST COUNCIL
SERVICE COORDINATION MECHANISM 2018
REVISIONS 07/2019

Overview of Hamilton County Service Coordination

Development of Revised Service Coordination Mechanism

The Hamilton County Service Coordination Mechanism has evolved over the years to address the changing needs of youth and families. Representatives from Hamilton County Job and Family Services, Hamilton County Developmental Disabilities Services, Mental Health and Addiction Services, Health Department, Hamilton County Juvenile Court, Education, Hamilton County Family and Children First Council (FCFC), and Early Intervention Collaborative developed the Hamilton County 2018 Service Coordination Mechanism. Revisions to the plan were made after receiving input from each of these representatives. After several revisions, the plan is presented to the FCFC Executive Committee for review and final approval.

There are multiple agencies and programs in Hamilton County available to serve youth who need service coordination. Many youth and their families do not have "single system" issues; they require a higher level of service coordination to meet their multi-system needs. In order to develop a seamless system of care for all youth 0 through 21 years of age with multi-systemic needs, the FCFC emphasizes early identification and early intervention with inter-system collaboration and service coordination in many of the services offered throughout Hamilton County. The guiding values and principles for the system of care is that service coordination is individualized, strength-based, promotes early intervention, is youth-guided and family driven, and culturally, racially and ethnically responsive to the population being served. Family voice and choice is involved in decision-making and supported with family advocacy options. Evidence-based treatments and specialized treatments are offered and encouraged for difficult to serve populations.

The Hamilton County Family and Children First Council principles promote the existence of a broad array of integrated services and supports to serve youth in the least restrictive setting possible. Duplicative and competing efforts are reduced or eliminated, while home and community supports are utilized, and service outcomes are evaluated. The Hamilton County FCFC seeks to establish a system that is coordinated on both the individual service level and system level. Historically, the Hamilton County FCFC was integrally involved in the development of a capitated, managed care program for youth with multiple needs in Hamilton County. The managed care program has evolved over time and in 2011; it changed from Ohio Choices, Inc. to Central Clinic HOPE for Children and Families. HOPE for Children and Families is one of the main entities in Hamilton County for service coordination. The information contained in this service coordination mechanism plan will detail the efforts of HOPE for Children and Families as well as the other programs and services that constitute service coordination in Hamilton County. Monthly reports are provided to the FCFC detailing

the progress of service coordination efforts and families served in Hamilton County. Hamilton County FCFC reviews these reports and continues to provide feedback on such issues as service gaps, the importance of family involvement in service coordination design, as well as system level planning and monitoring, and the promotion of cross training opportunities in the workforce.

Target Population

Eligibility for Hamilton County's Service Coordination mechanism is targeted at youth who have multi-system needs and will benefit from a formalized service coordination mechanism. These youth with multiple problems typically cannot benefit from traditional services in isolation and require more coordinated, specialized interventions than the traditional service providers can offer.

Criteria for FCFC Service Coordination Recipients

The criteria indicating need for FCFC Service Coordination within Hamilton County include the following:

1. Hamilton County resident
2. Youth ages 0 through 21 years of age
3. Multi-system involvement or cross-system needs
4. Service and support needs are not adequately met
5. Higher level or specialized care is indicated
6. At risk for out-of-home or emergency placement
7. Assistance needed to navigate traditional systems and other community resources
8. Condition or identified risk that crosses two or more systems (i.e., mental health, substance use disorder, education, developmental disabilities, juvenile court, child welfare, housing, vocation).

Another element included in the current service coordination mechanism addresses youth adjudicated delinquent, unruly, and youth who are at risk of involvement in the juvenile justice system. Unruly youth are defined as "youth who commit an offense that if committed by an adult would not be against the law; i.e., truancy, curfew violation, incorrigibility". For purposes of the Service Coordination Plan, youth *at risk* will be defined as youth who are beginning to exhibit behaviors of an unruly nature, or who due to biological, psychological and/or environmental influences may be more likely to develop such adverse behavior patterns without outside intervention by schools, courts, social service agencies or families. The plan also addresses the needs of Child Protection Services involved youth or youth in the custody of Job and Family Services. While FCSS funding restrictions, do not permit the use of FCSS funding for service coordination activities for youth in custody, youth who are in the custody of child protective services are not restricted from accessing FCFC service coordination. Hamilton County has a variety of tools available to assist with at risk youth including Family Access to Integrated Recovery (FAIR), and the Alternative Response Team. Hamilton County Child Protection Services provides or contracts for a variety of services for youth in custody (such as, mental health counseling and treatment, parenting skills training, social development services, intensive in-home assistance, etc.) but youth can also be referred to FCFC Service Coordination at any

time if a youth has needs in multiple systems. The needs of these special populations are addressed with the goal of early identification of cross system needs so that appropriate interventions can be established to reduce further service involvement, court involvement, and avoid out-of-home placement. It should be noted that no family is refused the opportunity to

refer themselves for consideration of service coordination, that opportunity is always available through the Intersystem Service Coordination Committee Referral line.

FCFC Service Coordination Mechanism

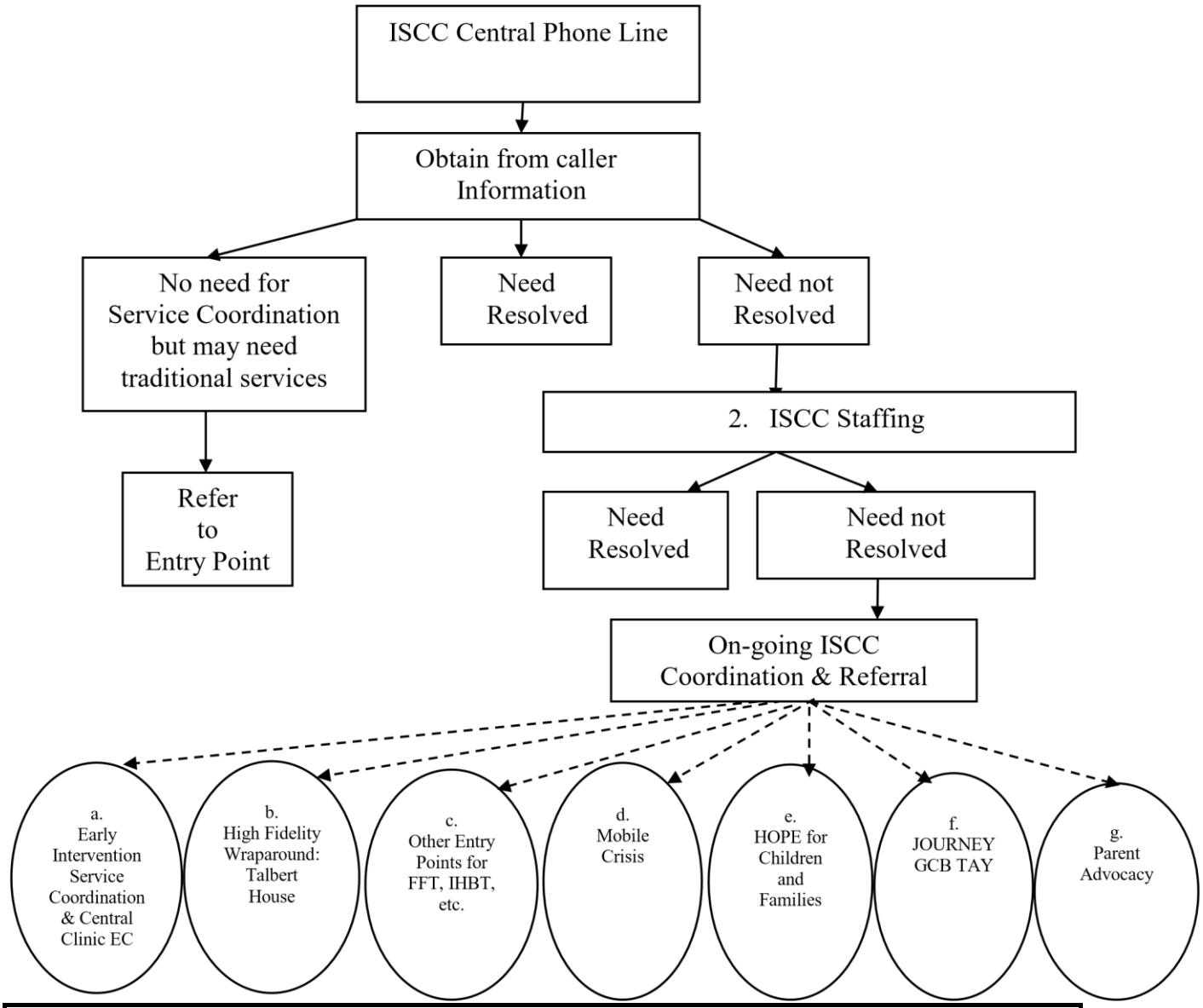
Hamilton County has designed its service coordination mechanism to meet the unique level of care needs of multi-system involved youth and families. All youth and families can access FCFC service coordination through the Intersystem Service Collaboration Committee (ISCC) and ISCC Phone Line. The ISCC will consider several options for meeting the FCFC service coordination needs of children and families or young adults including the following (see flow chart below):

Levels of Coordination-

1. Information and Referral: Call resolved by providing information to the caller or referral to traditional services because service coordination is not needed or desired by family
2. FCFC Service Coordination: Convene an ISCC staffing
    - Child and family, or young adult needs resolved after staffing meeting
    - Child and family, or young adult may need ongoing service coordination through ISCC
    - If need is not resolved after staffing meeting and ISCC is not the most appropriate entity to provide service coordination, referral may be to one of the following entities as appropriate for the service coordination:
        a. Early Intervention Service Coordination (up to age 3) - Children, 3-5 years of age, who need Service coordination services will be referred to Central Clinic Early Childhood Services.
        b. High Fidelity Wraparound: Talbert House (6-21 years of age)
        c. Intensive Services Entry Points such as Functional Family Therapy (FFT), Intensive Home-Based Treatment (IHBT), etc. (12-17 years of age)
        d. Mobile Crisis (no age restrictions, serve both youth and adults)
        e. Residential Treatment and Other Specialized Interventions): HOPE for Children and Families (5- 17 years of age)
        f. JOURNEY to Successful Living: Greater Cincinnati Behavioral Transition Age Youth Program (16 – 22 years of age)
        g. Parent Advocacy Services

Additional information about the levels of coordination is available on pages (pages 1314)

Avenues for Accessing Hamilton County FCFC Intersystem Service Coordination



Components of FCFC Service Coordination

The Intersystem Service Collaboration Committee (ISCC) and phone line is the entry for staff, families, and young adults to service coordination and individualized services needed by multisystem youth (ages 0-22) and their families.

The Intersystem Service Collaboration Committee is comprised of representatives from the following agencies: Hamilton County Job and Family Services (HCJFS), Hamilton County Mental Health and Recovery Services Board (HCMHRSB), Hamilton County Juvenile Court (HCJC), and Hamilton County Developmental Disabilities Services (HCDDS), the Legal Aid Society of Greater Cincinnati, Hamilton County Educational Services Center (HCESC), family member and Cincinnati Public Schools. These representatives meet as necessary for the purpose of case consultation, service planning, information sharing and inter system collaboration. Staff, families, or young adults who are seeking direction and guidance in locating or obtaining

services or a more complex "package" of services/service plan that can not be accessed in more traditional ways or who have not been able to overcome obstacles within the service systems may refer a youth's case to this committee.

Principles of FCFC Service Coordination The guiding principles of the ISCC are:

- The needs of the child and family or young adult are the most important factors in deciding the types, intensity and duration of services and interventions provided.
- The primary task of the service coordinator is to develop a family or young adult teammade up of caring people who are imaginative problem solvers and are willing to try an array of services including non-traditional ideas in meeting needs. • Family involvement when approved by young adults in transition is crucial at all levels.
- The lead service care coordinator guides the Intersystem Service Coordination Team through a process of strength discovery and facilitates Individual/Family Service Care Coordination Plans by building upon strengths, hopes, dreams and other natural supports.
- Strength based assessments explore significant life domains including: social, cultural, spiritual, educational and vocational needs/resources.
- Community based supported living arrangements are preferable.
- Achieving the best service outcomes for the lowest cost is a shared responsibility ofproviders, funders, communities, families, and young adults.
- Services must respect and respond to the unique culture (such as racial, religious, ethnic,social-economic) of each family and/or young adult.

Referrals to ISCC

Families and agency staff, including from a juvenile court, can make referrals for service coordination by contacting the ISCC central phone number (513-946-8668). The ISCC representative who answers the call will complete the Intersystem Service Coordination Request Form (Addendum A) which documents information for the person being referred as well as the person referring, date of receipt of the referral contact, demographic, Medicaid managed care plan, presenting problem, system involvement, and disposition information. The ISCC member who takes the call may immediately resolve the issue during the phone call by providing information to the caller or making a referral to a parent advocate or traditional services.

Level of Coordination – Information and Referral

After collecting and reviewing the family's information, the ISCC representative may determine there is not a need for intersystem coordination. However, the child, family or young adult may benefit from traditional services. The ISCC will then contact one of the following points of entry to assist the family or young adult in accessing traditional services:

- *Mental Health Access Point (MHAP: 513-558-8888)* is the centralized point to access Mental Health and Recovery Board funded services in Hamilton County. MHAP takes calls from providers, public and private entities and the public, screens for service need and refers the child and family to the proper provider(s) for service. MHAP has connection capability for many of the services provided in the mental health system. For

youth who are deemed "unruly" or "at risk of being unruly," the mental health system offers a comprehensive range of services that begin with a diagnostic assessment and determination of level of care needs. Once the initial eligibility as a child with a severe emotional disturbance (SED) is determined, MHAP connects the child to the appropriate community-based service. MHAP also has connection responsibility for many "high end" services, e.g. inpatient, crisis stabilization, mobile crisis response, and respite services, and may choose to connect the child to an appropriate level of treatment if needed. For youth who have not benefited from a traditional array of services, MHAP can work with providers to develop a unique "service package" designed to meet the specific needs of the child and family.

- *Recovery Health Access Center (RHAC: 513-281-7422*) is a centralized point to facilitate access to alcohol and other drug treatment, prevention, and information. RHAC offers information and referral, clinical screening services, clinical assessment services, level of care recommendations, referral for treatment, and transitional support for those awaiting admission to treatment. RHAC also offers a phone line that operates 24 hours a day, seven days a week.

- *Family Access to Integrated Recovery (FAIR: 513-651-4142)* is a program of Mental Health Access Point (MHAP). As part of a collaborative effort between the Hamilton County Mental Health and Recovery Services Board and Hamilton County Job and Family Services (JFS), FAIR was implemented in 2010. FAIR is responsible for the evaluation, referral, and care management of the mental health and/or alcohol and other drug needs of children and family members who are involved with JFS.

  FAIR provides an entry to mental health and alcohol and other drug services, and monitors the service to ensure the child welfare goals of safety, permanence, and wellbeing are incorporated into treatment. FAIR primary functions include evaluation, referral and care management oversight; and assistance to JFS Caseworkers in the identification of children and families in need of mental and/or AOD services. Available services include triage of referred cases, emergency triage and evaluations Diagnostic Assessments, connection to community service, Care Management oversight, and Case Consultation for JFS workers. Admission criteria include an open Job and Family Services case and identified mental health and/or alcohol and other drug needs.

- *Hamilton County Developmental Disabilities Services Introduction and Eligibility Department* (513-559-6990) provides an entry to the two-step eligibility process for Developmental Disabilities services. The two-step eligibility process includes confirming a developmental disability and evaluating the individual's functional abilities if a diagnosis is confirmed.

- *Legal Aid Society of Greater Cincinnati – Individual Education Cases (513-241-9400):* The Legal Aid Society of Greater Cincinnati provides free, civil (non-criminal) legal assistance to low income families and individuals to help them achieve economic security

and family stability. Legal Aid provides a wide range of services including legal representation, information, advice and referral for low-income persons in need of legal help. The Legal Aid Society helps children succeed in school through individual client representation, development of key collaborations and partnerships (e.g. community partners, MHRSB, Job and Family Services, Juvenile Justice), and advocacy to promote systemic change. In the arena of education and child safety, the Legal Aid Society helps clients in the following areas:

- Obtain special education supports
- Prevent suspensions and expulsion
- Address education needs of children in foster care (e.g. preventing expulsions, securing special education services, ensuring enrollment and school stability, helping them make progress towards diplomas and assisting collaborative efforts for their transitions out of the child protection system)
- Represent children in abuse, dependency and neglect cases

The Legal Aid Society also works to enforce the education rights of English language learners, unaccompanied minors, and homeless students, to secure positive behavior interventions and supports and mental health assessments and services, to reduce the likelihood of involvement in the juvenile justice system, and to build awareness of the biologic effects of Adverse Childhood Experiences and trauma informed school practices.

- *The United Way 211 Helpline* provides information and referral to the public for a wide variety of social services in Hamilton County and the greater Cincinnati region.

If the family and/or young adult's need is not met through this initial call, the ISCC representative will refer the case to the ISCC committee member from the system most closely involved or most likely to be connected with the case. This ISCC committee member will call the family within 24 hours of receipt of the referral form. During the call to the family, the ISCC member will conduct further assessment to determine if the child meets the criteria for FCFC service coordination (page 1).

If a youth or family needs more immediate assistance with a crisis they may be referred to the Hamilton County Mobile Crisis Team which is equipped to make visits 24 hours a day, 7 days a week to the home or other community settings to assess youth and family needs. The goals of the Mobile Crisis Team are: to facilitate treatment for persons with chronic mental illness; to avert a psychiatric emergency crisis and perhaps a subsequent hospitalization by providing intervention, information, and referral; to ameliorate a crisis situation in the least restrictive setting for the immediate protection of the health and safety of the persons involved; and to reduce the criminalization of persons with mental illness. The goal of the Mobile Crisis Team is to provide stabilization of a crisis situation at the time of on-site response without referral to more restrictive environment such as the hospital or police intervention but assist with the connection to the hospital for the purposes of safety of self and others, if needed.

If the situation is not of an immediate crisis and the youth and the family's need rises to the level of requiring service coordination, the ISCC member offers to bring the case to the committee for unique service planning and staffing. The ISCC member will discuss with the family their right to initiate a family service coordination plan meeting. Family needs and requests concerning the time and location of the meeting will be considered when scheduling the meeting. Prior to the case being staffed at the ISCC, family members are advised of their right to invite any support persons (including a parent advocate, mentor, or another support person) whom they feel would be helpful to the process. Advocates can be obtained from the Parent Advocacy Connection, Developmental Disabilities Council, local educational service centers, YouthMove and other entities and resources of advocacy and support. Families and youth are also informed of their right to have a service coordination meeting before an out of home placement is made or in the case of an emergency, their right to have a meeting within ten days of the emergency placement. The meeting provides an opportunity to explore less restrictive community-based options and in the event of a placement provides an opportunity to plan for the child's return to the community. The youth and family are also informed of their rights and the procedure related to dispute resolution.

Notification Procedure

The ISCC member at this level is responsible for notifying the family, school district, agencies involved, support persons of the meeting by phone and in writing 5 to 7 days before the meeting. Once the meeting is initiated, family members will be advised of their rights concerning confidentiality and will be asked to sign a release of information form (Addendum B) If other providers and family support members are present for the family service coordination plan meeting, they will also be asked to sign a document agreeing that none of the family personal information will be shared with others outside without written consent of the family (Addendum C). During the initial meeting the ISCC will review a form that has a listing of the family's rights and responsibilities (e.g. right to initiate a Service Coordination plan meeting, the right to invite support persons of their choice). One of the rights listed is the right of the family to approve their lead service coordinator.

Once all documents are signed and all members communicate understanding of the need for confidentiality, the ISCC will continue the assessment of the family needs. Using guided interviewing and active listening with the child, family caregiver, agency/provider staff or significant others, ISCC members will assess strengths, needs and cultural implications for the family. The ISCC may resolve the issue through the ISCC staffing or make additional recommendations and referrals including referrals for further assessment using the CANS and other cultural/goal discovery tools). Based upon information presented by the family and feedback accepted at every suggestion, the ISCC may begin the process of developing family service care coordination and crisis plan that will be used for ongoing service coordination and the plan will be shared with the service provider. If the youth has multi system needs, but is not multi system involved, the ISCC provides the ongoing service coordination. In addition to the procedures described above, the committee must follow all the other guidelines of the intersystem service coordination mechanism.

The service provider will be chosen that best meets the child, family or young adult needs and a referral will be made as appropriate to: Early Intervention Service Coordination (Central Clinic for children ages 3-5), High Fidelity Wraparound (Talbert House), Other Entry points for Family Intensive Services such as Functional Family Therapy or Intensive Home Based Treatment, HOPE for Children and Families, or JOURNEY's Greater Cincinnati Behavioral Transition Age Youth Programs. It is understood that families involved with the early intervention system may receive service coordination with this defined mechanism only if the families have multi-system needs that are not being met with the traditional early intervention services. In this case, the families would convene a team and follow all the steps described in the Intersystem Service Coordination Mechanism to develop individual family plans with quality family needs identified. Thus, the Hamilton County FCFC agreed that the Family Centered Services and Supports would be available for families enrolled in FCFC service coordination using the process described in the Mechanism. The EI service coordinator will remain the lead with assistance from the service coordination team. The Lead Service Care Coordinator will be responsible for scheduling and facilitating all meetings, completing and updating all forms (such as, Individual Family Service Care Coordination Plan
(Addendum E), and Service Care Coordination Crisis Plan (Addendum F), etc. associated with the service coordination process and tracking progress of the plan and child, family or young adult. The ISCC will be responsible for documenting decisions and recommendations that will be shared with the referring individual, as well as the family or young adult in follow-up. A copy of the plan will be shared with the family or young adult.

Monitoring Progress/Documenting Outcomes

ISCC follow-up will include disposition and each service provider will monitor progress made by the family or young adult and document outcomes. Each family service care coordination plan will have individualized objectives for the child, family, and/or young adult. Disposition and data will be tracked on the ISCC Tracking Sheet (based on the Family Centered Services and Supports tracking sheet) and monthly and bi-annual reports will be sent to the Hamilton County FCFC. Information will assist the Family and Children First Council in knowing who is being served, whose needs are being met, as well as those groups of children, families and young adults who are not being served. The data will assist the FCFC in identifying service gaps, systems strengths, and opportunities for improvement. Ultimately, the goal would be to use data to inform Hamilton County FCFC's decisions and use of resources to improve the system of care.

Public Awareness

Information and the phone number to access the ISCC for service coordination will be distributed throughout provider agencies, family groups such as NAMI, youth and young adult groups, and their own systems by the ISCC members. Awareness efforts are also coordinated with other community entities such as WIC, Head Start, Early Head Start, and BCMH. This information will include a description of the committee, its purpose, how to access it, and the ISCC central phone number. To better understand the role and function of the ISCC, agency staff will be encouraged to attend trainings. For example, Hamilton County Mental Health and Recovery Services Board hosts monthly informational and supportive sessions called Case

Management Solutions that provide relevant training information and support for case managers and this meeting could also be used as a forum for educating the system about the ISCC and the Service Coordination Mechanism. Hamilton County Developmental Disabilities Services also provides information about the ISCC and the Phone line as a part of the agency's training of all new Service and Support Administrators. The process and the phone number for accessing the ISCC, the "front door" function for service coordination beyond what is traditionally provided, will also be accessible through the Ohio FCFC website at: **(**http://www.fcf.ohio.gov/Portals/0/Home/Contact%20Us/Hamilton/Hamilton%20SCM%20revised%2010.2011.pdf) and will be placed on the Hamilton County Developmental Disabilities Services website as the Administrative agent for Hamilton County Family and Children First Council.

The ISCC may refer youth requiring FCFC Service Coordination to HOPE for Children and Families, which is a system of care, serving high end multi need youth (ages 5-17) and their families or Early Intervention Service Coordination (0 through age 2) and Central Clinic Early Childhood Services (ages, 3-5), High Fidelity Wraparound (Talbert House; ages, 6-18), or JOURNEY 's Greater Cincinnati Behavioral's Transition Age Youth Programs (ages, 16-22) and other family intensive programming such as FFT or IHBT.

The ISCC and all providers will abide by the following procedures for service coordination:

Service Providers FCFC Coordination Procedures
Upon a provider's acceptance of a referral, enrollment occurs within 24 hours. A Team Leader will be assigned within one working day. The Team Leader familiarizes himself with the case and makes an assignment within one business day to a service care coordinator based on the family's input as to who will be the lead service care coordinator. The Lead Service Care Coordinator is responsible for contacting the family and introducing them to the program within 48 hours of assignment and will offer the family a family/team meeting within five days of the initial call. Family needs and requests will be considered when scheduling meeting times and locations.

During the intake meeting, the service care coordinator has the guardian/client sign the Consent for Services form that includes the following information:

1. Client Rights Policy and Grievance Procedure
2. Client Responsibilities
3. HIPAA Notice of Privacy Practices
4. Provider Code of Ethics

5. Information on how to look at or get copies of client's clinical records
6. Information of Access to a Parent Advocate
7. Hours of operation

The service care coordinator also asks the guardian/client to sign releases of information in order to communicate with other providers and potential team members.

During this initial meeting, the lead service care coordinator assists the family in identifying natural supports, providers, representative from the child's school district and/or family advocate, mentor or other supports that will become a part of the Service Care Coordination Team. Families are informed that they have the right to initiate a Family Service Care Coordination plan meeting as needed and that they can invite any support persons of their choice, including a family advocate, mentor, or other support person to those meetings. Advocates can be obtained from the Parent Advocacy Connection, Developmental Disabilities Council, local educational service centers, YouthMove and other entities and resources of advocacy and support. The family has the right to request a service care coordinator.

The Service Care Coordination Team will be made up of approximately five to nine members and will meet at least monthly to discuss treatment needs and progress. Additional members may be added and others removed at the discretion of the family, except for conditions in which it is not optional, such as a juvenile justice court order. The service care coordinator will keep all team members informed about the service care coordination plan when their participation is needed.

The service care coordinator notifies all potential Team members of the date, time, and location of the initial team meeting. At the initial team meeting and all subsequent team meetings, the service care coordinator will have the team members sign a Care Coordination Team Agreement to Maintain Confidentiality (Addendum C)**.** The service care coordinator will distribute meeting minutes that includes information regarding the next meeting.

All agencies will have clear procedures for the development of a family service care coordination plan and crisis plan (and safety plan, as needed). Both the coordination plan and crisis plan are developed at the time of intake. Child, family, or young adult strengths in several life domains are to be included in the development of the service coordination plan and utilized throughout their involvement.

The team working with the child, family, or young adult develops and regularly monitors a set of goals based on the needs and strengths of the child, family, or young adult. All members of the team actively participate by bringing their resources, skills, and knowledge to the table. Responsibilities of team members are determined at the meeting and documented in the minutes, which are distributed to each team member. The lead service care coordinator will assist with the coordinated assignment of responsibilities (assessment, service plan development and implementation, assistance in transitional services, service activity tracking, and monitoring of service satisfaction). Team responsibilities are listed on Individualized Family Service Coordination Plan (see Addendum E). Each team meeting is used to monitor the progress and track the outcomes of the individual's service care coordination plan. The team monitors and tracks if the child is in out-of-home placement to assure continued progress, appropriateness of placement, and continuity of care after discharge from placement with appropriate arrangements for housing, treatment and education. This information can be shared in aggregate with FCFC to assist in planning and decision making related to prioritizing services, filling service gaps and creating new approaches.

Procedure for Out of Home Placement Meeting

The service coordination mechanism in Hamilton County is committed to providing wraparound, community based, least restrictive, and flexible in-home services to prevent out of home placement. Out of home placements are only considered when other less disruptive options have been exhausted and the youth's needs and functioning may indicate a need for an out of home placement. A family service care coordination plan meeting will occur prior to a non-emergency out of home placement. However, in the event of an unexpected out of home placement, the Service Care Coordination Team or ISCC (if the child and family is not involved with a service provider) will meet within 10 days of the emergency out of home placement. The meeting provides an opportunity to discuss progress with all parties including the family in the hopes of planning for the youth's return to the community. HOPE for Children and Families partners with Hamilton County Job and Family Services Utilization Management Department about out of home placements. A predetermined funding arrangement accounts for the financial support of the residential placement of these youth.

Procedure for Monitoring Progress and Tracking Outcomes

The service coordination mechanism in Hamilton County assures that in addition to monitoring progress and tracking outcomes through teams, providers prepare extensive reports on outcomes annually. The report includes information on out of home placements and the information is periodically utilized to inform FCFC about out-of-home placements and the needs of high-end multi-system youth and families. Data will also be collected and reported bi-annually on the following measures: number of referrals by system, total number of youth enrolled in FCFC service coordination/wraparound, total number enrolled in FCFC service coordination/wraparound by gender (male, female, transgender), number of enrolled youth by demographic data (race, age), agencies involved with youth at time of referral, categorization of significant concerns or needs as identified by assessment, progress in areas on subsequent assessments, and percentage progress on identified goals). Additionally, data is collected monthly, quarterly, and annually on a number of outcome measures in the following general categories: out of home care placements, child functioning, family functioning, satisfaction, cost effectiveness of services, access, serving youth in the local community, and additional outcomes. This information will be shared with the Hamilton County FCFC monthly, bi-annually, and as requested who will use the information to inform the decision-making process of the FCFC as it seeks to evaluate and prioritize services, fill service gaps, and create new approaches to obtain better results for families, children, and young adults.

Procedure for Family Confidentiality

All providers adhere to all HIPAA rules concerning confidentiality, which require that information be kept locked and secure. Families or young adults are informed that records can not be released without a properly completed and signed release of information (Addendum B) with the following exceptions noted: suspicion of child/adult abuse/neglect; belief that a person served is a danger to themselves or others; an emergency where information is necessary to protect/insure health and safety; in response to a valid court order or subpoena (may be overridden if court determines disclosure is not for bona fide purposes or if they compromise confidentiality); in response to requests from Ohio Legal Rights; and to validate an insurance

claim. Families or young adults are provided information about the confidentiality policy at enrollment. Providers require that employees keep information confidential, and employees are trained annually on the confidentiality policy. The entire Team signs a form indicating their agreement with maintaining the confidentiality of matters discussed in the Team (Addendum C).

Procedure for Assessing Strengths, Needs and Cultural Discovery and Plan
Providers conduct an initial screening/assessment within 30 days of referral. Because not one assessment tool is applicable to all groups, different providers use different tools. All providers assess strengths, needs, and cultural discovery using information from the child, family/caregiver, agency/provider and/or significant others. The primary assessment tool for our Service coordination mechanism process will be the Child and Adolescent Needs and Strengths Form.

- HOPE for Children and Families utilizes information from the Child and Adolescent Needs and Strengths Form (CANS, see Addendum D), Diagnostic Assessment Form, the Hamilton County Integrated Referral Form and initial interviews with families and service providers. A review of this material, including an assessment of strengths, needs and cultural discovery are conducted within 30 days and is used to develop the family service care coordination plan and the service care coordination crisis plan. The Cultural Discovery assessment is completed using information obtained from interviews with the child, family/caregiver, agency/provider, and/or significant others.
- Early Intervention Service Coordination utilizes a routines-based interview and ecomapping along with the screening tools; Ages and Stages and Ages and Stages-SE. A developmental evaluation is completed utilizing the Battelle Developmental Inventory. Central Clinic utilizes a strength-based interview and screening tools (such as the Devereux Model, Ages and Stages, Home Inventory, DECA, and Achenbach Child Behavior Checklist) for children ages 3-5 who are in need of service coordination.
- High Fidelity Wraparound is an evidence- based process provided by Talbert House. Staff utilize information from the Diagnostic Assessment Form and expertise in wraparound philosophy and protocols to assess the strengths and needs of youth with mental health needs that are interfering with the youth's functioning.
- The Lighthouse Individualized Docket Services program (LIDS) provides needed treatment and associated services for youth involved in the juvenile justice system who are participating in the official (Individualized Disposition Docket) or diversion (Pretrial Diversion Docket) mental health courts and who are diagnosed with a serious emotional disorder who also may have a co-occurring substance use disorder. Evidence-based programming interventions include Functional Family Therapy (primary), Structured Sensory Interventions for Traumatized Children, Adolescents, Parents (SITCAP), and The Seven Challenges.
  Lighthouse Youth Services, St. Joseph Orphanage, and Camelot Community Care are providers of Intensive Home-based Treatment if a child and family's service coordination needs should rise to that level. Evidence-based screening and assessments determine eligibility, individual needs and the best treatment for each youth.

- JOURNEY's Greater Cincinnati Behavioral Transition Age Youth Program (specifically the Transition to Independence Process Program) utilizes information from the Diagnostic Assessment Form and especially designed strength-based assessment questions from the Daniel Memorial Independent Living Skills Assessment Tool to identify the strength, needs, and cultural discovery information of transition age youth (ages, 16-22) in their various life domains.

The family service care coordination plan is developed by the Team using the strengths and needs of the family or young adult in several life domain areas, including but not limited to:

- Behavioral/Emotional Needs
- Family/Relationships
- School/Education
- Child Strengths
- Developmental Needs
- Trauma
- Juvenile Justice Needs
- Vocational/Employment Need
- Life Functioning/Independent Living
- Substance Abuse
- Social/Recreational
- Child Risk Behaviors
- Home and a place to live
- Health/Medical
- Cultural/Spiritual
- Financial

The Team utilizes the strengths and needs information to inform the development of the service care coordination plan (Addendum E) within 30 days of the initial meeting. The service coordinator helps the child, family, or young adult to identify a vision that is informed by strengths, prioritized need statements, and identified community resources (formal and informal supports). This information leads to the identification of outcomes/goals with target dates and interventions. During this process, the service coordinator is careful not to confuse needs with services. Once the plan is developed, it is signed to signify the agreement and support of all persons signing the document in assisting achievement of the plan.

Dispute Resolution Process

Families must be informed of the dispute resolution process upon intake into the service coordination process. All Hamilton county agencies have their own grievance procedures and dispute resolution processes for children, families, and young adults receiving services from their own systems. The local dispute resolution process shall serve as the process that must be used first to resolve disputes among agencies represented on the county council concerning the provision of services to children, including children who are abused, neglected, dependent, unruly, alleged unruly, or delinquent children and under the jurisdiction of the juvenile court and

children whose parents or custodians are voluntarily seeking services. Those procedures will remain intact and comply with section 121.38 of the Revised Code. The local dispute resolution process shall be used to resolve disputes between a child's parents or custodians and the county council regarding service coordination. Parents or custodians shall use existing local agency grievance procedures to address disputes not involving service coordination. The dispute resolution process is in addition to and does not replace other rights or procedures that parents or custodians may have under other sections of the Revised Code. If a grievance is made regarding an out of home level of care decision or placement issues, the child/family will follow the Hamilton County Job and Family Services Utilization Management grievance procedure.

For those wishing to obtain specialized services that have been denied or who have complaints about their services or Service Coordination plans that cannot be resolved through the agency normal grievance procedures or those that have a complaint originating with their ISCC phone line contact, the dispute resolution process is detailed below.

- If the family, young adult, or agency is not satisfied after the ISCC phone line contact or after having completed the agency grievance procedure, they (family, young adult, or agency) may submit a written account of their complaint to the Intersystem Service Collaboration Committee, who will convene an ISCC meeting. The complaint should be directed to the central ISCC phone number; the case will then be assigned to the ISCC member from the system with which the family has had primary involvement. The ISCC member will then be responsible for convening and coordinating the meeting and distributing written material to Team members. The agency representative, family, young adult and any support persons or family advocates of their choosing will be invited to attend the meeting by the ISCC member responsible. The Team will review the case within 10 working days and render a decision, which shall be sent to the family, young adult, or agency.
- If the family, young adult, or agency is still dissatisfied, they can appeal to the Family and Children First Council. The family, young adult, or agency will send the written description of the complaint to the Family and Children First Council Coordinator who will forward it to the County agency directors (Executive Committee) along with case information from appropriate systems (Dispute Resolution Form Addendum H).

- The ISCC member who was originally responsible for the case will be responsible for collecting all appropriate records and materials for the FCFC coordinator to send to the County agency directors (Executive Committee) prior to the meeting.

- The FCFC coordinator will convene a meeting with all system directors (Executive Committee) within 15 working days to discuss the complaint. The family, young adult, or agency will be notified of the meeting date and will be invited to attend if they so desire. The directors will review the situation and make a determination about disposition. Resolution of the issues will be decided by a majority vote of the four system directors. The FCFC Coordinator will issue a written determination of the findings of the system directors to the family or agency within 10 days of the meeting. The determination will

include a plan of care governing the manner in which the services or funding is to be provided.

The dispute resolution process as described above will not take longer than 60 days from the time a family, young adult, or agency initiates a complaint until a written disposition of its findings is received from the County system directors. The entire dispute resolution process recognizes and uses the entities and relationships within the community that reflect Hamilton County's unique culture and characteristics.

Each agency that is providing services or funding for services that are the subject of the dispute resolution process shall continue to provide those services and the funding for those services during the dispute resolution process. Nothing in this section shall override or affect decisions of a juvenile court regarding an out-of-home placement, long-term placement, or emergency out of home placement.

An additional vehicle available is to request the OFCF Cabinet Council review individual family service coordination plans, and unresolved county disputes through a State Service Coordination Committee made up representatives from the cabinet agencies and from the Office of OFCF. Guidance and specific requirements for requesting a review, including forms to be used for a request, are available at:
htpp://www.fcf.ohio.gov/CoordinatingServices/ServiceCoordinationStateCommittee.aspx.

The State Service Coordination Committee will review cases when there is an unmet family or young adult need that the county FCFC is unable to fulfill, or when the county is unable to develop a family service coordination plan that leads to significant improvement in family or young adult functioning or stability. This committee may review case documents submitted by the county FCFC and make recommendations to the OFCF Cabinet Council for its review and approval. With the OFCF Cabinet Council's approval, the Office of Ohio Family and Children First will respond, in writing, to county FCFC requests within 45 days of the receipt of the request by the State Service Coordination Committee.

Also, when requested the OFCF Cabinet Council may provide an administrative review of unresolved local disputes regarding conflicts among parents, young adults, agencies and/or councils pertaining to the county FCFC service coordination process or decision made during child and family team meetings or the ISCC committee meetings. This dispute must concern a decision made or process proposed or implemented during a phase of the county service coordination process regarding a young adult, family or child who is formally involved in the county FCFC service coordination, including disagreement regarding denial of a family into the process. Agencies, providers, parents/legal guardians, or the young adult, who have participated on a family service coordination plan team, may request this dispute resolution review. The State Service Coordination committee may review such requests and make recommendations to the OFCF Cabinet Council for its review and approval. With the OFCF Cabinet Council's approval, the OFCF will respond in writing within 30 days of the receipt of the request. The OFCF will not review cases for which the complainants have sought a juvenile court ruling.

The local early intervention (EI) dispute resolution process is aligned with the county service coordination mechanism. Parents or guardians who have a grievance should first submit that grievance in writing to the EI provider that provides their service coordination services. If the parent/guardian and the EI funded agency are unable to resolve the matter, the parent/guardian can submit the grievance in writing to the Hamilton County EI Contract manager. If the parent/guardian is still not satisfied, a grievance can be filed with the Hamilton County Family and Children First Council, who will utilize the HMG Steering Committee (made up of Executive Committee members) to review the grievance and make a ruling within 15 days of hearing the dispute. Their decision will be final. However, at any point that the parent/guardian is not satisfied, they have the right to submit a written complaint to the Ohio Department of Developmental Disabilities (ODODD). The decision of ODODD will be final. Parents are notified of this process and their rights in a brochure that is distributed to them upon entering the early intervention system.

How Parents and Agencies are informed of Dispute Resolution Process

The Hamilton County Intersystem Service Collaboration Committee created a brochure describing the committee's role as an entry gate to service coordination and individualized services for youth, families, and agencies. The brochure also describes the dispute resolution process and parents' rights or young adult's rights to avail themselves of the dispute resolution process. Parents are included in all aspects of the dispute process, they choose. The brochures will be given to all families or young adults who receive services from one or more of the Service Coordination agencies listed above upon entry to the program. These brochures are available to counties/agencies through the ISCC. This brochure will be distributed to every family who enters service in any of the aforementioned programs and is available to agencies and families when calling the ISCC Central Phone line.

Process and Components of Service Coordination Plan for Provider

Designation of Responsibilities

HOPE for Children and Families, Early Intervention, High Fidelity Wraparound (Talbert House), and other intensive services such as FFT or JOURNEY GCB will designate a lead service care coordinator as the person responsible for monitoring the implementation of the service care coordination plan designed by the team. The entire process is done in equal partnership with the child and family or young adult who approves the lead service care coordinator. The service care coordinator works to ensure that all the services identified in the service care coordination plan are appropriate, available, and provided in the least restrictive environment as possible. The service care coordinator also makes sure that all individuals involved with the child and family or young adult are aware of their strengths and assists in the coordination of responsibilities. The service care coordinator monitors the interventions to determine if they are leading to positive outcomes and if the appropriate resource or support is not available notifies team members and the ISCC for assistance in problem solving.

The service care coordinator acts as facilitator at the meeting where the date and time of the next meeting is set. He or she is also responsible for providing a copy of the team minutes to all team

members, which includes the date, time, and location of the next meeting. If a team member misses a meeting, the service care coordinator is responsible for notifying the team member by phone and in writing with adequate notice of the meeting date. In addition, each member receives a copy of the meeting minutes, which includes the date, and time of the next meeting.

Responsiveness to Child and Family or Young Adult
The ISCC emphasizes the importance of agencies capturing each child and family or young adult's unique needs, strengths, and culture to develop meaningful plans and services that engage the family or young adult and build the community's capacity for meeting the needs of youth and families in the least restrictive environment.

- HOPE for Children and Families has guidelines that the assessment of strengths, needs and cultural discovery must be completed within 30 days of referral in preparation for its use in the family service care coordination plan. HOPE utilizes the CANS as the standardized assessment tool for identifying youth and family needs and strengths. HOPE staff utilize the Charting the Life Course tool along with the CANS to complete the family service care coordination plan. Additionally, HOPE for Children and Families rigorously trains their staff about the strength-based assessment and interview process and how to utilize this information from the CANS and Charting the Life Course to develop and monitor the service care coordination plan. HOPE for Children and Families takes great care to educate families about their philosophy on family's needs, strengths, and culture, and the intent to provide services in the least restrictive environment as possible. Finally, HOPE for Children and Families conducts audits to ensure that a family's strengths, needs, and culture are reflected in the service care coordination plan.

- Children in Hamilton County, from birth to age three, may receive their service coordination through Early Intervention (EI). EI is a statewide system that provides coordinated services to parents of infants and toddlers with disabilities or developmental delays in Ohio. Within Hamilton County, providers utilize the Ages and Stages, Ages and Stages-SE, Routines Based Interview and other screening tools along with the Individualized Family Service Plan to capture children needs, strengths, and cultural discovery information. This information is used to connect multi-need, multi-system young children and families with appropriate resources and services including clinical services provided by the MHRSB, educational services provided by the Cincinnati Public Schools and other county school districts, and EI services provided by HCDD Services. Families of children birth-2 years old who contact the ISCC line and need service coordination for multi-system needs beyond what early intervention provides and are determined eligible for intersystem coordination through FCSS are directed to Central Clinic. The Central Clinic service coordinator will conduct a cultural and strength based assessment utilizing a strength based interview and screening tools that capture the child's needs, strengths, and cultural discovery information (such as, the Devereux Model, Ages and Stages, HOME Inventory, DECA, and Achenbach Child Behavior Checklist for children 0-5 1/2). Per ISCC guidelines, the service coordinator is responsible for utilizing this information to develop the plan within 30 days. Once the plan is developed the service coordinator is also responsible for assisting the family in

implementing the family service coordination plan and communicating progress on the plan to the ISCC. When a child is involved in both early intervention and service coordination through the FCFC, the main provider of service coordination will be early intervention. The service coordination mechanism will support and provide resource assistance for the individualized family service plan (IFSP).

- Youth and families who contact the ISCC with multiple system involvement (e.g. education and mental health) and need assistance to address mental health needs that interfere with the youth's educational success will be directed to High Fidelity Wraparound provided by Talbert House. High Fidelity Wraparound provided by Talbert House is primarily provided in a school-based program or context. The program utilizes its expertise in wraparound philosophy to assess the strengths and needs of the youth with educational challenges who are often transitioning from structured environments such as Partial Hospitalizations back to educational and treatment supported classrooms. Staff are trained to educate families about the wraparound process and to engage families in the decision-making process. The Talbert House service coordinator (facilitator) utilizes the wraparound philosophy to incorporate youth and family need and strength information into a family service coordination plan (Addendum E) within 30 days of enrollment. The service coordinator (facilitator) is trained to pay close attention to issues of race, ethnicity, cultural and gender identity in the planning process. The service coordinator will implement the plan and report its progress back to the ISCC. Talbert House High Fidelity Wraparound conducts quarterly audits to ensure fidelity to the wraparound process.

- Young adults, ages 16 -22, who contact the ISCC with multiple system involvement (child welfare, juvenile justice, and DD services system) and have significant mental health needs that need to be addressed while transitioning to adult services will be referred to JOURNEY's GCB's Transition Age Youth Program. The JOURNEY program was a SAMHSA funded grant program with unique protocols that has been sustained through MHRSB funding. The JOURNEY Greater Cincinnati Behavioral Health Services (GCBHS) Program utilizes the Transition to Independence Process to help these young adults to receive support to address needs related to emotional/behavioral health, education, vocation, housing, and life skills development. The GCBHS service coordinator has been trained in various treatment models and practices (such as Motivational Interviewing and the Daniel Memorial Independent Living Skills Assessment Tool) to identify the strengths and needs (including cultural needs) of transition age youth. A family service coordination plan (Addendum E) will be developed within 30 days based on the information from the transition age youth strength-based assessment interview. Progress on the plans will be reported back to the ISCC.

- Other Treatment Interventions such as FFT and IHBT: The Lighthouse Individualized Docket Services program (LIDS) provides needed treatment and associated services for youth involved in the juvenile justice system who are participating in the official (Individualized Disposition Docket) or diversion (Pretrial Diversion Docket) mental

health courts and who are diagnosed with a serious emotional disorder who also may have a co-occurring substance use disorder. Evidence-based programming interventions include Functional Family Therapy (primary), Structured Sensory Interventions for Traumatized Children, Adolescents, Parents (SITCAP), and The Seven Challenges. Lighthouse Youth Services is the identified provider for the mental health courts. Hamilton County Juvenile Court screens potential referrals for behavioral health and recovery services needs. Youth without a current pre-diversion disposition evaluation are referred to the Mental Health Access Point for assessment. Upon referral, Lighthouse Youth Services utilizes the Child and Adolescent Needs Scale to determine needs. The target population for FFT is males and females, aged twelve to seventeen, with behavioral health problems who are involved in the Juvenile Justice system. While FCFC funding cannot be used to support adjudicated youth, they are still able to receive their service coordination through the FFT program, if it is determined that this is the best service to meet their need. Intensive Home-Based Treatment services in Hamilton County can be provided by Lighthouse Youth Services, Camelot Community Care, and Pressley Ridge if the child and family's needs require this level of intervention.

For additional guidance on matters of cultural competency, system partners and providers will refer to local and national resources including the following:
http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53
https://www.thinkculturalhealth.hhs.gov *Timelines for Completing Goals*

Within 30 days of enrollment, the team develops the Service Care Coordination Plan. The team projects timelines for the completion of the goals. The team reviews these goals as part of the monthly Service Care Coordination Plan meetings and formally reviews the plan every six months. The team will make decisions at the monthly meeting regarding whether to continue, discontinue or revise the goals. The family/youth can request to schedule a meeting at any time and during a time that is convenient to them with the assistance of the lead service care coordinator.

Crisis and Safety Plans

A preliminary crisis plan is developed in conjunction with the family during the initial meeting (Addendum F). Within 30 days of enrollment, a more comprehensive plan is developed. The crisis plan details options for preventing a known crisis and options for supporting a youth/family through an event based on family preferences and needs. A safety plan (Addendum G) which addresses any safety concerns or safety programming needed is written as needed and is reviewed regularly (daily, weekly, monthly, etc.) based on the needs of the youth and family. The crisis plan is reviewed regularly during service care coordination meetings and formally at least every six months. The crisis plan is always reviewed and changed as crisis situations arise. A copy of the crisis plan and the safety plan (when indicated) is given to the youth and family or young adult.

How Unruly and Delinquent Youth will be Served

The Hamilton County Service Coordination Process also accounts for youth that are alleged unruly through the efforts of our Juvenile Court. Hamilton County Juvenile Court tries to

identify and intervene to prevent a child from becoming further involved in the juvenile court system. During the development of the individualized family service coordination plan, many strategies and behavioral health initiatives are considered and adopted as options in the plan to divert further juvenile justice involvement. Besides HOPE for Children and Families, the following behavioral health initiatives exist in the community to divert unruly and delinquent youth through provision of case management and therapeutic treatment including:

- *Hamilton County Juvenile Court's Unofficial Truancy Diversion Program:* Hamilton County Juvenile Court's Unofficial Truancy Diversion Program is a collaborative effort between the Court, local law enforcement agencies, referred children and families, the community and school districts to promote change in behavior that will divert children from formal involvement with the Juvenile Justice system. The goal is to provide accountability for a child's school attendance, while identifying and connecting children and families to appropriate services and interventions that support the educational and developmental needs of the child.

- *Hamilton County Juvenile Court's Behavioral Health Services: Intervention Unit* is assists families in crisis with children exhibiting unruly or minor delinquent behavior by providing a diversionary process as an alternative to processing through the juvenile justice system. Families are empowered with an understanding or new perspective of their child's behavior. This allows them to pursue solutions through their own resources, with a family counselor at the Intervention Unit or with the assistance of a community agency. Youth can be referred by a parent, community program, magistrates as well as directly by a Probation Officer. Licensed clinicians provide intervention, short-term counseling services, and connection to ongoing services.

- *TeamChild*: *TeamChild* is a collaboration between Juvenile Court's Probation Department and the Legal Aid Society of Greater Cincinnati, provides interventions and advocacy so that children involved in the juvenile justice system can return to and remain in school and improve their educational success. Upon referral, Legal Aid provides advocacy to ensure school stability by addressing supports and interventions related to special education and school discipline, and by representing the youth and family in areas related to health, mental health, custody, housing or other household legal problems.

- *Unofficial Dockets*: Hamilton County Juvenile Court prioritizes diversion of youth when appropriate. Juvenile Court utilizes several unofficial dockets to hear unruly and minor misdemeanor charges. Successful completion results in the charge being dismissed and the youth not having a record with the Court. These programs include Community Courts, Teen Youth CALL Court, Substance Abuse & Traffic programs as well as an Unofficial Court docket.

- *Community Courts:* 14 active Community Courts hear cases. In 2016, 932 cases were referred to Community Courts directly from either law enforcement or the community. Unofficial Hearing Officers in the community hear the offenses and impose sanctions. Cases can also be referred to the Teen Youth CALL Court for diversion.

Youth Court is a collaboration with Hamilton County Juvenile Court, Cincinnati Academy of Leadership for Lawyers (CALL) and local high school student volunteers. The goal is to use positive peer pressure to ensure that young people who have committed minor offenses pay back the community and receive the help they need to avoid further involvement in the justice system. Benefits also include evening hearings and successful completion will result in the juvenile not having an official record. In 2016, 68 cases were heard by the Teen Youth CALL Court.

Cases that involve first offenders charged with traffic or substance use can be referred to the Substance Abuse Program and the Traffic Program. In 2016, 739 cases were diverted to these programs.

The Court employs (2) full time Hearing Officers to hear unruly, truancy and minor misdemeanor offenses that are not diverted to other diversion programs. In 2016, Unofficial Hearing Officers heard 819 cases.

The Hamilton County Family Service Coordination Process will also be made available for youth that are adjudicated unruly or delinquent. Primarily the service coordination process will be managed through HOPE for Children and Families but other resources and processes may be considered as well in the hopes of improving the outcomes for youth adjudicated unruly or delinquent.

Public Awareness of Service Coordination Mechanism

The process and the phone number for accessing the ISCC can be accessed through the state of Ohio's FCFC website at: **(http://www.fcf.ohio.gov/Portals/0/Home/Contact%20Us/Hamilton/Hamilton%20SCM%20revised%2010.2011.pdf)** and will be placed on the Hamilton County Developmental Disabilities Services website as the Administrative agent for Hamilton County Family and Children First Council. Hamilton County Developmental Disabilities Services also provides information about the ISCC and the Phone line as a part of the agency's training of all new Service and Support Administrators. Hamilton County efforts to educate the public about the service coordination mechanism process and the ISCC phone number have included distributing to families and contract agency front line staff a summary sheet describing the service coordination mechanism process and the ISCC phone number. Based on feedback from a focus group, brochures were created and distributed to parents, schools, service providers, and other key venues for families that have youth with multiple service needs (e.g. doctor offices, hospitals, etc). The brochures will be reviewed and revised to reflect changes to the Service Coordination Mechanism process and the ISCC phone number. The brochures will be distributed to parents, schools, service providers, parent advocates, child welfare, juvenile court, and developmental disability provider settings. Awareness efforts are also coordinated with other community, educational, or social marketing efforts of such entities as WIC, Head Start, Early Head Start, and BCMH.

Opportunities to educate service providers will be explored by presenting information at conferences, coalition and committee meetings such as the Children's Oversight Committee and Early Intervention Collaborative. The Hamilton County Family and Children First Committee and Intersystem Service Coordination Committee will continue to discuss, explore and implement ways to increase public awareness of the service coordination mechanism.

Fiscal Strategies for Supporting Service Coordination

Funding Decisions for Services in the Family Service Coordination Plan
Funding decisions are informed by child or young adult's needs and the service coordination team and facilitated by the service coordinator in consultation with the service coordinator's supervisor or ISCC, as appropriate.

Decisions regarding Family Centered Services and Supports
The Hamilton County FCFC agreed that the Family Centered Services and Supports (FCSS) would be available to families accessing FCFC service coordination to meet the unique nonclinical needs of children and families as identified on the individualized service coordination plan. As identified in the mechanism plan the funding has restrictions as to eligible services and eligible youth (e.g., adjudicated youth may receive service coordination but are not eligible for FCSS funding). Agency and Hamilton County FCFC refer to FCSS guidance documents to ensure compliance with eligible services and youth.

High Fidelity Wraparound
The Hamilton County Mental Health and Recovery Services Board currently funds High Fidelity Wraparound services provided by Talbert House. Behavioral Health Redesign funding options may be explored as an option for future funding of High Fidelity Wraparound services.

Maximization of flexible resources
Hamilton County's system partners engage in active efforts to maximize resources through collaboration. Hamilton County also values utilizing natural and community resources.

Pooling of Funding to Support Service Coordination
Funds are pooled among the County agencies (child welfare, juvenile justice, mental health and substance abuse, developmental disabilities) to support the costs of service coordination and services. In addition, state and local levy dollars support service coordination.

Reallocation of funding from institutional services to family-centered services
The continuing emphasis on less restrictive placements and community-based treatment results in less spending on residential treatment. These savings are used for mentoring and other flexible community-based services that assist the child and family with achieving treatment goals. Savings realized from wrapping services in the community to avoid out-of-home placement are reinvested within the program to serve more youth and families.

Ohio Early Intervention Service Coordination funding for eligible youth
Hamilton County DD Services administers the service coordination grant and sub-contracts with Lighthouse Youth and Family Services for the provision of service coordination. There is no cost to families for service coordination.

Quality Assurance of Service Coordination Mechanism

Part of the monitoring of the Service Coordination Plan is an annual examination of the number of children in out of home placement. HOPE for Children and Families tracks and monitors out of home placements made within its program and produces monthly, quarterly, and annual reports (Addendum I) that analyzes and tracks levels of care, length of stays, and other outcomes/data. In addition, there also are a number of different efforts among the child-serving systems to track and monitor other youth in out-of-home placement. Each of these agencies has its own way of tracking numbers of youth, and each has a protocol for monitoring the progress, clinical appropriateness of level of care, and outcomes for these youth. This is done via multisystem teams in most instances, and various clinical tools are used to ensure standards are met. Some of these tools include the Ohio Scales, and the CAFAS.

The Intersystem Service Collaboration Committee (ISCC), which holds oversight responsibilities for the multi-system collaborative efforts within the Service Coordination Plan, as requested gathers information on multi-system involved youth in out of home care and other data/outcome requirements. Additionally, the youth not in out of home placement that are staffed within this committee will be tracked via a database that will include plans and final dispositions for those youth. As requested, the information is shared in report form with the Family and Children First Council and its Executive Committee. These numbers will also be available to the state annually upon request. The review of the Hamilton County Service Coordination plan will formally occur annually to ensure the plan accurately captures how service coordination is occurring in Hamilton County.