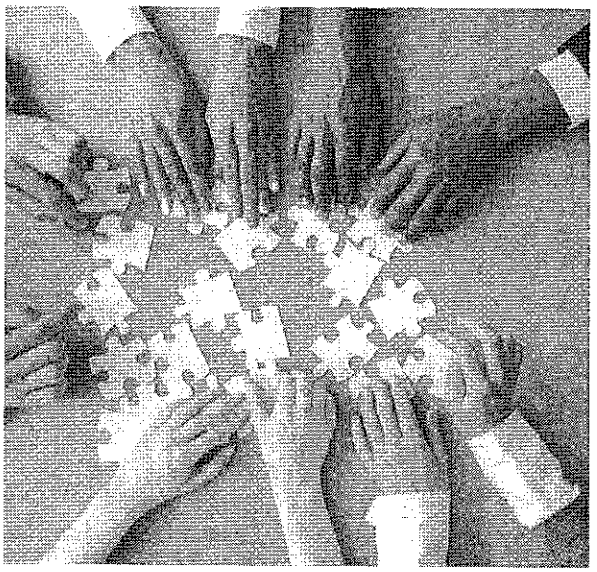
Richland County
Coordinated Service Team Initiative
Interagency Agreement



A Collaborative System of Care

Richland County Health & Human Services

Coordinated Services Team Initiative (CST)

Interagency Agreement (5/23)

Richland County Coordinated Services Team Initiative Mission Statement: The Richland County Coordinated Services Team Initiative strives to improve the lives of children involved with multiple services through the establishment of a comprehensive, strengths-based, coordinated, community-based system of care, centered on the child and their family. Special emphasis is on serving children who have a severe emotional disturbance.

Philosophy

The Coordinating Committee of the Richland County Coordinated Services Team Initiative believes:

1. The *basic needs for food, clothing, housing, safety and medical care must first be met* in order to enable families to address other needs.
2. Whenever possible, services can best be provided in a *family and community setting*, rather than a residential or institutional setting.
3. Families as partners will have *voice, access, and ownership* in the development and implementation of the initiative.

Coordinated Services Teams Initiatives

Coordinated Services Teams (CST) Initiatives help provide a complete, personalized system of care. They focus on kids with complex behavioral health needs.

The CST itself is a team of family members, service providers, and others. They work to design and carry out a coordinated services plan for the child. We also call this model of care "wraparound."

The result of CST Initiatives is a plan of care that meets the needs of the child and family with community-based supports. This lets the child live their best life at home.

Guiding Principles Directing the Coordinated Services Team Initiative

The Coordinated Services Team Initiative will:

1. Serve children and families with multiple needs regardless of ability to pay and without regard to race, religion, national origin, sex, sexual orientation or disabling condition;
2. Be child/family-centered, with strengths and needs dictating the types and mix of services provided;
3. Encourage families to become full participants in the planning and delivery of services;
4. Promote early identification and intervention to enhance the opportunity for positive outcomes;
5. Provide service coordination to ensure that multiple services are developed and delivered in a coordinated, collaborative, strengths-based and confidential manner;
6. Ensure a smooth and coordinated transition from the child-to the adult-service system;
7. Protect the rights of the child and his/her family and promote effective advocacy on behalf of the child and family and other similar families in the county.

CST Initiatives Vision

Our vision for CST Initiatives is:

1. To transform the children's mental health and substance use system in Wisconsin.
2. To better meet the needs of kids and families.
3. To create a seamless, complete children's behavioral health system.
4. To use wraparound as a model for support.

CST Core wraparound values include:

1. **Family voice and choice**—The team asks for family and child input during all phases of the wraparound process. All planning is grounded in what the family needs. The team aims to give options that reflect the family's values and choices.
2. **Team-based**—The team includes people the family approves. They are committed to the family through informal, formal, and community support and service relationships.
3. **Natural supports**—The team actively seeks out and promotes involvement of people from the family's networks. This includes interpersonal and community relationships. The wraparound plan has activities and methods that use sources of natural support.
4. **Collaboration**—Team members work together. They share responsibility for setting up, making happen, watching over, and reviewing a wraparound plan. The plan reflects team views, mandates, and resources. It guides and coordinates each client's work towards meeting the team's goals.
5. **Community-based**—The team uses services and supports that take place in the most inclusive, responsive, and accessible settings. All settings should be the least restrictive and safely promote getting the family and child to thrive in home and community life.
6. **Cultural and linguistic responsiveness**—The process shows respect for the child, family, and their community. It builds on their values, preferences, beliefs, culture, and identity.
7. **Individualized and developmentally informed**—The team creates and implements a custom set of strategies, supports, and services. These help meet the goals in the wraparound plan.
8. **Strengths-based**—The process and plan find, build on, and enhance the abilities, knowledge, skills, and assets of the child and their family, their community, and other team members.
9. **Unconditional**—The team does not give up on, blame, or reject the child and their family. When faced with challenges or setbacks, the team keeps working toward meeting the goals in the wraparound plan. They do this until they agree that a formal wraparound process isn't needed.
10. **Outcome-based**—The team connects goals and strategies in the plan with ways to observe or measure markers of success. They monitor progress based on these markers and revise the plan if needed.

Program Evaluation

The Coordinating Committee, which agrees to comply with all State Department of Health and Family Services evaluation requirements, will conduct ongoing evaluation of the Richland County CST initiative.

Expected Outcomes Include:

- Success in meeting the Plan of Care goals and objectives;
- Improved overall school performance by student participants in CST;
- Reduced out-of-home placements;
- Other family outcomes as established by state-mandated indicators;
- Interagency collaboration as measured by provider satisfaction surveys;
- Participant program satisfaction as measured by CST survey instruments.

Evaluation information will serve as a basis for project modification and be used to update the Interagency Agreement as necessary.

Roles and Responsibilities of CST Initiative Partners

Partners are asked at a minimum to:

- Participate on Coordinated Service Teams
  - If an individual enrolled in the Coordinated Service Team Initiative is involved with your agency, the expectation is that at least one person from your agency will serve on the Coordinated Services Team.
  - Participation on Coordinated Services Teams includes regular attendance at team meetings, participation in decisions, and involvement in the Plan of Care.
- Provide in-kind match costs for services outlined above (e.g. staff time and availability to participate on teams and committees, and meeting space for teams and committee meetings if needed.)
- Be involved in services such as referral, intake, assessment, collaborative case planning, service coordination and support response planning. This will entail the necessary sharing of information among CST Initiative members as authorized in Release of Information documents.

Richland County CST Initiative Procedures

Outreach: Richland County Health & Human Services will promote awareness of the CST Initiative in Richland County through community outreach efforts that may include community meetings, local media reports, the distribution of a CST Initiative brochure and ongoing communication between Human Services and potential community partners in the CST Initiative.

Referral: Richland County Health & Human Services will accept referrals from all appropriate sources: If you or anyone within an agency with whom you are working is considering making a referral and the individual meets these criteria, please contact a CST Service Coordinator at 608-647-8821 to begin the referral process.

Eligibility Criteria:

- Family resides in Richland County;
- Family has a child 0-18 years of age that is being served by at least two systems of care (including youth justice, alcohol and other drug services, mental health treatment, special education, child welfare services);
- Parent(s)/caregiver(s) are willing to actively participate in the CST process or at least learn more about the process;
- Family would benefit from services that keep the family intact or support reunification;
- Family is able to identify at least one goal.
- Family (with limited assistance) is able to identify someone who has had a positive influence on the family and/or is able to advocate for them;
- Priority for CST enrollment is provided to children who meet criteria as severely emotionally disturbed and also for children who are at risk of out-of-home placement or who are currently in out-of-home placement;
- No child or family will be excluded from participating in CST services due to the family's inability to pay for services or resources.

Intake: Richland County Health and Human Services CST program staff will, with 30 days of receiving the completed referral, approve or disapprove the referral for the CST Initiative. If the child who is involved in two or more systems of care and his or her family are found to be ineligible, or if it is determined that enrollment in the initiative is not the best method of meeting the needs of the child and his or her family, staff from the coordination agency shall assist the child and family in identifying and accessing needed services or resources from appropriate providers.

Initial Meeting: The Service Coordinator and any other appropriate party will meet with the parents/guardian in an initial meeting. This meeting will provide an overview of the CST process and identify possible team members. This will be an informal meeting that takes place wherever the parent/guardian is most comfortable. Discussion of the family's goals may also take place at this initial meeting.

Assessment, Collaborative Case Planning, Service Coordination and Support Response Planning: As part of the assessment process, the Service Coordinator or CST Facilitator will complete a Child and Adolescent Needs and Strengths (CANS) tool, which addresses many aspects of the individual's life, to identify the strengths and needs of the individual and family. CST Team members are identified and recruited to join the team. School staff, mental health providers and primary care providers, school resource officers, family members, friends, and Children and Youth Service workers are a few examples of possible team members. The family and individual identifies and approves all team members. The team then selects the top three priorities from the assessment summary and develops a Plan of Care to address these priorities. Each team also develops Support Response Plans to pre-plan crisis intervention with the people and/or agencies who may be involved in crisis resolution.

After the initial Plan of Care is completed, the team provides on-going support and monitoring, meeting as often as necessary to review the Plan of Care, ensure progress toward goals, and conduct plan modification as necessary. Once progress toward the goals set by the team is being made, the team develops a Transition Plan which focuses on long-term planning efforts to build/maintain self-sufficiency abilities after the formal Coordinated Services Process has ended.

CST team involvement is 9-18 months. Team members meet initially for 45 minutes to one-hour sessions approximately every-other week for the first two months of programming. After the Plan of Care is implemented, teams meet on average once every 3-6 weeks and later every 2-3 months as the team considers transition out of the formal CST process.

Designated Administering Agency

Service Coordination is provided by the administrating agency – Richland County Health & Human Services. The administrating agency also agrees to supervise the CST Service Coordinator. The Service Coordinator for the CST Initiative in Richland County can be contacted by calling 608-647-8821.

Interagency Conflict Resolution Procedure

All conflicts involving CST Initiative participants will be referred to the Service Coordinator, 608-647-8821, who will work with the parties involved to find a resolution. If unsuccessful, the Service Coordinator will make a determination and issue a written decision and provide a copy of the decision to the parties involved, as well as to the Coordinating Committee.

Parties may appeal the Service Coordinator's decision to the Coordinating Committee for consideration. The conflict will then be brought to the entire Coordinating Committee at the next scheduled meeting for discussion. If the party remains unsatisfied with the decision of the Coordinating Committee, the State Division of Hearings and Appeals may be contacted.

Conflicts regarding specific agencies or agency personnel should be referred to the specific resolution (grievance) procedure of that agency.

Interagency Information Release Authorization

Consent for release of information relating to a child shall be obtained from the child's parent, or the child, if appropriate or required by law. Results from all pertinent prior evaluations and assessments documenting the strengths and needs of the child enrolled in the initiative and his/her family, including educational, medical, vocational and psycho-social evaluations and assessments shall be gathered by the Service Coordinator or other appropriate party in order to effectively

serve the child and his/her family through the CST Initiative. Likewise, CST Initiative community partners will be asked to sign an information release form to facilitate communication among the various entities involved for programming purposes.

Role and Responsibilities of the Coordinating Committee

- Prepare the Interagency Service Agreement (renewed every year) for project partners; outlining the mission, vision, values and principles of CST, as well as expectations for partner organizations and agencies.
- Assess how the project relates to other programs providing service coordination at the county or local level and take steps to work with these programs to avoid duplication of services;
- Identify and address gaps in service;
- Establish and review operational policies and procedures and ensure they are monitored and adhered to. Examples include referral and screening procedures, conflict resolution policy, and flexible funding policy;
- Ensure quality, including consumer/family and agency partner satisfaction and adherence to program core values;
- Establish target groups to be served;
- Work to ensure that individual members act as liaisons between their organization and the initiative – sharing information on a regular basis;
- Regularly attend and participate in Coordinating Committee meetings;
- Oversee the development and implementation of the initiative;
- Develop a plan for orientation of new Coordinating Committee members to the coordinated services team approach;

Further, the Administering Agency and the Coordinating Committee will continually strive to provide ongoing training opportunities for members of the Coordinating Committee. These training efforts will serve to enhance the overall quality of the CST Initiative in Richland County.

In addition to specific duties as agreed to herein, agencies and individuals accepting membership as partners to the Richland County Coordinated Services Team Initiative accept and support the mission, values and principles and conditions outlined in this Interagency Agreement.

Further, participating CST members consent to provide information on available community resources known to them which could benefit participating families. Family teams will work together to determine how the needs, which may require some financial support, will be met via creative funding options.

Coordinated Services Team Initiative (CST)

Agency Partnership Agreement Rev. 08/17/2023

Instructions: A representative from the administration of each of the following agencies should read the entire Interagency Partnership Agreement, sign this form and return it to the CST Coordinator.

Richland County Services Team Initiative Members include the following:

Richland County Health & Human Services

Name	Representing	Street	City	Phone
Tricia Clements	Richland Health and Human Services	221 W. Seminary St.	Richland Center	608-647-8821

Revised: 08/17/2023

Richland County Health & Human Services

Agency Coordinated Services Team Partnership Agreement

_____ accepts and supports the mission, values, principles, and
(Agency Name)

conditions as outlined in this Interagency Agreement and commits to the associated responsibilities.

_____ _____
Name (please print) Title

_____ _____
Signature Date

_____
Business Address

_____ _____
Business Phone Business Fax

_____
Email Address