Community That Cares

System of Care Development and Implementation Manual

Community That Cares
serving Carroll, Lee, Ogle, and Whiteside Counties

Illinois Children's Healthcare Foundation

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TABLE OF CONTENTS

1 Introduction
2 1.0. Planning
3 2.0. Governance structure: decision-making and oversight at the system level
4 3.0. System management: day-to-day decision-making
5 4.0. Services
11 5.0. Workforce recruitment
12 6.0. Family involvement at all system levels
13 7.0. Youth involvement, support and development
13 8.0. Clinical staff involvement, support and development
13 9.0. Stakeholder and community orientation, training and communication
15 10.0. System-level advocacy
15 11.0. Financing
17 12.0. Information management
18 13.0. Quality improvement
18 14.0. Evaluation
20 15.0. Impact for children/families from the care system improvements
20 16.0. External technical assistance and consultation
20 17.0. Cultural competence
21 18.0. Sustainability/longevity of the leadership
21 19.0. Plans for preparing the next generation of system leaders

Appendices

23 A.1. Bylaws
29 A.2. CTC Leadership agreement
32 A.3. CTC Tier-based system of care
33 A.4. 0–3 Interventions
34 A.5. 3–5 Interventions
35 A.6. 6–11 Interventions
36 A.7. 12–18 Interventions

Introduction

The Children's Mental Health Initiative, Building Systems of Care, Community by Community (CMHI) projects funded by Illinois Children's Healthcare Foundation (ILCHF) represent diverse communities and therefore reflect diverse care systems. Though the systems are different, each community has attended to a similar set of processes to develop their system to where it is today.

This manual, a requisite project element, highlights the methods this community engaged in to develop their unique care system from the initiation to the conclusion of ILCHF funding. Each of the four community manuals include descriptions of the collaborative activity among the mental health, education, medical, and other community stakeholder systems. Each area represented potential barriers and innovations in the system. These processes reflect varying levels of adherence to the Child and Adolescent Service System Principles (CASSP).

1.0. Planning

1.1. Vision

Located in northwestern Illinois, the counties of Carroll, Lee, Ogle, and Whiteside form a rectangular geographic area located approximately 100 miles west of Chicago. Most of the area lies north of Interstate 88. The Mississippi River provides the western boundary for two counties, Whiteside and Carroll. Covering approximately 2,600 square miles with a population of about 160,000 individuals, the largest population density is located in Sterling/Rock Falls, with roughly 24,000 individuals. Collaboration among these four counties grew in the 1960's as a group of concerned citizens sought to develop a community mental health center as part of the Community Mental Health Act of 1963, which led to the incorporation of Sinnissippi Mental Health Center in 1966. Over the years there were cross county collaborative relationships developed among providers and with different groups coming together to address specific treatment or population groups. However, each of the four counties maintained their individual perspectives and county level priorities.

Various organizations and individuals which would later become part of the Community That Cares (CTC), a system of care for children's mental health, started to network in 2008 as part The Autism Program (TAP) of Illinois. Partners came together to assess the needs of children in our communities who were on the spectrum. The TAP planning group conducted community forums in several counties to gather input from parents, providers, and community resources with the hope of expanding resources and inclusion for individual and families. These collaborations aligned well with the Illinois Children's Healthcare Foundation initiative of 2009 to develop a system of care for children's mental health. Many key members of the TAP planning group became part of the CTC project at the county, as well as the larger system level.

The vision of the Community That Cares was to develop a system of care that would encompass children and families from prior to birth into adulthood. Input was included from members of an adult system of care grant also being implemented in the same four counties, supported by the Substance Abuse and Mental Health Service Administration (SAMHSA). CTC developed plans and structures to implement prenatal screening for mothers, and universal screenings for social-emotional concerns for all children in the four-county region. The first **vision statement** for CTC was:

> All individuals from conception through the lifespan living in Carroll, Lee, Ogle, and Whiteside County will be supported within their communities to reach their optimal level of development, health, and wellness.

The **mission statement** developed for the Community That Cares:

> The sustainable development of a system of care for children's mental health, which integrates promotion, prevention, screening/early identification, early intervention, treatment, and transitional care, and includes linkages with primary care providers.

In 2012, Kreider Services, Inc. (KSI), and key partners in the community and the CTC system of care, were awarded a Health Resources Service Administration (HRSA) Rural Health Network Planning grant, primarily to explore the service gaps of children with special needs. Then in 2014, a consortium comprising CTC members was awarded a HRSA Network Development grant to establish a pediatric developmental center for children, based on the findings and recommendations of the Network Planning Grant. Through the process of strategic planning, CTC realized that some children with special needs may not have been clearly identified within the larger system of care. As a result of integrating CTC with the Rural Health Network (organized as part of the HRSA grant process) the combined and **current vision** of CTC is:

> A collaborative community with children and families flourishing.

As part of the planning year in 2011, a total of 13 focus groups, multiple key informant interviews, and a 4,000 Household Survey of Family Needs were completed. The Household Survey evidenced concerns at the child and family system level. Parents reported being under a significant amount of stress due to financial concerns, parenting and children's behaviors, and other family relationships. Across 34 social, emotional, and behavioral conditions, parents identified their leading struggles as sleeping difficulties, feeling sad and depressed, and relationship problems. Among children 0-5, parents identified struggles with temper tantrums and difficulty focusing, while among children ages 6-18, parents identified struggles of difficulty focusing, trouble listening, and learning disabilities. Among youth reports found within the Illinois Youth Survey, nearly one out of three 6th graders reported significant symptoms of depression, with nearly 22% of Lee and Whiteside County 10th graders reporting they had seriously considered suicide over the past year (2008).

At the community systems level, results evidenced no consistent cross agency protocols or procedures, considerable fragmentation among child and family service providers, and no consistent protocols for screening children. No public schools (out of 84) were completing social and emotional screenings, and there was a lack of awareness of resources, limited communication across providers (particularly with primary care), poor access to assessment and treatment services, limited infant and early childhood mental health providers, and poorly coordinated positive mental health and prevention programing. These findings guided the development of the goals for the Community That Cares system of care.

1.2. Goals

The goals for the Community That Cares were developed to be consistent with the vision described above and included the following:

- Improve the early identification of children's needs through enhanced screening efforts
- Support families and providers through enhanced outreach and care coordination
- Provide comprehensive assessment and effective treatment services to children birth to 18 and their families
- Increase promotion of positive mental health and prevention initiatives and programming
- Maintain an accountable governance structure and increase community ownership of the system of care

The emphasis on prevention and early intervention was based in part on the model outlined in *"A Public Health Approach to Children's Mental Health,"* published by Georgetown University in 2010. As the only multi-county site within the ILCHF Children's Mental Health Initiative, CTC was challenged with implementing a system of care that would encompass approximately 38,000 children.

In addition to the specific goals of the project, and regardless of the challenges inherent in managing a large geographic area, there was broad support that all four counties remain part of the project, as the system of care grew. The four counties have been identified by the State as a catchment and Local Area Network for over 50 years. Even with the complexities of four counties, each with their own unique aspects, the CTC membership remained committed to maintaining all four counties within the system of care.

2.0. Governance structure: decision-making and oversight at the system level

One of the primary tasks of the planning year 2011 was the development of a governance structure and refining processes for offering screenings to and capturing data for up to 38,000 children. A Steering Committee, comprising 13 voting members and 8-10 associate members, was developed. Bylaws were adopted, and a governance structure was established. The Executive Committee worked to refine the implementation of the components of the system of care. Dozens of Memoranda of Understanding (MOUs) were completed with area obstetricians, pediatricians, and other healthcare providers; four health departments; early childhood providers; and many of the 84 schools in the area at that time. The design and implementation of the Family Care Coordinator Program, which was integral to many components of the project, was an essential part of the planning year.

CTC endeavored to bring a diverse and representative group of partners to the table. We approached the project with an attitude of inclusiveness for all child services entities and families. In order to strengthen local relationships, CTC engaged consultants and community champions for different sectors of the system of care. One consultant worked for the local Federally Qualified Health Center (FQHC) and two of the champions were area physicians. As the project grew in size and complexity, CTC added community coaches to focus on specific areas within the system of care. CTC recruited coaches for Community/Family engagement, Schools, and Primary Care. The community coaches assumed a leadership role within their areas of expertise and reported to the Steering Committee. The addition of community coaches provided the project director with additional support, while allowing more time to grow the system of care across the four-county area.

Each of the community coaches advocated effectively within their areas of specialty on behalf of CTC, being able to "speak the language" of each of their respective systems and organizations. Physicians helped persuade residents and fellow practitioners of the value of social emotional screening and the important role of the Family Care Coordinators. The Community/Family Engagement coach helped improved relationships with other agencies and advocated tirelessly for expanding youth and family services. One of the most helpful areas was the implementation of the School Coach. It became apparent that schools and mental health providers had differing organizational requirements and statutes, which made collaboration challenging at times. Having an individual who was knowledgeable about both systems facilitated the development of processes and protocols for the completion of social-emotional screenings and the submission of anonymous screening data.

As the system of care grew and expanded to include other resources, especially the awarding of four HRSA grants (2012, 2014, 2015, 2017), additional structures were developed to address additional oversight needs. This included the development of a consortium comprising three agencies to meet the requirement of the HRSA projects. The consortium board met separately but reported regularly to the CTC Steering Committee. For several years there were some duplicative processes, until the two systems were fully integrated in 2016, as the Northwestern Illinois Children's Care Collaborative. The flexibility of the CTC system of care supported the creation of a pediatric developmental center, the sustainability of the Family Care Coordinator Project, and the implementation of a pediatric patient-centered medical home.

3.0. System management: day-to-day decision-making

Sinnissippi Centers, Inc. is the designated financial agent for the Community That Cares project and is responsible for staffing decisions, providing systems management and day-to-day organizational decisions. There were five (5) full time staff and two (2) part time staff identified in the CTC project: the Lead Agent (PT), the Project Director (FT), four (4) Family Care Coordinators (FT), and a Parent/Family Engagement Coordinator (PT).

The Project Director is responsible for general oversight of the system of care:

- Monitoring and maintaining compliance with funding and oversight entities
- Interfacing with the Steering Committee, often in a leadership role
- Direct or indirect supervision of key project staff
- Building financial and structural sustainability
- Cultivating and maintaining community and system of care partnerships and relationships
- Ensuring the data collection for evaluation and quality improvement processes

The Lead Agent supervises the Project Director and actively participates in the CTC system of care. In situations beyond the scope of the Project Director and Lead Agent, the resources of the Sinnissippi administration and agency have been available to all project staff. In the absence of the Project Director or Lead Agent, other agency personnel are identified to act in their stead.

4.0. Services

4.1. Service array (types of services allowable, for whom, and under what conditions)

POPULATION SERVED

All children and families within the counties of Carroll, Lee, Ogle, and Whiteside are part of the population included in the scope of the system of care model. The Community That Cares initially sought to provide early screening and identification for social, emotional, and behavioral concerns for youth, beginning prenatally and continuing throughout adulthood for the population of all four counties. CTC also provided supportive services utilizing Family Care Coordinators to assist with referrals and linkages for any family that struggled with a social, emotional concern. During the first year of project implementation (2012), it became apparent that the resources available to the project did not support the breadth of these services goals. Prenatal screenings continued to be provided as part of specific area home visiting programs, such as Healthy Families Illinois, but it was not feasible to implement throughout all four counties. Building an integrated system of care for the lifetime of area residents remained an aspirational goal, but CTC elected to focus screening efforts on youth from birth to age 18.

SYSTEM/COMMUNITY DEVELOPMENT

With the assistance of community champions and coaches, several work groups were developed to improve planning and services for area youth.

- One of these groups, Sauk Valley STARS, comprises early intervention community leaders, which include Child and Family Connection, Parents as Teachers, Head Start, Early Head Start, pre-schools, Healthy Families, and 4 C's. This work group continues to meet every other month to discuss the needs of their agencies, clients, and how they can support each other without duplicating efforts.
- The school work group focused on school engagement, which was a significant undertaking with over 80 individual schools within the CTC area. The school work group comprised a group of school counselors and social workers that were supportive of implementing social-emotional screenings and hoped to expand social-emotional learning resources for their respective schools. The group met to address challenges during the implementation process, discuss various screening tools, and help with the submission of anonymous screening data to CTC. The School Coach actively supported the work of the group, helped develop spreadsheets for scoring and tracking screening data within each school setting, and advocated for the expansion of social-emotional curriculum. Resources from the CTC project helped provide Second Step curriculum to districts through the four counties. The School Coach also implemented a Counselor Academy that continues to meet twice during the school year. The Counselor Academies provide ongoing training, CEUs and CPDUs, as well as a forum for discussing local concerns.
- Staff from the University of Illinois partnered with CTC to provide Youth Mental Health First Aid training through the four counties. CTC has been able to provide the majority of these trainings at a reduced cost to participants, with support from ILCHF, the Savanna Women's Club, and the Ogle County 708 board.

CARE COORDINATION—THE FAMILY CARE COORDINATOR PROGRAM

- **Family support.** The Family Care Coordinator program was first envisioned to provide shorter term support of 30 to 90 days of service. The expectation was that FCC staff would meet with the family, screen for social-emotional concerns within the entire family, make referrals, and provide needed linkages. As the program evolved, it became apparent that this model was not meeting the needs of many families who struggled with chronic stressors and multigenerational social, emotional, and/or behavioral concerns. The FCC staff often provided more than 30 to 90 days of services. In order to help build sustainability, CTC assisted one or more family members to become clients of the community mental health center, if indicated, in order to be eligible for Medicaid or other payment options.

- **Leadership/community integration.** The FCCs assumed leadership in developing and chairing community level child and family teams. This team encompassed the service providers and front-line staff of each of the individual communities. The CTC SOC respected the limited amount of time front-line workers have to participate in meetings. The decision was made to combine meetings, as much as possible. The Whiteside county team merged their meeting with the Local Interagency Council (LIC). The Ogle and Carroll Counties child and family teams continue to run monthly. The Lee County child and family team struggled getting started, so they merged with the LIC/Whiteside County child and family team. FCC staff continues to attend meetings when available in Lee County, such as an interagency group that meets periodically. The goal of these meetings is to offer education to the team members, report/update on what each individual agency is doing, collaborate, problem solve, and maintain/grow the system of care. Family care coordinators also provide community education about the FCC program and CTC system of care. One of the ways that they accomplish this is by attending other community meetings and by participating in a number of community events. The FCC in Carroll County, for example, attends three other community meetings on a regular basis.

EARLY CHILDHOOD MENTAL HEALTH SERVICES

CTC was able to expand early childhood mental health services with support from the ILCHF grant. For the first several years of the project, three staff provided primarily home-based services to children under the age of five. An infant mental health consultant was available to provide support and consultation to staff. A clinician with a certificate in play therapy was team leader for the early childhood providers and services were given in all four counties. As the financial support from the grant was gradually reduced it was not possible to sustain home-based service provisions throughout the entire geographic area. One parent educator is trained in the Circle of Security and provides these services on a case-by-case basis. At present, early childhood mental health services are primarily available in Ogle County. Early childhood mental health services, especially for birth to three, remains an ongoing need within the communities.

FAMILY ENGAGEMENT/PARENT COORDINATOR

Family engagement has been an important part of the CTC vision. With several staff trained to be leaders in Parent Cafes and Parenting Journey, numerous community-based events occur on a regular basis. A number of community members have been trained as Parent Café facilitators and regularly conduct Cafes throughout the four counties. With the support of other agency organizations within the system of care, family engagement remains an active part of CTC. A local church supported the development of several parent support groups that have become self-sustaining. Family engagement activities are offered throughout the four counties, often in in partnership with local schools.

SPECIALIZED ASSESSMENT SERVICES

As the system of care has continued to evolve, CTC/Sinnissippi became part of a consortium that received a HRSA Network Development grant in 2014 for the implementation of a pediatric developmental center, Florissa. The presence of a pediatric developmental center in this area has enhanced specialized services to children and families by providing psychological assessments, autism evaluations, and counseling services. Florissa's board is made up of members from Kreider Services, KSB Hospital, and Sinnissippi Centers. The center is now integrated on site at a KSB clinic which houses several pediatricians. CTC has provided care coordination, counseling, sibling groups, and parent cafes at the on-site as well. Florissa is sustained through client fees and fund raising, foundations, and United Way.

MENTAL HEALTH ASSESSMENT AND TREATMENT SERVICES

Children and families who reside within the four counties are supported in accessing mental health and substance abuse services at the provider of their choice. Sinnissippi Centers is a community mental health organization providing a comprehensive array of outpatient mental health, substance abuse, psychiatric, and crisis intervention services. Other behavioral health and/or substance abuse service providers,

which serve children and families within the system of care, include the Federally Qualified Health Center (FQHC) located at the Whiteside County Health centers, Lutheran Social Services of Illinois, Florissa (pediatric developmental center), Katherine Shaw Bethea Hospital system, and a number of private practitioners. There are no pediatric psychiatric inpatient beds available within the four counties.

4.2. Provider network

The provider network for the Community That Cares encompasses resources throughout the four counties. The provider network was organized at the cross-county level to encompass the Steering Committee with 13 voting members and an additional 8-12 associate members to reflect the composition of the area. Representation at this level included Sinnissippi Centers mental health centers, Tri County Opportunity Council, University of Illinois School of Medicine local evaluators, Juvenile Justice, Juvenile Probation, Public Health, the Department of Children and Family Services, Special Education, Lutheran Social Services of Illinois, and the Convener of the Local Area Network. Members at large included representatives from the faith-based community, parent partners, early childhood organizations, and additional local service providers. Each county identified key partners from public health, education, and other child serving entities. Monthly meetings were established for the Steering Committee and the county teams. The Executive Committee met several times a month during the planning and implementation years. Well over 100 community partners have been identified as participating in the system of care at the cross county, county, or local level. Establishing MOUs during the planning year and initial implementation years was essential for implementing and collecting data from the multiple screening locations.

Beyond the CTC Steering Committee, work groups, and county level teams, CTC participates in many community events through-out the four-county region. The Whiteside County Care Coordinator developed a unique community event in Whiteside County, called the "Taste of Fiesta." Taste of Fiesta brings together services providers for children and families, with a designated area for early childhood providers to present the array of services available to the community. The "Early Childhood Court" was located in a large gazebo where all early childhood providers had booths showcasing services. Each provider has literature about development and growth for parents and games and prizes for the children. "Taste of Fiesta" invites vendors of all kind. The event showcases local Hispanic culture and offers food, music, dancing, and bilingual presenters. The event offers education, support, and stigma reduction. Taste of Fiesta is now a 501C3 and takes place annually.

The first Taste of Fiesta in 2012.

Taste of Fiesta "Kid's Court" in 2017.

With the support of CTC, the school coach developed a learning opportunity for school counselors, called the Counselor Academy. Speakers are provided to address areas of interest to the school counselors, and CEUs are provided for attendees. Presentations have included play therapy, the impact of trauma on brain development, learning and behavior, suicide assessment, anxiety, ADHD, LGBTQ concerns, crisis intervention, and many more topics and areas of interest. The Counselor Academies provide an opportunity

Play Therapy training at the Counselors Academy.

for networking and sharing among school counselors, social workers, and other social services providers. Areas of interest for discussion and presentation are elicited from local counselors. Now in its fifth year, the Counselor Academy occurs in the fall and spring.

In 2015, Morrison CUSD 6 was awarded a grant to implement school-based behavioral health services within their school district. The expectation was that a behavioral health counselor from the community mental health center would be self-sustaining at the end of the academic year. The project successfully navigated the systemic differences between school counseling and onsite behavioral health services and was able to demonstrate ongoing financial and service sustainability. School-based behavioral health services are now being provided on-site in five districts across 14 separate school sites, with ongoing conversations for additional expansion.

4.3 Meeting basic needs

Many families that require help with meeting basic needs are referred to the Family Care Coordinator program. The system of care partners in all four counties have come to know that Family Care Coordinators provide ease of linkage to the program and minimum wait times. Due to their knowledge of each geographic location, FCC staff has identified both formal and informal resource networks. They have been able to locate scarce resources, including an air conditioner during a heat wave when everyone was sold out.

There are times when food banks, rent/mortgage assistance, and access to transportation continue to be a struggle in our area. Housing for individuals with a felony history remains a challenge. Access to convenient transportation is an ongoing issue. Even though each county has a transportation system, scheduling appointments for children can be cumbersome.

The Community That Cares partners continue to identify linkages with area resources as a high priority for children and families. Sharing of resources is a regular agenda item on county team meetings. The role of the Family Care Coordinators has been supported through additional grant funding (HRSA) and incorporated into other contracts (DCFS). Under some circumstances, care coordination and/or case management may be reimbursed by Medicaid. The existing Care Coordinator staff has expanded their roles and generated additional Medicaid revenues.

4.4. Evidence-based practices

- Response to Intervention (RTI)—in collaboration with schools
- Second Step Social Emotional Curriculum—provided to schools
- Youth Mental Health First Aid—community-based
- Parent Café/Strengthening Families—family engagement
- Circle of Security—early childhood mental health
- Care Coordination—Family Care Coordinator Program

4.5. System access

Families may enter the system entry at any point, from any referral source: schools, community members, self, primary care, and any child-serving organization or program. Early on in the development of the system of care, partners agreed that there is no "wrong door" for accessing services for children and families. A one-page referral form was developed and shared with the community to facilitate referrals.

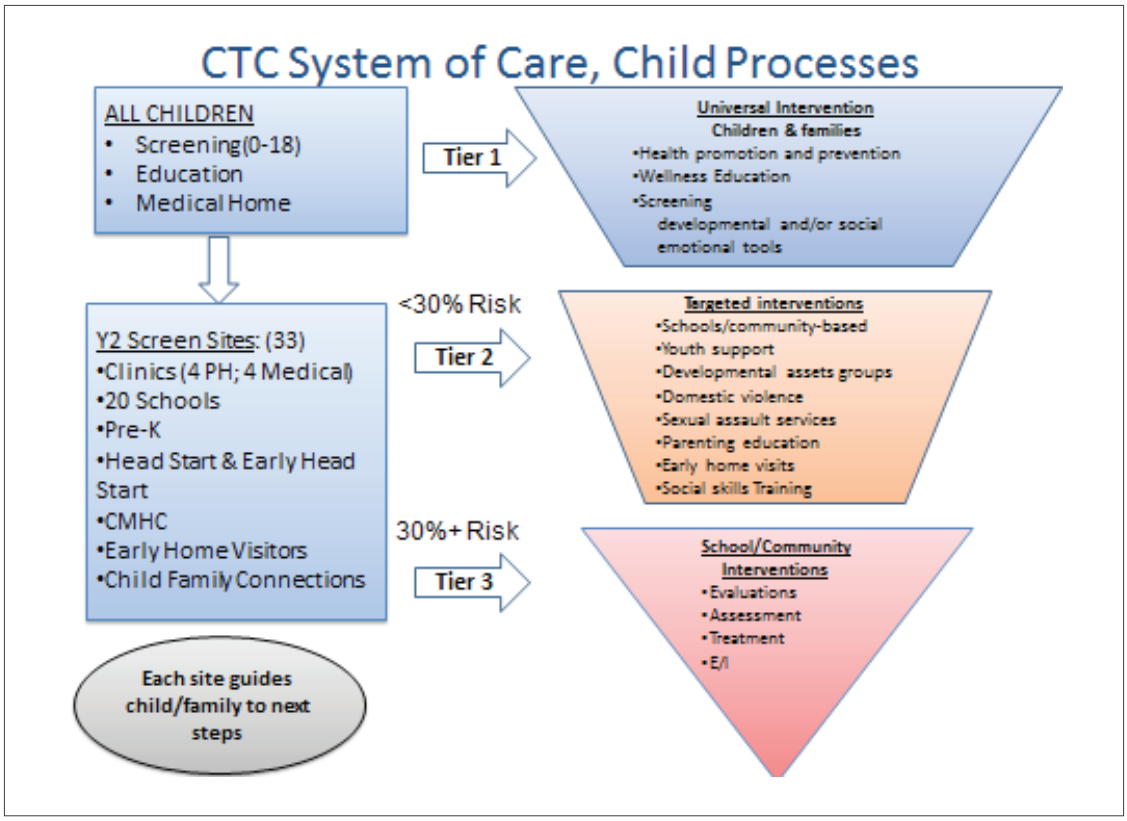
4.6. Screening, assessment and evaluation

Screening is provided at multiple levels and locations within the CTC area. A number of schools have elected to provide annual social-emotional screenings. Most schools have elected to use the Pediatric Symptom Checklist (35) although some have implemented the SSIS. Each school has developed its own protocols for responding to positive screenings, based on a tier system. Tier 1 applies to all children who receive universal interventions, education, and support. Tier II reflects children identified with some concerns, who may benefit from linkage to community or school-based additional supports. Tier III youth often require additional assessment or evaluation. The school counselor, social worker, and/or administration decide if concerns are best addressed at a level one intervention, as part of the school program, or if a recommendation for a referral should be made to the parents. Student needs may also be evaluated and addressed through additional assessments, a 504 plan, or an Individualized Education Plan (IEP).

Most pediatricians and early childhood programs complete developmental and social-emotional screenings, utilizing Ages and Stages or the DIAL. Healthy Families Illinois (HFI) and Parents as Teachers administer the 4PsPlus prenatally. Each provider or program determines what recommendations are made to parents. Many primary care providers refer to the Family Care Coordinator program and rely on the FCC staff to make referral and linkages to community resources.

4.7. Decision-making at the service delivery level

CTC, with clear input from area partners, chose to keep screening data provided to the system of care anonymous. This allowed our partner, client, patient, and/or student data to remain confidential. CTC developed flow charts as suggested guidelines for partners who agreed to provide social-emotional screening. Memoranda of Understanding have been signed with all screening sites, identifying the decision tree individually based upon a tier system. The basic level includes universal interventions, such as after school programs, Scouts, and mentoring; the highest point on the tier model could be residential placement. Below is an example of the CTC System of Care Child Processes.



4.8. Care management/coordination

The Family Care coordinator (FCC) program has evolved since the implementation of the system of care model in 2011. At the beginning of the project, FCC staff accepted referrals from all partners and community sources. The referrals were not required to be Sinnissippi Center clients. At this point, the protocol was for FCC staff to meet with a family, identify needed resources, provide the appropriate linkages, report back to the referral source, and move on to the next referral. The process of identifying the family's needs included offering screening tools to all family members, discussing the needs of the family, and together with the family, developing a family care plan. The expectation was that the Family Care Coordinator would meet with the family and complete the process within 30 to 90 days.

During 2012, the first year of implementation, it became apparent that 90 days was not long enough to provide support and complete the linkages that many families needed. Often families referred by the community were experiencing chronic stressors and had a history of multigenerational trauma and challenges. Some families struggled to maintain linkages to the identified resources without ongoing support and encouragement. The Family Care Coordinator staff had more flexibility than many agency-based services and was able to meet families in the home at non-traditional times. Some families experienced re-occurring periods of stress and required intermittent, but ongoing, support from the Family Care Coordinators.

CTC now recognizes that the FCCs play an important role in assisting families to follow through with recommended and needed resources. Not all families have the capacity or willingness to link quickly to a variety of services. Some families have had negative experiences with service providers in the past and are mistrustful of "the system" in general. The current Family Care Coordinator program continues to accept referrals from our partners and community resources. They offer social-emotional screening tools to all family members. We also ask the parents to participate by completing the Protective Factors Survey. The FCCs remain engaged with some families far beyond 90 days in order to establish trust and assist the family in completing successful linkages.

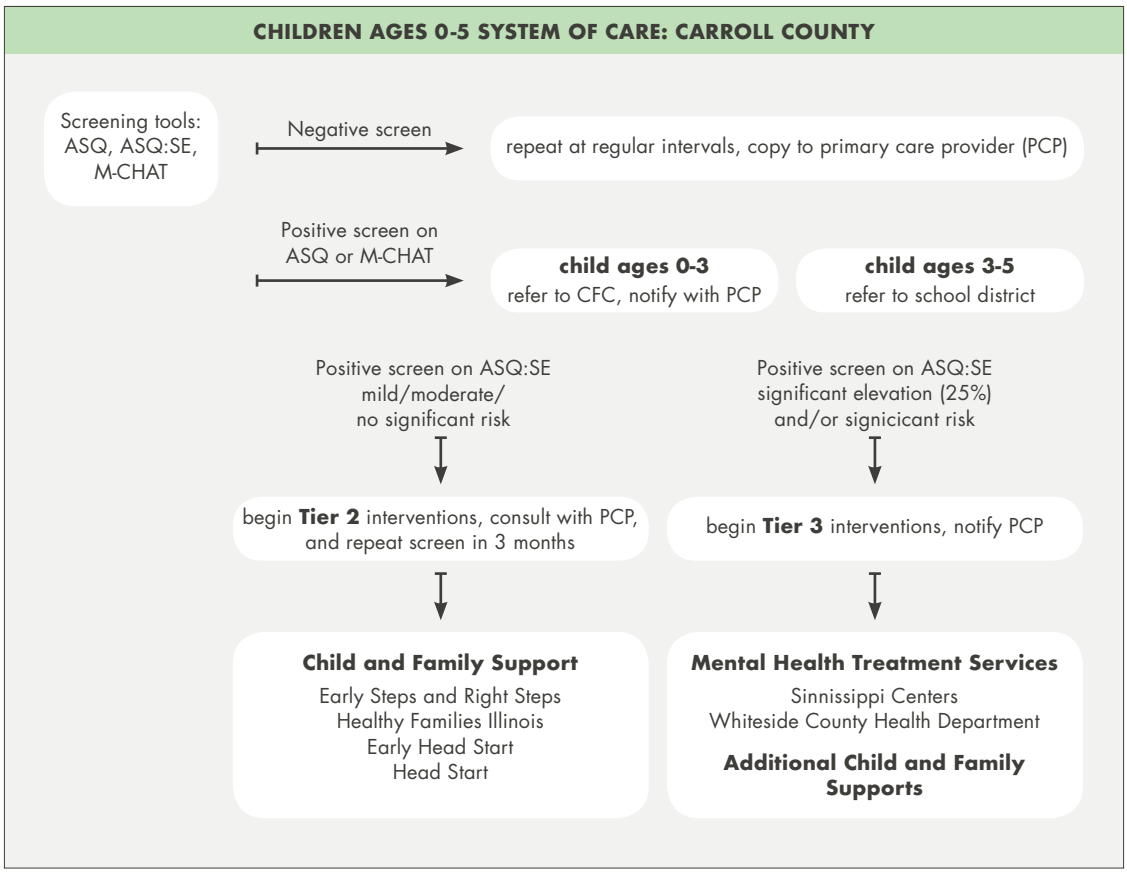
4.9. Crisis management at the service delivery level

CTC provides a range of crisis services in addition to the 24-hour crisis services provided by Sinnissippi Centers. CTC offers on-site crisis intervention and supportive services to organizations that have suffered traumatic events, such as suicide, death of teachers or students, attempted school shootings, accidents, or other community events. CTC has also provided Suicide Awareness, Prevention, and Stigma Reduction presentations to area high schools on a regular basis, reaching well over 1,000 students.

4.10. Crisis management at the system level

The Community That Cares has experienced several systemic crises. During Year 1 of Implementation (2012), the project grew rapidly. The needs of the various components of the system of care became challenging for the Project Director to manage effectively. This led to a modification of the project design and the expansion of leadership through the involvement of community level coaches. A coach was identified for specific areas within the larger system: primary care, schools, family engagement, and community development. The coaches coordinated their activities with the Project Manager. This diversification of leadership provided better collaboration and improved relationships with each of these sectors. During Year 2 of Implementation (2013), the lead agent and the project director left the agency for new challenges within six months of each other. One of the original architects of the system of care project was available to assume the role of lead agent/project director. Together with the assistant project director, the project continued to grow. The development of the NWILCC Consortium, the Rural Health Network established by the receipt of several HRSA grants, and the ongoing involvement of the community coaches diversified the leadership within CTC.

The CTC procedures and processes have been clearly documented. A Data Dictionary has been created for each spreadsheet and document for which data is collected. Flow charts have been developed to illustrate various steps in the reporting process. See "Children ages 0-5 System of Care Carroll County" below as an example.



5.0. Workforce recruitment

The staffing plan for the CTC system of care began with the lead agent, project director, four family care coordinators, and a parent coordinator. The first project director and lead agent were an integral part of writing the original grant application. The care coordinators and parent support coordinator were hired/reallocated during at the end of the planning year, 2011. An early childhood clinical position was added during the first year of implementation, 2012. During the first year of implementation, the decision was made to modify one of the family care coordinator positions to an assistant project director to better manage the scope of the project. The family care coordinator who became the assistant project director accepted an external position in 2013, and the position was filled from within Sinnissippi Centers.

CTC has had two previous project directors, one previous lead agent, and four family care coordinators since the beginning of the project. Based on utilization of services, we decided that there was not a need for four (4) family care coordinators. The original staffing plan included a family care coordinator for each county. Due to the difference in county populations, three care coordinators were able to respond to family referrals. The fourth position was transitioned into an assistant project director/team leader.

The original project director and lead agent left the organization within six (6) months of each other, as the project was ending its second implementation year (2013). The first project director was effective in establishing community partnerships and in nurturing the growth of the system of care from inception. The fiscal agent hired a second project director who had an education background and who worked

effectively with the school coach. This helped expand the scope of engagement with a number of schools. The second project director moved on after six months. The assistant project director was promoted at that time and continues as the project director.

As the project evolved, differing skills were needed for the growth of the project. During the planning year, it was essential to have the ability to make personal connections with a wide variety of community members. As the project grew rapidly, it was important to have the ability to delegate and modify the original model to accommodate multiple demands. The community coaches were part of this evolution. Sustainability became the primary focus at the end of year two. The CTC model was initially funded for only three years of implementation. With the focus on sustainability, other skills became helpful: fundraising and grant writing.

The original design for the FCC program called for staff that had strong connections to the community but who did not necessarily have previous clinical background or experience. Because the FCC staff received many challenging referrals that were not able to be successfully managed within 90 days, the program evolved to incorporate not only care management but skill teaching, parent education, and periodic crisis management. With the support of a three-year HRSA Outreach grant, the FCC program was able to focus on families with many challenges who were often difficult to engage in services. The present model allows the FCCs to work with the families as long as is needed to successfully engage them in needed services and resources. The FCC staff often becomes part of the family's treatment team. This has resulted in FCC staff learning new skills in order to provide service that is eligible for reimbursement through Medicaid, managed care, or other third-party payers. Three of the original FCC staff have moved on to other positions or challenges. The fiscal agent filled these positions.

CTC, in partnership with the Rural Health Network, successfully developed a Pediatric Developmental Center (Florissa), with the support of a HRSA Network Development Grant. This brought a registered psychologist, doctoral level interns, and post-doctoral PhDs to our area, greatly expanding the professional resources available to the community. Florissa provides comprehensive specialized assessments for children far beyond the four counties that comprise CTC.

In general, CTC and partners have struggled in recruiting professionals. The CTC community has only one practicing psychiatrist, recently hired by a local hospital. He does not see children. Telepsychiatry is utilized by hospitals and the community mental health center in this area to meet these needs. There is a waiting list for Early Intervention speech therapy, social-emotional therapy, and occupational therapy. It is difficult to recruit master's level clinicians and social workers at the community mental health center. Schools also have experienced challenges in recruiting social workers and counselors.

6.0. Family involvement at all system levels

While parent involvement is a core value of the CTC system of care, it has been challenging to have parents, who are not Sinnissippi employees, attend the Steering Committee on a regular basis. Some of the families that we work with have jobs during the day or struggle with multiple demands and are unable to participate consistently.

Another barrier to parents attending the Steering Committee meetings is the focus on higher level systems issues, such as funding, grants, and interagency communication. The system of care is addressing this with a different strategy. Parents appear to be more comfortable actively participating with the parent engagement work group. Three parents are participating actively with the work group. They meet regularly and are working on different ways to involve parents in the system of care.

Parents are asked to complete social, emotional screening tools for their children at many different service providers, i.e. pediatrician, school. The families have welcomed the FCCs into their homes, have participated in Parent Cafés and/or Parenting Journey, and many have follow through with the linkages recommended by the family care coordinator.

7.0. Youth involvement, support and development

There has been limited direct youth involvement in the development of the CTC system of care. However, youth are involved by participating in the FCC program and by completing the screening tools. Youth are actively engaged with the FCCs and help to determine the family care plan. While CTC and NWILCCC believe youth involvement would be a benefit, it has been difficult to achieve due to transportation struggles in our rural community.

8.0. Clinical staff involvement, support and development

The project director and Steering Committee have identified the structure and protocols of the Community That Cares programs and staff. The project director oversees the training of the FCCs and helps establish expectations, along with the fiscal agent, Sinnissippi Centers. The lead agent, project director, and FCCs provide education and presentations to partners, community members, schools, and community organizations.

The minimum educational qualification for the FCC position is a bachelor's degree in a human service or education-related field. Additional orientation and training were provided through shadowing, clinical supervision, online training, and other internal and external training opportunities. FCC staff was trained to administer the screening tools utilized by CTC. FCC staff was familiarized with area resources. Staff was also provided training in their particular areas of interest. One staff member became a Youth Mental Health First Aid trainer. Several others became Parent Café facilitators.

Mayfest in Mt. Carroll, IL 2014.

As the FCC program has evolved to provide ongoing support over time to families who may have experienced trauma or have significant mental health or substance abuse concerns, additional training and support has been provided to staff. The FCCs were exposed to staff with more clinical skills, and they shadowed other service providers to learn these skills. In order to be sustainable, staff learned to comply with Medicaid documentation requirements.

The FCC staff continues to refine these skills and participate in regular supervision.

The skills of area clinicians and administrators have been enhanced through trainings in early childhood development, brain development, and various child and trauma-focused interventions provided by NTI.

9.0. Stakeholder and community orientation, training and communication

As a rural area with limited resources and relative stability of agency and staffing, there were existing networks, both formal and informal, within the four counties of this project. Sinnissippi Centers, Inc. had identified the counties of Carroll, Lee, Ogle, and Whiteside as the focus of the development of a community mental health center, using funding from local county 708 boards in three of the four counties. Lee County Public Health Board later became part of the funding and support structure for community mental health. Other organizations, such as LSSI, Kreider Services, and KSB and CGH hospitals have strong roots in our communities. With distinct, but overlapping missions, organizations and individuals were occasionally competitive, but more often collaborative in working together on behalf of the members of these counties.

Over the years efforts such as the Local Area Network (LAN), county level court collaboration (1500 Boards), and other initiatives offered opportunities to partner. In 2012, Kreider Services, Inc. (KSI) received a HRSA Rural Health Network (RHN) Development Grant to explore the needs of the community on behalf of developmentally challenged individuals and their families.

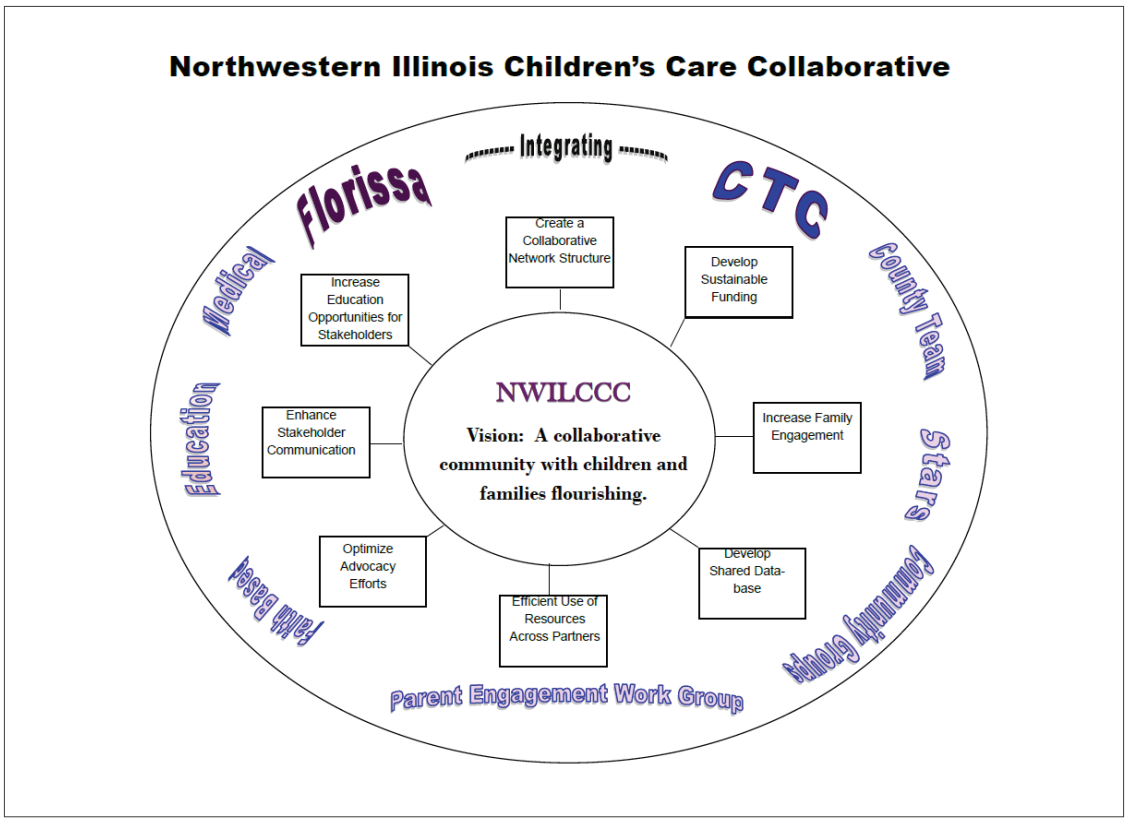
In 2010, SCI was awarded the planning grant that was to become the Community That Cares (CTC). Many individuals and organizations involved in the RHN planning process were also part of the executive committee that developed the Steering Committee for CTC. The opportunity to develop a comprehensive children's mental health system, including families, pregnant women, newborns, early childhood, and all types of developmental, social, emotional and behavioral health care needs of youth, ranging from prevention to treatment, became the focus of the ILCHF CMHI CTC initiatives.

Building on the strength of the first Rural Health Network Planning Grant, and the ILCHF CTC support, a HRSA Rural Health Development Grant successfully brought a Pediatric Developmental Center to the area, as part of the growth of our system of care for children. Additional funding through ILCHF offered support to two important components of our system of care, with one-time only resources for Florissa (PDC) and a school-based behavioral health counselor pilot project. Both these projects continue to grow. Florissa appears to be well on the road to sustainability with the ending of the HRSA Development Grant. The school-based behavioral health counselor model is being replicated in other schools within Whiteside, Ogle, and Lee counties.

Family Care Coordination is another important component of our system of care, as is finding ways to make it financially sustainable. Early ideas for having other providers contract for and fund a portion of the service were not viable. Efforts were directed at locating other funding sources and making the services Medicaid eligible. Another Rural Health Services Administration (HRSA) outreach grant was awarded for care coordination, which provided another three years to work towards sustainability. The care coordination program itself became a recognized and highly utilized resource, often reaching out to children and families when the situation did not meet the parameters of another program. A HRSA Care Coordination Outreach grant allowed the system of care to reach out to challenging and hard-to-engage families who required long term support.

With the range of initiatives being provided as part of the system of care, from education, prevention, promotion, early intervention, screening, early childhood, social-emotional development, tier-based intervention, care coordination, and assessment and treatment in four different counties, the community does not always know who is making suicide awareness presentations in the schools, engaging screening sites, providing Parent Cafes, offering family care coordination, bringing in educational offerings, and offering a range of assessment and treatment services. Yet, these are all reflections of the successful growth of the system of care for children's mental health in Carroll, Lee, Ogle, and Whiteside counties.

Various funding entities have required consortia, advisory committees, boards, and community input. In order to accommodate and incorporate the RHN, the Florissa consortium, and CTC the Northwestern Illinois Children's Care Collaborative was formed to encompass all these entities. When asked to explain who we are, we will refer to the graphic below, give a brief overview of the journey, and say we are a system of care to improve services for children. The system of care has goals, work groups, and monthly meetings to keep the system moving forward.



Communication occurs on multiple levels. There are county level groups that regularly share information with each other. The community-wide group meets quarterly and has a large email listserv that is utilized to share information, events, and training opportunities throughout the four-county area and beyond. We have started to use technology, including GoTo Meeting and Google Calendar, to post and share information, as well. Individuals who are expressing an interest in one of the systems of care and one of the work groups are invited to join the monthly meetings to provide additional training and information. However, we are finding that while the existing network remains viable and engaged, time is often limited due to funding and budgetary struggles.

10.0. System level advocacy

The lead Agency, Sinnissippi Centers, Inc. (SCI), is a member of several professional organizations, including CMHA, IABH, and The National Council and is active in many advocacy efforts to enhance services for children and families. SCI has also partnered with other providers at the state level to advocate on behalf of children and families during the last two years without a state budget. At the local level, members of the system of care have made combined funding requests to area resources, presented jointly at community events, and supported each other at local 708 and 553 board presentations. One 708 Board has a separate line item for CTC initiatives. ILCHF has been a significant resource for connecting CTC with resources for advocacy, such as the Sargent Shriver National Center on Poverty Law.

11.0. Financing

11.1. Purchasing/contracting

The first year of the project, SCI used funds to support community development mini RFPs; after the first year, efforts were refined to support social-emotional curriculum in area schools. Schools were provided with Second Step curriculum, as part of the engagement process to submit screening data. CTC spent approximately $50,000 over the course of the project to provide social-emotional resources to area

schools. As part of the project, CTC also contracted with the Whiteside County Health Department to have an APN assist with the planning process. As managing the expanse of the project became more complex, CTC added coaches who were contractual providers: community coach, medical coach, and school coach. The last two years, the school coach has been the primary contractual resource. CTC utilized contractual help with for marketing and developing resource materials. Additional funds were utilized for brochures and promotional materials. CTC covered expenses for two staff to be trained in Youth Mental Health First Aid, as well as for two care coordinator staff to receive training on recognizing and working with individuals with personality disorders. Walmart $10.00 gift cards were purchased for cohort participants to complete the PRQ and CBCL.

11.2. Provider payment rates

Sinnissippi Centers is a licensed MRO and DASA provider and is able to bill most insurance companies. Revenues from Medicaid are limited by statute; an add-on rate has been approved for the past year. Reimbursement rates vary by insurance provider. SCI has had limited involvement with MCO entities during the course of the grant. SCI has also actively participated in efforts to obtain the 1115 Waiver for the state. Approximately 70-80% of children and families served through the FCC component and other clinical services are Medicaid eligible. Effective April 1, 2018, all Medicaid recipients in the four-county area will be enrolled in an MCO.

11.3. Revenue generation and system reinvestment

The primary sources of revenue generation have been through Medicaid reimbursement and other client funding sources. CTC has formed a consortium with Kreider Services, Inc. and KSB hospital to collaborate on grant applications. Through this partnership, approximately two million additional dollars has been added to our system of care over the past seven years. ILCHF grant funds provided support for the FCCs until December 2014. A HRSA Outreach Grant has provided funding for the FCCs since May 2015. Now in year 3 of the HRSA grant which began May 1, 2015, efforts are increasing to make the FCCs fully sustainable by April 2018. Through our improved relationships with schools, and additional funding though the ILCHF, a model for providing school-based behavioral health care services has been developed and is being replicated in other schools. One of the local 708 boards has added additional funds for CTC. There is enhanced collaboration at multiple levels in our communities, not only with children's services, but with increased partnering with law enforcement, primary care, and other service agencies.

11.4. Billing and claims processing

Business and IT components are part of the SCI organization. The organization is able to track services delivery and submit billing and claims to multiple funding sources. Medicaid is a primary source of revenue for the agency, and as a licensed MRO provider, claims are submitted electronically. The agency also utilizes an insurance eligibility clearing house to obtain current information for insurance billings. SCI is on the provider panels for many commercial insurance entities. Due to our rural status, we were not included in the first round of MCOs; however, effective April 1, 2018, most Medicaid recipients in this area will be assigned to an MCO. We have had challenges in obtaining single provider exceptions when servicing clients who have MCO coverage from outside our area. Making clients fully eligible for Medicaid reimbursements is a challenge for FCCs. The FCCs are not trained clinicians and are not able to complete the mental health assessment and treatment plans required for billing. Part of the sustainability plan moving forward is to identify ways to increase Medicaid revenues for the FCC services.

Although SCI has a functional billing and claims process, we have encountered challenges in trying to integrate billing functions across agencies. Florissa, the pediatric developmental center, which is part of our system of care with a key consortium of three different entities, has not been able to develop a mechanism for billing within the three systems (MRO Rule 132, Primary Care, and DD services). Funding streams and billing requirements remain siloed and complex.

11.5. Utilization of ILCHF grant funds over time

Funds from the CMHI have been utilized in many ways to enhance learning and collaboration among schools, primary care, child serving entities, and the community. Some key benefits from the support of ILCHF over time:

- Planning/Early Implementation
  - Funding during the planning year was used to engage the University of Illinois as our evaluator. As part of the planning year, a community survey was completed which was used to guide the growth of the project.
  - Funding supported the staff and consultants who were needed to develop and implement the multi-county rural model, which became CTC, including forming the Steering Committee, implementing bylaws, and developing county level teams.
  - Resources from ILCHF, including NTI Upstream consultation, provided high level consultation, education, and training.
  - A local and cross site evaluation process was developed.
  - Community was engaged through mini RFPs, marketing materials, brochures, and community presentations.
- Implementation
  - ILCHF funds supported several key staff positions during the first several implementation years, including project director, family care coordinators, parent support coordinator, and early childhood mental health clinicians.
  - Funds were also critical in purchasing social-emotional curriculum for schools, which often became the mechanism for developing MOUs for schools to complete and submit anonymous screening data.
  - ILCHF funding provided support to engage community coaches to help manage the growth and diversity of the project.
  - Funding from ILCHF provided support for the evaluation components, and materials for tracking the cohort.
- Transition to sustainability
  - As parts of the system of care moved towards sustainability, ILCHF funds gradually decreased but continued to support key components of the project, including the project director, project lead, and a portion of the FCCs, the community coach for schools, and the parent support coordinator.
  - A portion of ongoing funds has also been utilized for purchasing social-emotional curriculum for more schools.
  - Ongoing evaluation and reporting requirements of the grant were met.

12.0. Information management

12.1. Protecting child/family privacy

- All SCI staff are trained periodically in HIPPA, Illinois Confidentiality Act, and how to complete compliant release of information forms for any clinical services. A multi-agency ROI developed by another CMHI site was adapted for use with CTC.
- Information provided by screening sites was submitted anonymously. This was a particular concern of schools that didn't want their schools possibly receiving a negative impression due to variability in screening results differing between schools.
- If a referral was made to the FCCs or other clinical services, a compliant release was completed prior to sending information to the referral source, other than referral completed or not completed.

12.2. Sharing information between systems

While the value of sharing information among providers is a core component of the system of care, consistent with models of child family teams and WRAP, any information about clinical services requires fully compliant releases of information. Sharing anonymous screening results was accomplished using Memoranda of Understanding (MOUs). The CTC Steering Committee and county level teams became clearing houses/listservs for sharing information about trainings, community events, Parent Cafes, and other items of interest to the SOC members.

12.3. Electronic medical records

SCI and many partners in the system of care have some form of Electronic Medical Records (EMRs). Due to the reporting requirements of various funding sources, documentation and reporting mechanisms vary dramatically. Even within SCI, programs must use separate reporting data bases (SAWIS for DCFS and Cornerstone for HFI). There is not an operational Health Information Exchange (HIE) within our area. There have been discrete settings where staff have been able to input information into another agency's EMR, but there is no interoperability between EMR and other data systems at this time.

13.0. Quality improvement

The Community That Cares utilized both provider and consumer satisfaction surveys to gather feedback. Satisfaction surveys are gathered after Parent Cafés, organized trainings, and events. Satisfaction surveys are sent to referral sources for the family care coordinator program. The FCC staff requests parents complete a satisfaction survey at the completion of the program. An audit system was developed for the FCC records, which were not included in the agency Utilization Management review process. A process improvement initiative was completed as part of the HRSA Outreach grant, which examined the percentage of follow-through on referrals, based on the type of referral. The data indicated that referrals to the FCC program had a much higher probability for a successful linkage when the family was informed ahead of time that a referral for service was being made.

The most successful linkages occurred when the FCC was able to complete a "warm" handoff, which was a face-to-face meeting with the family. The data from this process improvement resulted in a modification of the recommended way that FCCs linked with families.

14.0. Evaluation

The initial vision/plan for the Community That Cares was to provide social-emotional screenings, and services to all children in the counties of Carroll, Lee, Ogle, and Whiteside. This plan included children prenatally through the age of 17 or high school graduation.

After being awarded the grant, the project proposal was modified to fit the expectations of ILCHF and NTI Upstream. A local evaluation was developed that included the identified expectations of both the local and cross site evaluations. Components important to the Steering Committee were included, as well.

LOCAL EVALUATION

The local evaluation initially focused on establishing and maintaining the CTC system of care, engaging partners, and educating the community on goals of CTC, especially what is and what was being accomplished. The FCC program was developed, and anonymous screening data was gathered from medical, educational and social service partners. Engaging schools and securing social-emotional curriculum for their students was a key initiative of CTC. Many MOUs were completed with the schools to determine if the social-emotional curriculum was benefiting the students, by improving attendance and grades and achieving a decrease in detentions and referrals. CTC also cultivated relationships with Carroll, Lee, Ogle, and Whiteside health departments, who provided prenatal screenings, as well as the agreed upon screening tools for the 0-3 population.

Managing the size of a multi-county project became challenging during year 1 of Implementation. The advisors from NTI who worked with CTC made the recommendation to develop community coaches to help manage the system components. These coaches worked with the specific groups in their areas of expertise. This helped to guide the decision making and refine areas on which CTC would focus.

The CTC project goals have remained consistent from Year 1 of implementation:

- Improve the early identification of children's needs through enhanced screening efforts
- Support families and providers through enhanced outreach and care coordination
- Provide comprehensive assessment and effective treatment services to children birth to 18 and their families
- Increase promotion of positive mental health and prevention initiatives and programming
- Maintain an accountable governance structure and increase community ownership of the system of care

However, there have been many changes to the objectives over the years. Some objectives were not obtainable for various reasons, including partners declining or unable to participate, varying definitions, staff changes within partners, and partners changing their policies. The goals and objectives that CTC established were a guide for decision-making and reflected the evolution of the project over time.

The results of monitoring referral patterns of the FCC clients provided additional knowledge about how to more successfully engage families. The changes to the data reported by the schools supported the CTC belief that children have benefitted from the efforts of the system of care. The anonymous data received from social-emotional screening of the children has proven to be valuable. The data obtained through the local evaluation provides local substantiation for the percentage of children who score positive on social-emotional screenings. The data collected as part of the local evaluation has been useful in applying for other grants and reporting to local funders and the community.

CROSS-SITE EVALUATION

The CTC community benefited from the trainings provided by Children's Research Triangle, which were offered to partners and the community at large. System Integration and Provider Awareness of Resources surveys have provided valuable information. The gap analysis results gave the Steering Committee knowledge of the professionals that are needed in our area.

The remaining requirements of the cross-site evaluation (cohort) did not appear to translate effectively to the local operations of the system of care. Recruitment for the cross-site cohort occurred in October and March. The recruitment process was not successful for all of the enrollment time frames. Once enrolled in the cohort, families were expected to remain in the study for the duration of the project, regardless of their connection with other services. There were times when it was difficult to physically locate these families. An additional challenge was that cohort protocols for CTC included all the minor children in a family who had a positive screening result, regardless of services provided. CTC families were asked to complete two (2) or more Child Behavior Checklists (CBCL) and Parent Relationship Questionnaires (PCR) during each cohort period. Both instruments are lengthy in nature, and over time families expressed reluctance to complete these tools, which they may have completed previously multiple times.

The cross-site cohort data was also designed to include confirmation of an assessment and follow up services. Due to the expanse of four county region and the limited availability of professionals able to provide the assessments, this information was challenging to gather and maintain. Some cohort client families had received assessment and treatment services in Iowa or Chicago. There was also some lack of clarity between NTI and the four sites on what constituted an assessment.

15.0. Impact for children/families from the care system improvements

Due to the large geographic size of the project, the first focus for developing the system of care was building relationships and engaging screening entities. With over 80 schools, 25 plus primary care clinics, four health departments, multiple day cares, and Early Intervention providers, establishing the structure and processes for the system of care was time consuming and took precedence over other aspects of the system. The population of children 0-18 in the area at the time the grant was approved was almost 38,000. Efforts during the planning and first Implementation year were focused on engaging potential screening sites, designing data collection processes, and addressing some of the concerns expressed by partners about the use of any data reported to CTC. The Steering Committee decided, in consultation with the local and cross-site evaluators, to have data screening submitted anonymously to CTC and to rely on the screening entities to score and respond to the positive screens in each setting.

CTC received feedback from client satisfaction surveys indicating that they were benefiting from the Family Care Coordinator program. Parents took time to write positive comments about their FCC workers. But, this does not directly answer the question of whether or not children were getting better. CTC developed two (2) ways to address that question.

One of the components of CTC was the expansion of early childhood mental health services. CTC randomly selected clients who participated in services and evaluated changes in the Ages and Stages Questionnaire–Social Emotional (ASQ-SE) scores. An examination of these results demonstrated improvement in the scores for the majority of the children who participated in services.

The school work group designed a process for tracking student performance over time, while being offered social-emotional curriculum, such as Second Step, throughout the year. The work group implemented the "school report card" system. This evaluated grades, attendance, and discipline referrals with specific guidelines and measures. The results from all participating schools were encouraging in the first year of gathering this data. However, due to budget impactors and staff turnover, only one school system continued to monitor the data that demonstrated positive results.

16.0. External technical assistance and consultation

- NTI Upstream with Ira Chasnoff, MD, and Rich McGourty, PhD, were provided as part of the ILCHF support and evaluation component. Training and consultation provided by Dr. Chasnoff and Dr. McGourty were helpful to the community, the providers, and the growing system of care.
- Input from the evaluation team selected by CTC, University of Illinois Health Systems Research at the Rockford School of Medicine, has been invaluable in helping to understand and organize the data involved in the project, as well as how to present and highlight key learnings as the project evolved. Our evaluator, Jim Powers, has been an integral part of the team.

17.0. Cultural competence

Cultural competence is an important tenant of the system of care. In particular the FCC program requires staff to accept families as they are and to respect their choices about when and if to make changes. This includes recognizing and respecting the family's culture, values, and beliefs. CTC utilized translation services when needed.

The rural culture often struggles with the stigma of mental illness. CTC continues to participate in community events and education opportunities to assist in stigma reduction. There are pockets of poverty in our rural community and families may struggle to find transportation to appointments. The FCC staff meets with families in their home or somewhere they feel comfortable. The FCC program provides transportation and helps the families learn to navigate the available public transportation systems. Some FCC staff have struggled to accept the conditions of homes or the slow rate of change in some situations. This has become an identified training need for all staff, but especially home visitors.

18.0. Sustainability/longevity of the leadership

This remains a challenge for CTC. Very few of the original voting members of CTC remain active. The CTC system of care has had several evolutions over the past seven years, and the community remains vibrant and committed to sustaining a system of care for children's mental health. The leadership of Sinnissippi Centers, Kreider Services, and KSB see the value of ongoing collaboration. With the changing landscape of funding in Illinois, it is difficult to predict future opportunities. However, the level of collaboration within our area remains exceptional. CTC, now known as NWILCCC, continues to participate in many community projects, with particular emphasis on growing partnerships with and presence in area schools. The progress in collaboration with all the schools in our area is a direct result of the CTC project.

19.0. Plans for preparing the next generation of system leaders

Planning for the next generation of system leaders remains a challenge. There are several individuals who have been with the project since 2008 with the RHN, and 2010 with CTC. However, many strong champions have moved on to different challenges, personally and professionally. With the multiple grants, initiatives, and consortia, very few staff have both the history and an awareness of the scope of what is transpiring. Parts of the system are evolving with different emphases. Kreider/Florissa is evolving into a strong partnership with primary care and KSB. Sinnissippi Centers have strong initiatives with care coordination and school-based behavioral health services. The value of community coaches/champions has been an important lesson learned. At this point the project director is planning to transition into other areas at the end of 2017. The project directors for Florissa and HRSA Care Coordination, along with the school coach, remain engaged but have competing demands. The STAR and the Family Engagement work groups are strong and moving forward under their own leadership, but other work groups are not as active. Two individuals within SCI have been identified to spend more time working with the system of care, with the hope that they can assist with data and system sustainability.

Community That Cares

System of Care Development
and Implementation Manual

Appendices

Community that Cares, Children's Mental Health Initiative

Community That Cares

Steering Committee BYLAWS

Effective Date: December 1, 2011

Article I. Structure and Purpose

Section 1: The Community That Cares Project is funded through the Illinois Children's Healthcare Foundation to oversee the implementation of a children's mental health system of care serving Carroll, Lee, Ogle, and Whiteside counties. This is a collaborative effort of service providers and community members within the four counties.

Section 2: The Steering Committee will serve as a policy-making and oversight body for the Community That Cares project.

Section 3: The purpose of the Steering Committee includes but is not limited to the following activities:

- Oversee the implementation of the Children's Mental Health System of Care.
- Oversee the development of an integrated network of care for children and their families.
- Ensure that all aspects of the Community That Cares Project incorporate and adhere to the vision, mission, and guiding principles.
- Establish a collaborative approach to the delivery of services across the spectrum which will increase the quality, appropriateness, and effectiveness of services and achieve better outcomes.
- To facilitate and promote the integration of care for children to best manage the coordination of services.
- To address risk sharing, resource pooling, performance expectations, outcome monitoring and staff training.
- To review on an ongoing basis the effectiveness of programs through evaluative data and to make recommendations consistent with the mission.

Section 4: It is the belief of the Community That Cares project that the spirit of collaboration is best served through mutual decision-making and consensus. Therefore in most cases, decisions made by the Steering Committee will be done by consensus and votes will be taken only in those situations where there is not clear consensus.

Community that Cares, Children's Mental Health Initiative

Article II. Mission and Vision and Guiding Principles of Steering Committee

Section 1: Mission: The sustainable development of a system of care for children's mental health which integrates promotion, prevention, screening/ early identification, early intervention, treatment, and transitional care, and includes linkages with primary care providers.

Section 2: Vision: All children from conception through the age of 18 living in Carroll, Ogle, Whiteside and Lee County will be supported within their communities to reach their optimal level of social, emotional, physical and cognitive development.

Section 3: Guiding Principles:

1. Carroll, Lee, Ogle, and Whiteside child serving providers will deliver services in a supportive fashion which respects the unique cultural, ethnic and linguistic needs of the children and families that are served and reflect strength based, family focused and individualized care.

2. Services for all ages of children and their families should be easily identified and accessible at any point of entry.

3. Families should be supported through all steps of the process and made aware of the resources available to their family both locally and outside of the area.

4. Families are a key partner in their children's services and care.

5. Services (promote positive mental health, prevention initiatives and programming, SART process) must be grounded in evidence based practice.

Article III. Members

Section 1: Steering Committee should seek to, in the spirit of collaboration, fill positions with representation from all four counties, made up of the following community entities essential to a comprehensive System of Care for children's mental health: Mental Health Agencies, Educational, Medical, Early Childhood Providers, Public Health, Criminal Justice System, Substance Abuse Agencies, Child Welfare Agencies, Faith Based organizations, Parent and Family Forum, and other child and family serving providers.

Section 2: The Steering Committee will be made up of a minimum of 12 members.

2.1 A member of the Steering Committee may resign at any time by submitting written notice to the Steering Committee Chair.

Community that Cares, Children's Mental Health Initiative

2.2 The Steering Committee shall be empowered to fill vacancies as they occur.

Section 3: The Steering Committee will be chaired by the Community That Cares Project Director. In addition, at the first meeting held in January of each year, members will also elect a co-chair and a secretary. The co-chair and secretary will serve one year terms. The chair, co-chair and secretary have the following responsibilities:

3.1. Chair: Maintain a general overview of the affairs and business of the Steering Committee, including all activities of any established workgroups of the Steering Committee and county level care teams; responsible for preparing the agenda; chair all meetings of the Steering Committee; set meeting dates and locations

3.2. Co-Chair: Take the place of the Chair when absent or incapacitated.

3.3. Secretary: Take minutes for all meetings; keep a record of the actions authorized by the Steering Committee; keep a record of attendance of all members; and notify members of meetings and activities.

3.4 Chair and Secretary are responsible for ensuring agendas, meeting minutes, and any other correspondence are sent out.

Section 4: If an officer of the Steering Committee (Chair, Co-Chair, Secretary) does not fulfill duties required as described in Article III, Section 3, that officer will be notified in writing of the meeting at which removal from office will be discussed and voted upon. At that meeting, the officer may present statements to the Steering Committee in an effort to retain the position. Removal will occur if so voted by majority of the members present at the meeting.

Section 5: Each member who agrees to serve on the Steering Committee shall sign a Leadership Agreement and be responsible to become as knowledgeable as possible about the Community That Cares project, local needs and strengths, services available and gaps in services.

Section 6: Steering Committee members are to regularly attend meetings. Steering Committee members may specify one person as their designee to attend meetings in the event they are unable to attend. Designees would have the same rights and responsibilities as the Steering Committee member.

Section 7: In the event that neither can attend, they are asked to notify the Chair. Steering Committee members who are absent for 3 consecutive meetings may be asked to resign and considered for replacement by a majority vote of the Steering Committee.

Article IV: Meetings

Section 1: Steering Committee meetings shall be held a minimum of six (6) times per year. Notification of regular meetings and a written agenda shall be sent to all Steering Committee members 3 working days prior to the meeting taking place. Chair/secretary will have responsibility for this task.

Community that Cares, Children's Mental Health Initiative

Section 2: A quorum of the Steering committee shall consist of one-half (1/2) of the Steering Committee membership.

Article V. Work Groups

Section 1. Subcommittees of the Steering Committee and Standing Work Groups.

1.1. Subcommittees of the Steering Committee include:
- 1.1.1. Funding Sustainability Subcommittee is responsible for identifying ways to sustain positions needed within the system of care for children's mental health. This includes identifying potential funding streams, grant resources, and other potential sources.
- 1.1.2. Human Resource Subcommittee is responsible for detailing a human resource plan of action.
- 1.1.3. Gap Analysis Subcommittee is responsible for identifying the gap between the number of existing providers and the number needed to fully sustain a system of care.
- 1.1.4. Bylaw SubCommittee is responsible for reviewing the bylaws annually and recommending any proposed changes to Steering Committee for vote.

1.2. Standing Workgroups
- 1.2.1. Screening Workgroup is responsible for carrying out the actions steps associated with the early identification of children needs from conception to age 18.
- 1.2.2. The Care Coordination workgroup is responsible for coordinating a community wide Tier based system and assist in the development of cross agency protocols.
- 1.2.3. The Assessment and Treatment Workgroup is responsible for establishing and implementing best practice protocols and procedures for a comprehensive assessment and evidence based treatment of children.
- 1.2.4. The School Based Workgroup is responsible for attending to school based needs, strengths, programming, and identifying existing Tier II interventions within the schools.

1.3. Records of all meetings shall be provided to the Chair on regular basis.

1.4. Membership on the Steering Committee is not a prerequisite for serving on a workgroup.

Section 2: Ad Hoc Workgroups

2.1 The Steering Committee shall have the power to form ad hoc workgroups on an as needed basis. These subcommittees may fulfill such purposes as studying problem areas and needs; helping to evaluate community needs; assessing current trends in the delivery of children's mental health services;

Community that Cares, Children's Mental Health Initiative

evaluating local community satisfaction and awareness of the Community That Cares Project; applying for funding and grants to support the Community That Cares project, reviewing evaluative data, maintaining continuous quality improvement, and fulfilling the need for any other activities related to the effective operation of the Community That Cares project.

2.2. Membership on the Steering Committee is not a prerequisite for serving on a workgroup.

Article VI: AMENDMENTS TO THE LEADERSHIP AGREEMENT

Section 1: Amendments to the Leadership Agreement may be proposed by any member of the Steering Committee by submitting a written proposal to the Chair. The proposed change(s) shall be presented at the next Steering Committee meeting and voted upon at the following meeting. Any proposed change(s) must be mailed five (5) days prior to the meeting when the amendment will be discussed and voted upon.

Section 2: A three-fourths (3/4) majority of the Steering Committee shall be required to adopt any amendment to the Leadership Agreement.

ARTICLE VII: DISSOLUTION

Should assets accrue to the Community That Cares Steering Committee and the Steering Committee is disbanded by a three-fourths (3/4) vote of the Steering Committee, said assets (upon the payment of all liabilities) shall be given to a comparable nonprofit organization serving children and families in the four county area which meets the requirements of a tax-exempt corporation under the US Internal Revenue Code, Section 501 (c) 3.
Revised: 11/8/11
Adopted:

In Witness thereof, the Members agree to the outlined bylaws effective 12/1/11

Member (Printed Name)	Member Signature/date	Agency

Community that Cares, Children's Mental Health Initiative

Community that Cares, Children's Mental Health Initiative

STEERING COMMITTEE LEADERSHIP AGREEMENT

Mission: The sustainable development of a system of care for children's mental health which integrates promotion, prevention, screening/ early identification, early intervention, treatment, and transitional care, and includes linkages with primary care providers.

Vision: All children from conception through the age of 18 living in Carroll, Ogle, Whiteside and Lee County will be supported within their communities to reach their optimal level of social, emotional, physical and cognitive development.

Overarching Goal: The purpose of the Steering Committee includes but is not limited to the following activities:

- Oversee the implementation of the Children's Mental Health System of Care.
- Oversee the development of an integrated network of care for children and their families.
- Ensure that all aspects of the Community That Cares (CTC) incorporate and adhere to the vision, mission, and guiding principles.
- Establish a collaborative approach to the delivery of services across the spectrum which will increase the quality, appropriateness, and effectiveness of services and achieve better outcomes.
- To facilitate and promote the integration of care for children to best manage the coordination of services.
- To address risk sharing, resource pooling, performance expectations, outcome monitoring and staff training.
- To review on an ongoing basis the effectiveness of programs through evaluative data and to make recommendations consistent with the mission.

Guiding Principles:

1. Carroll, Lee, Ogle, and Whiteside child serving providers will deliver services in a supportive fashion which respects the unique cultural, ethnic and linguistic needs of the children and families that are served and reflect strength based, family focused and individualized care.

2. Services for all ages of children and their families should be easily identified and accessible at any point of entry.

Community that Cares, Children's Mental Health Initiative

3. Families should be supported through all steps of the process and made aware of the resources available to their family both locally and outside of the area.

4. Families are a key partner in their children's services and care.

5. Services (promote positive mental health, prevention initiatives and programming, SART process) must be grounded in evidence based practice.

Responsibilities:

- Each voting member who agrees to serve on the Steering Committee shall sign a Leadership Agreement and be responsible to become as knowledgeable as possible about the Community That Cares project, local needs and strengths, services available and gaps in services.

- Steering Committee voting members are to regularly attend meetings. Steering Committee members may specify one person as their designee to attend meetings in the event they are unable to attend. Designees would have the same rights and responsibilities as the Steering Committee member.

- In the event that neither can attend, they are asked to notify the Chair. Steering Committee voting members who are absent for 3 consecutive meetings may be asked to resign and considered for replacement by a majority vote of the Steering Committee.

Organizational Statement of Commitment:

Our organization is committed to be an active member of the CTC Steering Committee. As a voting member, we attest that the vision, mission, goals, and guiding principles of the Steering Committee are in alignment with our organizational goals and policies. We agree to abide by agreed-upon decision-making processes set forth in the Community that Cares Steering Committee Bylaws and to support Steering Committee decisions. We agree to notify the Steering Committee, in writing, in the event our organization experiences a conflict of interest or is no longer able to support Steering Committee goals and priorities.

As evidence of our commitment to the Steering Committee, our organization agrees to do the following:

1) **Appoint** a designated representative and a backup person to attend Steering Committee meetings and conference calls.

- Name of Representative: _____
- Name of Backup Representative: _____

Community that Cares, Children's Mental Health Initiative

2) Authorize our representative to make decisions on issues or actions.

3) Actively assist with Steering Committee activities.

4) Supply the Steering Committee with our organizational name and/or logo.

5) Disseminate steering committee materials to our members or other stakeholders.

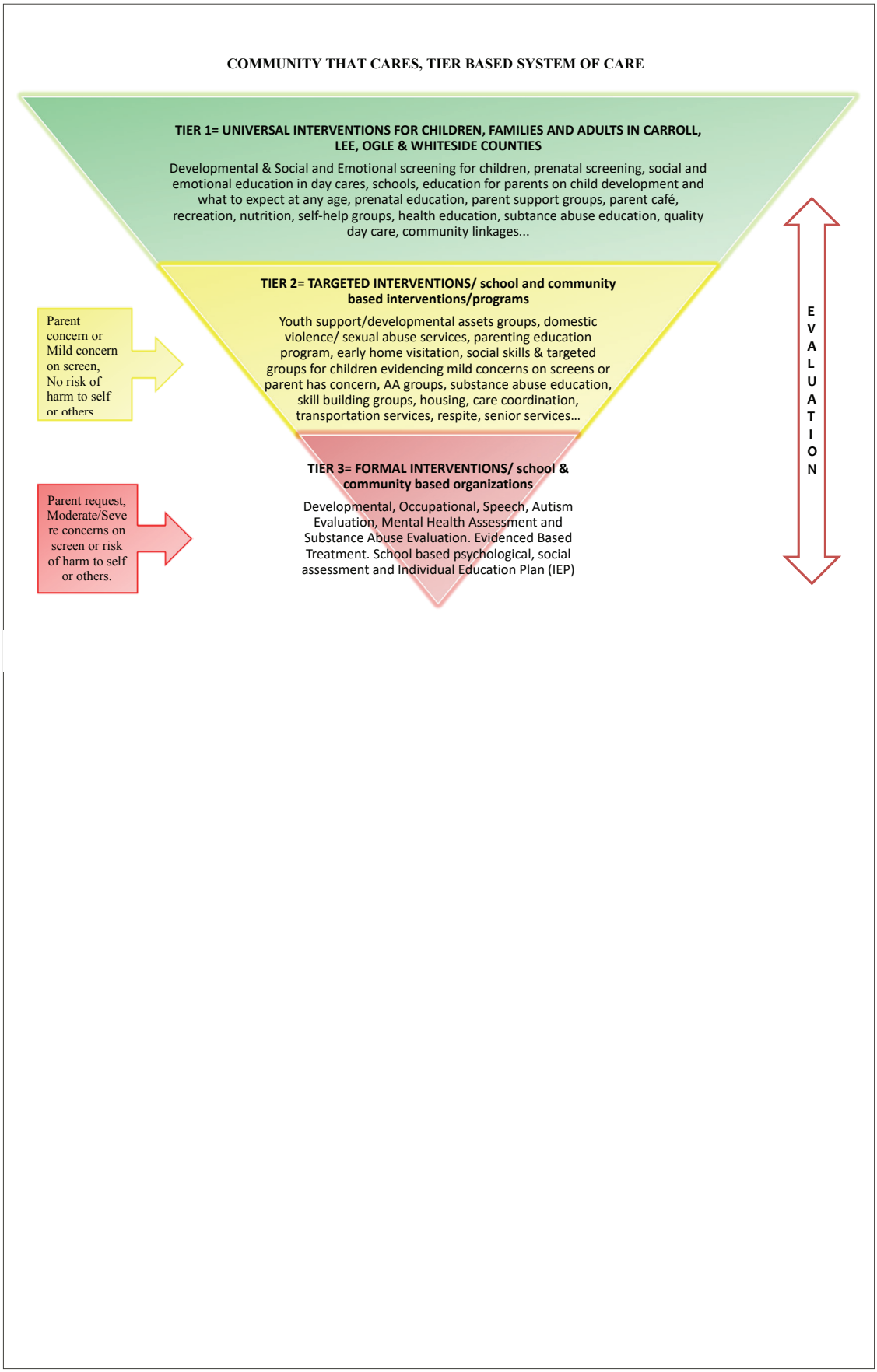
_____

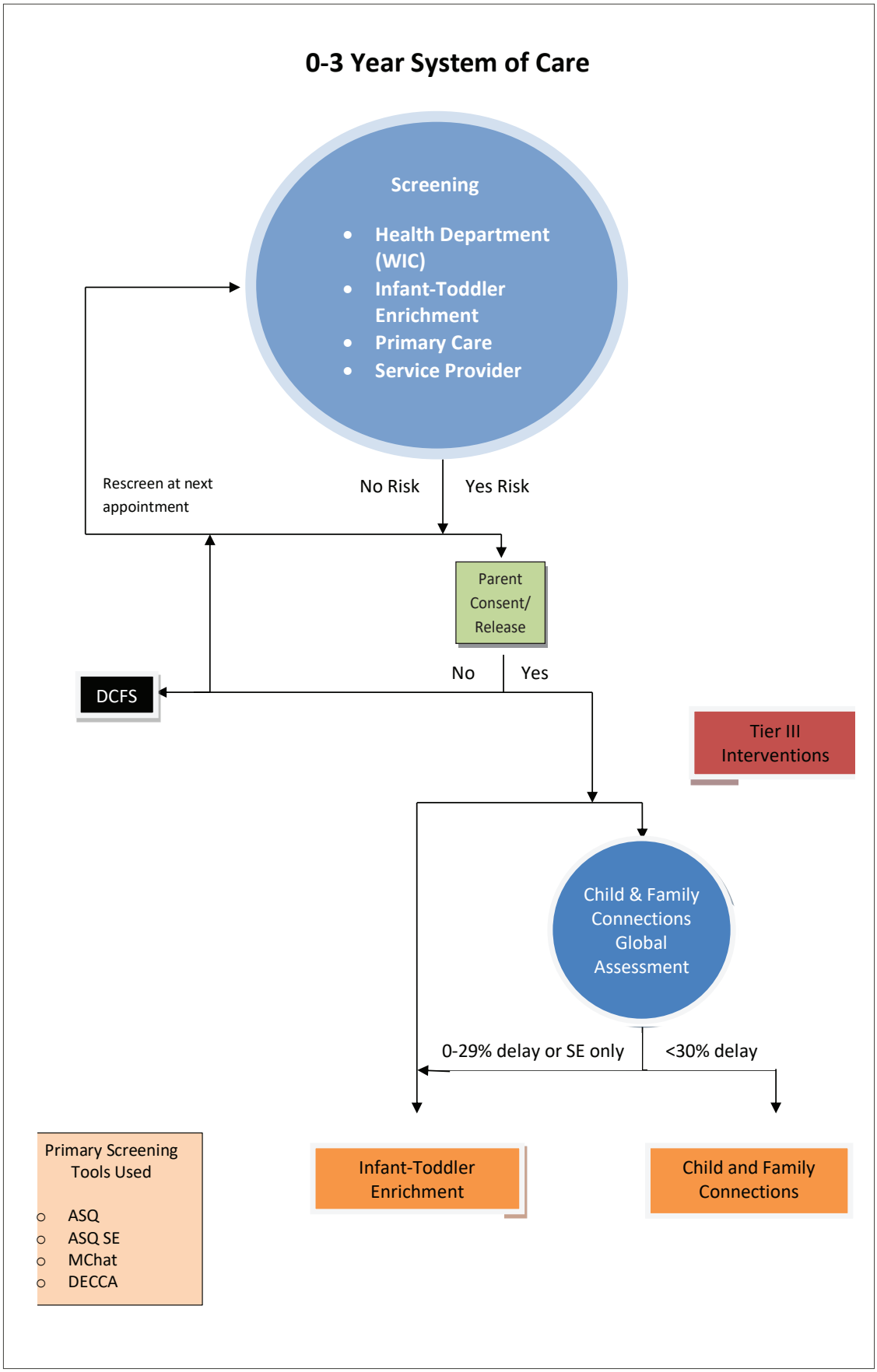
Signature and Title

_____

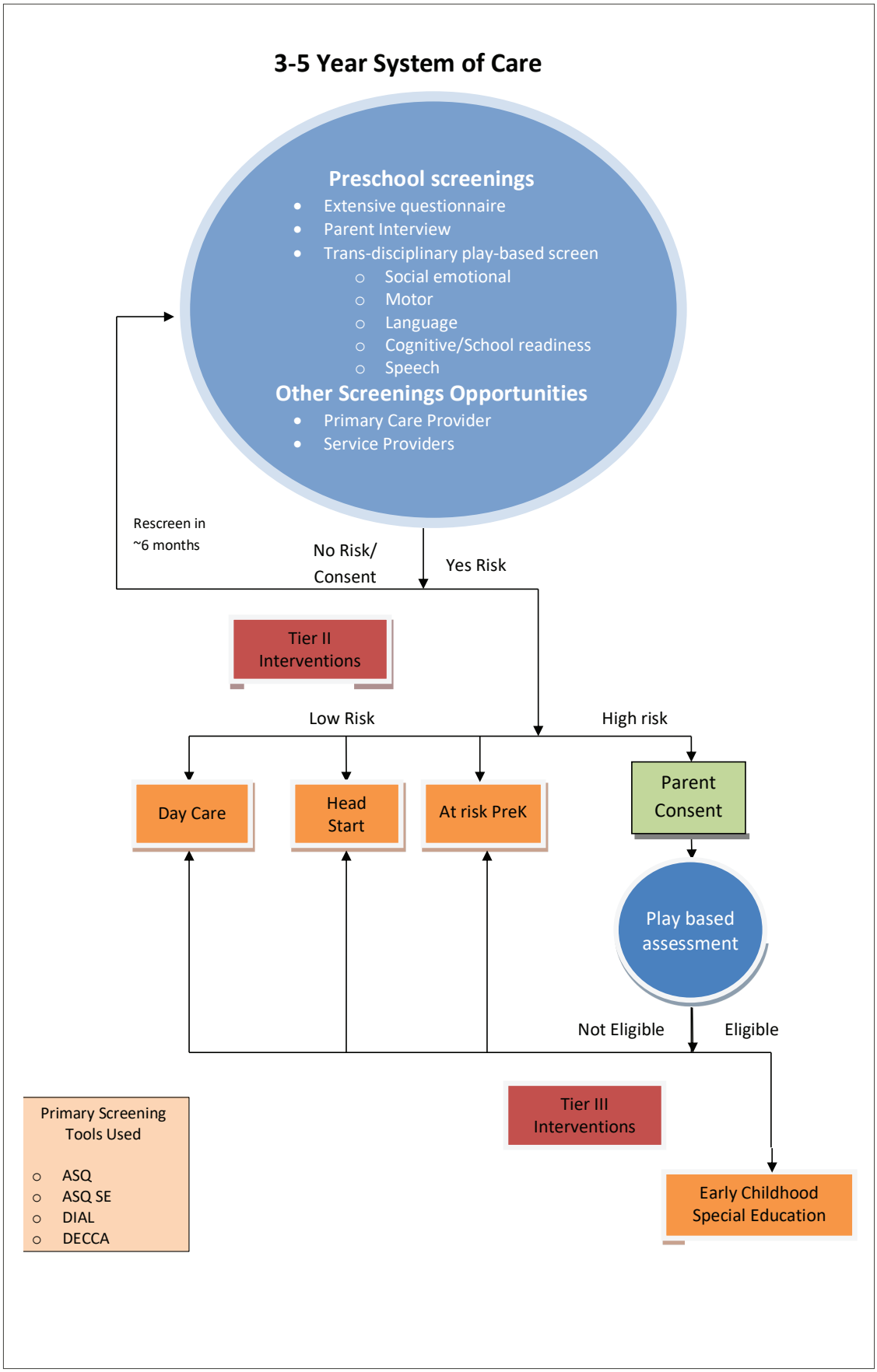
Date

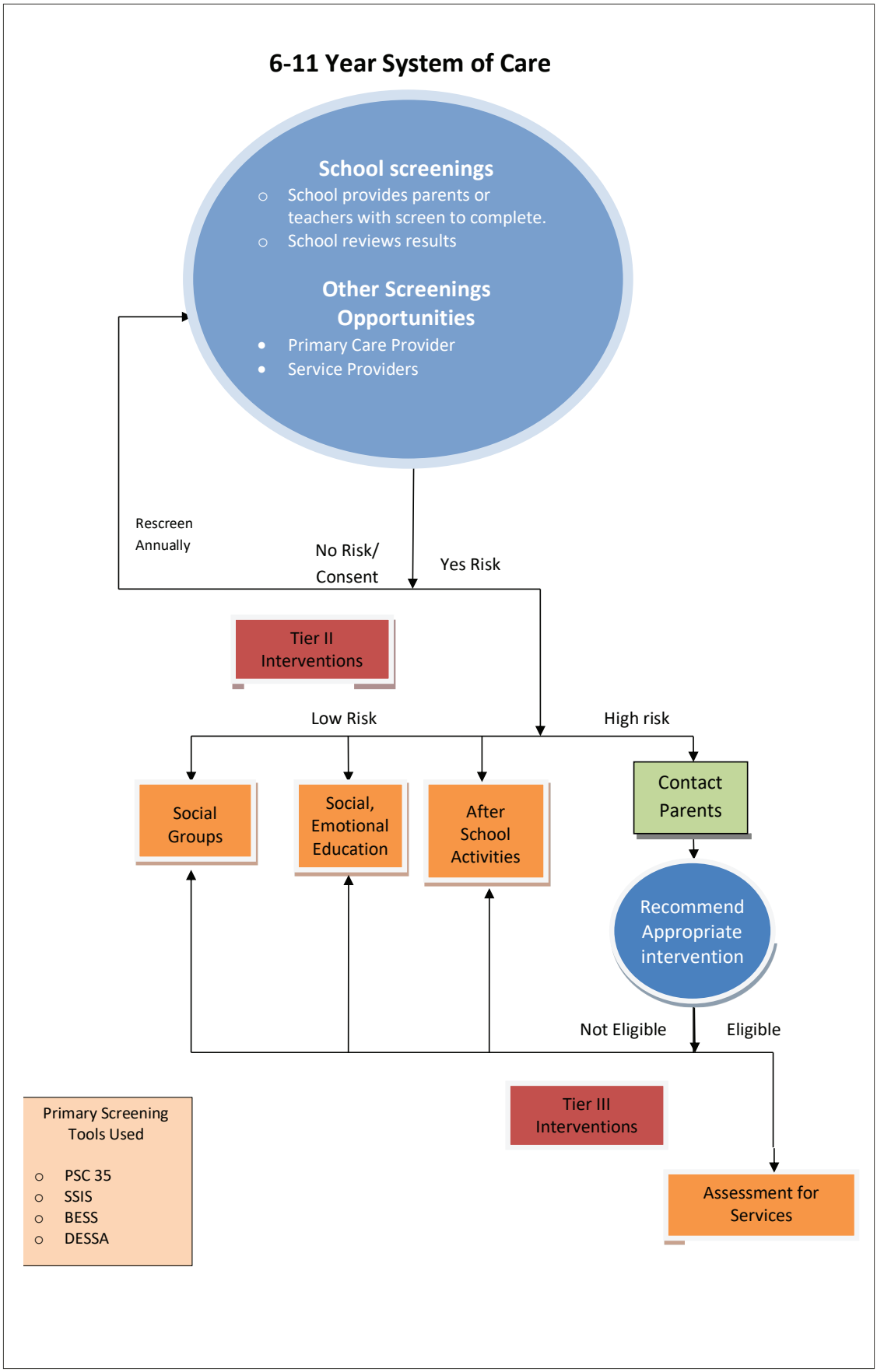
Appendix A.3. CTC Tier-based System of Care

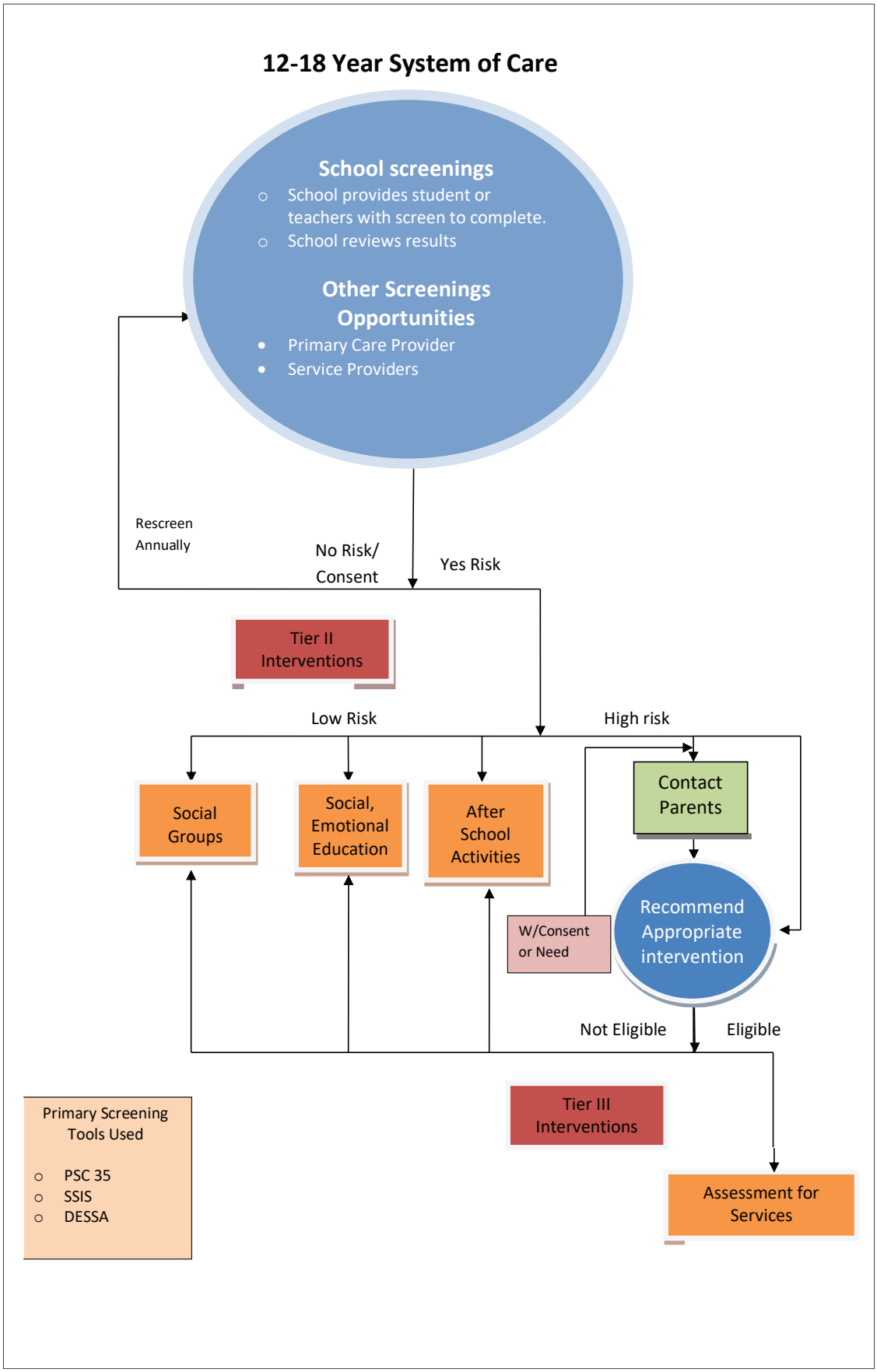



0-3 Year System of Care
Screening
Health Department (WIC)
Infant-Toddler Enrichment
Primary Care
Service Provider
Rescreen at next appointment
No Risk
Yes Risk
Parent Consent/ Release
No
Yes
DCFS
Tier III Interventions
Child & Family Connections Global Assessment
0-29% delay or SE only
<30% delay
Primary Screening Tools Used
ASQ
ASQ SE
MChat
DECCA
Infant-Toddler Enrichment
Child and Family Connections

Appendix A.5. 3–5 Interventions




6-11 Year System of Care
School screenings
School provides parents or teachers with screen to complete.
School reviews results
Other Screenings Opportunities
Primary Care Provider
Service Providers
Rescreen Annually
No Risk/ Consent
Yes Risk
Tier II Interventions
Low Risk
High risk
Social Groups
Social, Emotional Education
After School Activities
Contact Parents
Recommend Appropriate intervention
Not Eligible
Eligible
Tier III Interventions
Assessment for Services
Primary Screening Tools Used
PSC 35
SSIS
BESS
DESSA


12-18 Year System of Care
School screenings
School provides student or teachers with screen to complete.
School reviews results
Other Screenings Opportunities
Primary Care Provider
Service Providers
Rescreen Annually
No Risk/ Consent
Yes Risk
Tier II Interventions
Low Risk
High risk
Social Groups
Social, Emotional Education
After School Activities
Contact Parents
W/Consent or Need
Recommend Appropriate intervention
Not Eligible
Eligible
Tier III Interventions
Assessment for Services
Primary Screening Tools Used
PSC 35
SSIS
DESSA

FOR MORE INFORMATION

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Community That Cares
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