Alliance School-Based Care Coordination Report
Indicators and Outcomes for 2018-2019 School Year
Executive Summary

The purpose of the School Based Care Coordination (SBCC) team, in partnership with Wake County Public School System (WCPSS), is to identify and connect qualifying WCPSS students to behavioral health services. There are 7 program groups outlined in this report: Traditional, Traditional I/DD, Crisis, Psychiatric Residential Treatment Facility (PRTF), Diversion, Alternative Schools, and Family Partner Programs. The Traditional program works to connect students referred through the schools to behavioral healthcare providers who can assess and recommend appropriate treatment with the ultimate goal of improving their engagement in school. The Traditional I/DD program works to connect students and families referred by the Special Education department to community resources, behavioral healthcare providers, and assist to navigate the I/DD eligibility process. The Crisis program works to connect students referred from crisis facilities in partnership with Wake County Public Schools to support the child’s transition to appropriate level of treatment services and provide necessary supports as identified by the school system. The Crisis program has developed a uniform process with WCPSS to support significant school safety concerns. The PRTF programs seek to identify WCPSS students in PRTFs to ensure a quick and coordinated re-enrollment after they leave the facility. The Adult Diversion program obtains referrals from Wake County School Resource Officers with the goal of diverting 16-17 year olds who commit non-violent offenses at school from getting charges in the adult system. In addition, SBCC continues to develop two specialty programs. These are the Alternative School and Family Partner programs. All programs work with youth from a variety of insurance networks both in and out of the county including private, uninsured, Healthchoice, and families identified in both the tailored and standard plan Medicaid panels.

Process data, indicators, and outcomes are included in this report, as outlined in the data analysis plan created and agreed upon by Wake County Public Schools, Wake County Government, and Alliance Health, revised in 2018. The plan was revised to reflect changes in responsibilities for outcome data. Those changes are noted throughout the report.

Of note, the SBCC Team won a statewide Program of Excellence, Partnership to Improve Services award from the NC Council of Community Programs (now called the I2i Innovations Center) in December 2017. The Team was also invited to speak to the NC General Assembly about their work, particularly children in crisis.

Crisis Program

Referrals for the Crisis Program:

The SBCC program was allocated additional funding by Wake County Government at the start of the 2018-2019 school year to further develop a crisis program. The SBCC Crisis program has expanded over the 2018-2019 school year in an effort to meet the needs of the increasing number of child crisis admissions in our community. During this time SBCC has added two crisis liaison positions, one of which is embedded at Holly Hill Hospital and the other at WakeMed Hospital. Our liaisons have access to clinical records across multiple hospital systems and crisis facilities throughout Wake Co. SBCC Crisis liaisons review daily admissions data to triage cases that
meet criteria for SBCC involvement. Liaisons work diligently with parents/guardians to obtain the release of information for communication between SBCC and WCPSS. The SBCC Crisis Team Lead provides daily crisis updates to WCPSS leadership for WakeMed and Wakebrook CAS admissions, and weekly updates of Holly Hill Hospital admissions. The goal of our SBCC crisis work is to link children to appropriate MH/SUD/IDD services and to coordinate with the family, school, and treatment provider to support the child with their transition back to school after a crisis episode.

The SBCC Crisis team attributes their success over the last school year to collaboration with local crisis facilities, treatment providers, and counterparts at WCPSS, with intentional investment of resources and time to develop process and support this program. This collaborative effort has allowed SBCC leadership to facilitate meetings with key stakeholders including the Executive Director of Behavioral Health Services at WakeMed, Behavioral Supervisor at WakeMed, ED Manager and Nursing Supervisors at WakeMed, administrative leadership at Holly Hill Hospital, Alliance Health Medical Director and legal team, Vice President of MH Services with ESUCP, and Directors across departments at WCPSS. The key stakeholders have worked to address barriers, gaps, and develop uniform process. There has been a focus to assist families, address release of information, and a consistent method to communicate regarding planning with multiple systems.

The SBCC Crisis Liaison at Holly Hill Hospital regularly attends interdisciplinary treatment team meetings to assist with providing clinical background, discuss treatment recommendations, and coordinate aftercare plans. The liaison has been able to advocate for on-site child and family team meetings to assist with addressing safety concerns, discharge planning, and a successful transition back to school. The liaison has developed a formal referral form to facilitate timely notification of children who may benefit from School Based Care Coordination support.

SBCC Leadership worked to address gaps and barriers with engagement and worked to develop a formalized process with ESUCP CARES and Youth Villages High Fidelity which has been instrumental in linking children and families in crisis to services and wrap around support. In addition the SBCC Crisis Team has arranged meetings between these two service providers and WakeMed Behavioral Health leadership to streamline the referral process and collaborate to support children and families in crisis.

In response to growing concerns of school safety, the SBCC Crisis team has created a process to address high risk cases. The SBCC Crisis Liaison works with the facility to obtain pertinent updates and clinical information to provide immediate support and communication with families, WCPSS, providers, and the legal system, if necessary. A dedicated School Based Care Coordinator is assigned to monitor discharge planning and follow the consumer post discharge to coordinate the systems needed to support the child and family. For cases with a potential for imminent safety concerns at school, SBCC Crisis Team has worked with Alliance Chief Medical Officer and WCPSS Leadership to develop an immediate response system to alert WCPSS leadership, who will notify appropriate school staff.

SBCC leadership collaborates with Alliance Government Relations and WCPSS to stay abreast of legislation that focuses on school systems, crisis, and safe schools. This program continues to develop and evolve based on changing mandates and working to support Wake County
Government’s strategic behavioral plan, WCPSS school based mental health initiatives, and recommended guidance from DPI.

From July 1st, 2018 through June 30th, 2019 the Crisis Program received 272 new referrals, 219 agreed to participate in the program (see Appendix 2 for definitions). This is over a 360% increase in referrals from the 2017-2018 school year. In comparison, in the 2017-2018 school year, prior to the development of the crisis program, there were 74 referrals received, 51 served.

Performance Indicators and Outcomes:

The process indicators for the Crisis Program examined the number of students who received treatment after referral to the SBCC program and utilization of program across the school system. Process indicators for the Crisis Program are broken into 2 goal areas. First, the percentage who received an assessment or therapeutic service within 90 days of date referral received. Second, the percentage of releases of information (ROIs) obtained during the 2018-2019 school year. This is our first year measuring the percentage of ROIs obtained. This was identified as an outcome measure by leadership, both at WCPSS and Alliance, as the primary outcome measure for the Crisis Program. The ROI is essential in coordinating with our facilities and WCPSS to best support children and families in crisis.

It should be noted that data in this section accounts for 185 youth, those who accepted the referral and have Medicaid or no insurance.

<table>
<thead>
<tr>
<th>KPIs</th>
<th>16-17</th>
<th>17-18</th>
<th>18-19</th>
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<tbody>
<tr>
<td>% Treatment in 90 days</td>
<td>78%</td>
<td>56%</td>
<td>92%</td>
</tr>
<tr>
<td>% of ROIs obtained</td>
<td><em>did not calculate this data</em></td>
<td><em>did not calculate this data</em></td>
<td>79%</td>
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*For the 2018-2019 school year, measure changed to 90 days (vs 45 days in prior years) to take into consideration time spent at crisis facilities during crisis episodes.*
Process Data 2018-2019

The Crisis Program started capturing demographic data in the 2018-2019 school year and this is the first full school year reporting demographic data. Of the 272 referrals received during the 2018-2019 school year, the gender breakdown of referrals is 50% male, 49% female, and 1% transgender.

The ethnicity breakdown indicates African-American students accounting for 42% of the crisis referrals, Caucasian students at 24%, Hispanic at 21%, and unknown/other referrals at 13%.
Medicaid referrals accounted for 73% of all crisis referrals, private insurance at 13%, no insurance at 10%, and Healthchoice at 4%.

Referrals of high school students make up the majority (45%), middle school referrals make up 35%, elementary at 18%, and unknown/pre-k at 2%. Due to high schools having highest percentage of children presenting at crisis facilities, SBCC began targeted outreach to high schools and SAP counselors.
During the 2018-2019 school year, 82% identified English as their first language, 16% Spanish, and 2% other/unknown.

The Crisis Program received 272 referrals from crisis facilities, 34% of these cases originated from an Emergency Department (ED), 29% originated from Holly Hill Hospital (HHH), 22% originated from UNC Wakebrook Crisis and Assessment (CAS), 13% were Alliance internal referrals (Alliance Access, MH/SUD Care Coordination, and I/DD Care Coordination), and 2% “other”.
Crisis Program Success Story

“During hospital intake, a WCPSS student reported experiencing homicidal ideation towards another unidentified WCPSS student. As per SBCC process the assigned crisis care coordinator contacted the student’s parent for additional info. During the call the student’s parent confirmed the hospital’s report that the student had a previous diagnosis of Autism Spectrum Disorder. The student’s parent expressed interest in starting the I/DD eligibility process post discharge. At discharge the SBCC Crisis Team Lead alerted WCPSS re: the case of concern. The assigned crisis care coordinator followed up with the student’s guardian & assisted with linking to the Access center re: I/DD eligibility. The assigned crisis care coordinator followed up with the mental health treatment provider to confirm the student’s treatment engagement, and monitored the case. The assigned crisis care coordinator provided updates to the school & participated in multiple discussions re: the student’s return to school. The school reported having multiple safety and support plans in place re: the student’s return to school & later reported that the return to school was without issue or concerns. The case of concern was later closed to SBCC at which time the school was notified, as they reported having no further safety concerns. The school later contacted the previously assigned crisis care coordinator & reported that additional threats had been made by the student at school. The CC immediately alerted the mental health treatment provider, who met w/ the student that same day to further assess. The care coordinator followed up with the school, provided an update & discussed whether the school would be acquiring a signed ROI from the student’s parent to communicate directly with the mental health treatment provider. The school advised that they would do so. Per the ROI on file, the care coordinator provided the school with contact info to the student’s treatment provider. The care coordinator also advised the school re: the process of making a referral to CAS for future reference. The school expressed appreciation for the service provided by SBCC although the student’s case of concern had been formally closed. The mental health treatment provider later confirmed that they have a ROI on file to communicate with the student’s school & advised that the school would be contacted to collaborate.”

Traditional Program

Referrals for Traditional Program:

From July 1, 2018 to June 30, 2019, the Traditional Program received 310 new referrals, 169 agreed to participate in the program accounting for 55% of the most high risk families being successfully served. Referrals to the program continue to increase. The program’s collaboration with systems and addressing gaps in services resulted in a significantly higher percentage of students linked to a provider and resources in the 2018-2019 school year. The program is working to address barriers and support those children not initially engaged in the program in partnership with WCPSS Counseling & Student Services leadership. WCPSS continues to screen and improve the process to refer only the most at-risk children. SBCC works closely with school leadership to strengthen the referral process to community providers for those children who are not referred as part of the tier 3 process into the Traditional Program. The families that chose not to participate in the program were provided information regarding resources and ability to re-engage with School Based Care Coordination, if needed.
Performance Indicators and Outcomes:

The process indicators for the Traditional Program examined the number of students who received treatment after referral to the SBCC program and utilization of program across the school system. Process indicators for the Traditional Program is measured as the percentage who received an assessment or therapeutic service within 45 days of SBCC contacting the family.

It should be noted that data in this section accounts for 124 youth, those who accepted the referral, did not move into another school district during the year, and have Medicaid or no insurance.

<table>
<thead>
<tr>
<th>KPIs</th>
<th>14-15</th>
<th>15-16</th>
<th>16-17</th>
<th>17-18</th>
<th>18-19</th>
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<tbody>
<tr>
<td>% Treatment in 45 days</td>
<td>39%</td>
<td>51%</td>
<td>40%</td>
<td>39%</td>
<td>74%</td>
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Last year, leadership within SBCC successfully identified and implemented process improvements to ensure students were connected with services. This included streamlining internal processes and facilitating trainings about the SBCC program for WCPSS staff. Due to these process improvements, SBCC exceeded expectation by linking 74% of students to a provider within 45 days. Based on the formalized process and the team lead working to monitor each referral, the program was able to screen referrals for appropriateness and track barriers to engagement. There were specific measures put in place to overcome engagement barriers to include partnering with the C.A.R.E.S. pilot through Easter Seals. Leadership with SBCC and Easter Seals met to develop the pilot in November 2018. Please see attachment at the end of this report for additional information regarding the C.A.R.E.S. program. This collaboration resulted in successful support of the high risk families served in the Traditional Program.

For 2018-2019, SBCC leadership worked closely with WCPSS leadership to provide direction regarding the joint release of information (ROI). The team lead worked with identified referral sources, utilized technology, and guided WCPSS teams in a proactive manner to decrease the barriers in obtaining the Alliance ROI. This resulted in the ability of the program to provide immediate support to students and their families. SBCC leadership worked with Alliance Compliance department to remove barriers with methods of technology and received approval to utilize HIPAA compliant email communications in our initial outreach to families.
Process Data 2018-2019

There were 310 referrals to the Traditional Program between July 1, 2018 and June 30, 2019. The gender breakdown of referrals has remained consistent within the past 3 school years (roughly 40% female and 60% male). The ethnicity breakdown has changed slightly within the past school year (the percentage of White students decreased to around 24% from 26%, while the Black/African American population increased to around 43% from 38%, and the Hispanic population slightly decreased to 28% from 30%).

Seventy four percent of youth referred have Medicaid or no insurance as compared to 82% from the previous year. Referrals from elementary schools (all grade levels K-5) still make up the majority (54%), with kindergarten referrals consisting of 11%, an increase from last year at 8%.
The number of referrals for students with Special Education services has decreased 17% in the 18-19 school year, but this could be attributed to the separation of the Traditional and Traditional I/DD program. Language composition changed slightly with an increase in students who primarily speak English from 74% to 81%.

<table>
<thead>
<tr>
<th>Special Education</th>
<th>Primary Language Spoken</th>
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<tr>
<td>No</td>
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<td>230</td>
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<table>
<thead>
<tr>
<th>English</th>
<th>Spanish</th>
<th>Other</th>
</tr>
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<tbody>
<tr>
<td>250</td>
<td>56</td>
<td>4</td>
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**Process Indicators and Outcomes 2018-2019**

There were 169 students and their families who agreed to participate in the Traditional Program. Of this population, 124 participants had Medicaid or no insurance, therefore eligible to receive services through Alliance.

*Goal 1 – Improve engagement in treatment services within 45 days of contact with the family. Engagement is identified as at least one claim for a therapeutic service submitted to Alliance within 45 days of contact with the family.*
Results
The percent of youth receiving treatment in 45 days has jumped to 74%, a 35% increase as compared to the previous school year.

Traditional Success Story

School Based Care Coordination C.A.R.E.S. success story as written by Easter Seals:
“CARES Assessor received referral from SBCC team and went out at night due to parents’ work schedule. The family lived on dirt road with pot holes and assessors’ vehicle was not able to navigate down the road to reach the family’s home. The family had limited resources and was not able to be reached by phone. Assessor reached out to care coordinator to find a solution to help engage this family. The SBCC and CARES assessor paired up together to go to the home to engage family in services with a bigger vehicle that could navigate the road to the home. The care coordinator provided support during the assessment and helped with entertaining the children in the home while the assessor gathered needed clinical information. It was around the holidays and SBCC coordinated Christmas gifts for the family as the family had very limited resources. The family was successfully referred and linked to intensive in-home services and engaged through treatment.”

SBCC Traditional Success Story: “SBCC received a referral for a 19 year old, pregnant female who was homeless, living temporarily with her sister after leaving an abusive boyfriend. Student had also suffered a past miscarriage. This young woman had 9 therapists in the past 4 years. Her adoptive parents were not allowing her back in their home, but her adoptive mother was willing to be involved with helping with transportation and accessing services and resources. Since student was over 18, SBCC worked with her to obtain a new release of information to allow us to collaborate with adoptive mother. Student had several past crisis episodes, previous rounds of multisystemic therapy, intensive in-home, and medication management. Student was attending SCORE academy and not doing well. She had dropped out
of high school 30 days prior to graduation the previous school year. She was born addicted to
drugs, history of sexual abuse at age 12, history of verbal, physical, and emotional abuse. She
had current pending legal charges. She had been previously diagnosed with a learning disability
and had a history of suicidal ideation. SBCC referred her to a Behavioral Health Urgent Care
provider (BHUC) to start medications ASAP. SBCC also referred student to our Alliance court
liaison, who followed up on her legal case. Student was provided housing and vocational
resources. SBCC supported adoptive mother in obtaining resources and in following through
with all scheduled appointments and applications for the student. Following the initial
assessment for medications at BHUC, this young woman was referred to a provider determined
to be the most convenient agency for her and her mother to get to after the school day, and where
they could address all her behavioral health needs. Prior to closure to SBCC, care coordinator
confirmed student was attending therapy regularly, she had completed her high school courses
and graduated from WCPSS, had no crisis episodes, and had completed all court requirements.”

**Traditional I/DD Program**

**Referrals for Traditional I-DD Program:**

In the 2018-2019 school year, the leadership within WCPSS Special Education Department
prioritized the collaboration in this program and partnered to create a formalized process to
support the Traditional I/DD population. This includes a high level of support and immediate
response within Traditional I/DD, but also with Crisis and PRTF programs. Based on identified
needs and population, it was decided for the 2018-2019 school year, to have this program
analyzed separately from the Traditional Program. The referrals come directly from the WCPSS
Special Education Department. The items below were written by leadership at WCPSS regarding
the partnership that has been developed to support the children and families:

- Presented to Extended Content teachers at first quarterly meeting about available services
  and how to access.

- Provided information to Autism & Extended Content Standards Support Teachers
  (AECS) and Behavior Specialists (BS) to share with teachers about available services.
  Teachers are then able to share information with parents about available services.

- Collaborated with our Family and Community Connections team to provides information
to families new to WCPSS or about to move to Wake County about how to access I/DD
and other services through Alliance. This is very important to families who move here
and don’t understand the process is different.

- Coordinated with AECS to assist teachers and families in accessing resources regularly
  and attends AECS team meetings twice a month.

- Coordinated with BS to assist teachers and families in accessing resources.
• Students who present with challenging behaviors- SBCC Traditional I/DD care coordinators have been able to assist families in accessing outside services such as emergency respite, ABA therapy, Wright School, Murdoch Center, NC Start etc.

• Collaborated with AECS and BS in problem solving for students/families in crisis and how best to provide appropriate services in the school setting.

• More direct coordination and sharing of information between school and agencies to provide services in a faster and more efficient manner. A significantly higher number of students have been able to access community supports and services in the past two years with the support of the School Based Care Coordinators as compared to previous years.

• Ability for more direct communication with all parties to provide updated information and more complete data and services.

• Facilitated seamless transitions for students returning from residential placements, respite, and/or crisis hospitalization.

• The School Based I/DD Care Coordinators coordinate all services across home and school in order to provide consistency in strategies and interventions. This service is imperative to ensure the success of students with the most significant disabilities.

The Traditional I/DD Care Coordination team is working closely with Alliance Government Relations and WCPSS to provide ongoing education on the upcoming Medicaid transformation. The SBCC care coordination program helped facilitate community events and meetings to provide accurate and timely information to WCPSS and partners to support the families we serve in this program.

From July 1, 2018 to June 30, 2019, the Traditional I/DD program received 79 new referrals, 72 agreed to participate in the program.
Performance Indicators and Outcomes:

Services for the I/DD population typically take longer to put into place due to the integrated care model needed to serve this population with complex needs, as well as the availability of recommended services and capacity of existing resources to serve this growing population. The SBCC Traditional I/DD program is measured based on 3 performance indicators.

Goal 1 – Increase awareness regarding the I/DD eligibility process and assist families in navigating I/DD eligibility review.

The program served 72 referrals. Fifty four percent of these referrals were successfully supported through the I/DD eligibility process. SBCC worked closely with WCPSS, families, and Alliance to navigate the steps and documentation required to initiate this process. SBCC provided targeted outreach to schools and spoke with leadership in special education at “Spedapalooza”.

Goal 2 – Refer to treatment providers.

Fifty three percent were referred to treatment providers for therapeutic services in the 2018-2019 school year. At this time, 58% of those were linked with a service with the remainder on waiting lists which can account for a multi-month wait time.

Goal 3 – Refer to community resources.

In the 2018-2019 school year, the I/DD program focused on community resources and sustainability. Of the 72 referrals received this school year, 53% were referred to a community resource with a focus on collaboration with NC Start.

Process Data 2018-2019

This is our first year reporting demographic data specifically for Traditional I/DD (TRA-I/DD) referrals. There were 79 referrals who were referred to the TRA-I/DD program for the 2018-2019 school year. Thirty three percent of the youth identified as African-American, 32% as Caucasian, 6% as Hispanic, and 29% as “other” or not defined.
Youth with Medicaid or with no insurance represented the majority of referrals at 57%. The remaining 43% had private insurance. Ninety percent of the TRA-IDD referrals listed English as the primary language spoken in the home, 6% Spanish, and 4% as “other”. The majority of referrals at 62% were referred from elementary schools, 13% from middle schools, 23% from high schools, and 2% were children enrolled in WCPSS pre-K programs.

**TRA-I/DD Success Story**

“Student is a thirteen year old male who was referred for the Traditional I/DD program in February 2018. He has a diagnosis of autism, and was in regular classes with resource support.”
He was enrolled in a WCPSS middle school at the time of referral, but had not attended school since October 2017. The family was in crisis, with verbal and physical confrontations between student and his parents, especially his mother; escalating tensions between his parents, and significant anxiety on the part of his siblings. The police were called to the home on numerous occasions, and he had been to the ED four times, with one psychiatric admission. Student was depressed, and slept downstairs on the couch all day, staying up at night playing video games. SBCC assisted the family to navigate the I/DD Access process, which included assisting the family with obtaining an updated adaptive behavior inventory through the school system, as the child’s needs had changed considerably since the previous testing. Due to his parents income and his private insurance status, state funded services and Medicaid (b) services were not available to him. SBCC completed a referral for NC-START and the Alliance CIC team as additional supports. Residential placements were explored. Student was also referred to the Autism Society for behavior plan supports with a psychologist. SBCC assisted the family with the Care Review process, and getting him on the waiting list for the Wright School. SBCC advocated with WCPSS for day treatment services in a WCPSS slot at Ray of Hope. This was approved, and worked well for him from August through November 2018. In November the family was notified of an opening at Wright School. It took three attempts to get him to go there and stay for enrollment, but staff at The Wright School was patient, and he was enrolled on 12/3/18. SBCC, NC-START staff, and ASNC psychologist met three times with the parents to work on setting up structure and schedules for weekend and holiday visits. In mid-December, SBCC received this email from student’s father: “Just fyi, <name redacted> had a really good morning. He was difficult to get out of bed, but rocked and rolled once he got up. Went to school with no issues and no complaints. No grunting noises, which is a first so far. They had to take a picture of him when he got there and I haven’t seen <name redacted> smile as big as he did since he was really young. He went right back with the teacher laughing and joking. Pretty rewarding to see him smile.” Student did well at Wright School, and SBCC worked with WCPSS staff and his family to transition him home in June and prepare for the coming school year. SBCC, NC-START staff, and Autism Society psychologist worked with the family to plan for summer activities that provided structure and opportunities for social interaction. This student started high school in August. He has attended every day, has made some new friends, and is doing well academically.”

**PRTF Program**

**Referrals for the PRTF Program:**

The number of youth referred to the PRTF Program was 60. Fifty-eight consented to participate in the program which accounts for 97% of the youth referred. As of January 2018, the PRTF Program began quantifying number of Child and Family Teams (CFT) attended by PRTF care coordination. During this reporting period, the two PRTF care coordinators attended 150+ CFTs. CFTs support clear communication and collaboration between behavioral health providers and WCPSS to support the recovery process.
Performance Indicators and Outcomes:

The key indicator for youth leaving PRTF facilities include a timely connection with treatment and reconnection with schools. The data for the last three school years are as follows:

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<thead>
<tr>
<th>KPIs</th>
<th>16-17</th>
<th>17-18</th>
<th>18-19</th>
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<tbody>
<tr>
<td>% Reconnected with school within 10 days of discharge</td>
<td>63%</td>
<td>96%</td>
<td>100%</td>
</tr>
<tr>
<td>% of Treatment in 45 days</td>
<td>93%</td>
<td>92%</td>
<td>100%</td>
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Process Data 2018-2019

The PRTF Program starting capturing demographic data in February 2018 and this is the first full school year reporting demographic data. All 60 referrals received during the 2018-2019 school year listed English as their first language and Medicaid primary. The gender breakdown of referrals indicate males make up the majority of the PRTF referrals at 63%. The ethnicity breakdown indicates African-American students accounting for 50% of the PRTF referrals, Caucasian students at 45%, Hispanic at 3%, and Multi-Racial referrals at 2%. 
Sixty eight percent of the PRTF referrals were classified under Special Education (SPED) status. Referrals of high school students make up the majority (60%), with elementary aged children accounting for the lowest percentage at 15%.

<table>
<thead>
<tr>
<th>Gender</th>
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<td>38</td>
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<tr>
<td>Female</td>
<td>21</td>
</tr>
<tr>
<td>Transgender</td>
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<table>
<thead>
<tr>
<th>Ethnicity/Race</th>
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<tbody>
<tr>
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<td>30</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2</td>
</tr>
<tr>
<td>Multi-Racial</td>
<td>1</td>
</tr>
<tr>
<td>White</td>
<td>27</td>
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</table>

Sixty eight percent of the PRTF referrals were classified under Special Education (SPED) status. Referrals of high school students make up the majority (60%), with elementary aged children accounting for the lowest percentage at 15%.

<table>
<thead>
<tr>
<th>Special Education</th>
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<tbody>
<tr>
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<td>41</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
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<table>
<thead>
<tr>
<th>Grade Level</th>
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<tbody>
<tr>
<td>Elementary</td>
<td>9</td>
</tr>
<tr>
<td>Middle</td>
<td>15</td>
</tr>
<tr>
<td>High/GED</td>
<td>36</td>
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Process Indicators and Outcomes 2018-2019

The PRTF Program receives referrals from Alliance care coordinators who are working directly with the facilities.

From July 1, 2018 to June 30, 2019, the PRTF program received 60 new referrals, 58 of these students agreed to participate in the program. Fourteen of those 58 children discharged during
the 2018-2019 school year back into WCPSS. The remaining 44 children either stepped down from PRTF into another county/non-WCPSS school or remain in the PRTF setting at the time this report was generated.

Of note, from the previous fiscal year where cases were received 7/1/17 through 6/30/18, but discharged the next fiscal year from 7/1/18 through 6/30/19, an additional 11 children stepped down. Of those 11 children, 11 were enrolled in WCPSS within 10 business days accounting for 100%.

**Goal 1 - The PRTF program is to reconnect WCPSS students with a school and services upon discharge from a PRTF. The process indicator for the PRTF program is that students are enrolled in the WCPSS within 10 days of discharge from the PRTF.**

![WCPSS Students Re-enrolled into school within 10 days of discharge from PRTF](image)

**Results:** The SBCC PRTF team successfully enrolled 100% of those students who stepped down into WCPSS within 10 days post discharge from PRTF for the 2018-2019 school year.

**Goal 2 - Improve engagement in treatment services within 45 days of referral or discharge for youth who participate and have Medicaid or no insurance (services paid by Alliance).** Engagement is identified by at least one reimbursement claim submitted to Alliance for a therapeutic service within 45 days of the initial referral date or discharged date, whichever is later.
Results: The percentage engaged in services increased to 100% as compared to last school year.

SBCC PRTF Liaison Success Story

Student is a 17 year old male, special education student who was admitted to a PRTF in 2/2019. He was admitted to the PRTF after a hospital admission to local inpatient facility for aggression and impulsivity. Prior to his admission he was a student at Longview Alternative School. While at the PRTF, guardian did not agree with prescribing psychiatrists’ recommended medication regimen. SBCC PRTF liaison worked to support discharge planning and without a routine medication regimen, the student worked to implement strategies learned through therapy to support him in the classroom setting.

School Based Care Coordination PRTF liaison worked with WCPSS by:

- Collaborated with the educational department at the PRTF to assess/review strategies being implemented to support the student despite the absence of medication which resulted in increased irritability in the classroom setting and decreased motivation to attend class or complete his work.
- With guardian continuing to disagree with prescribed medication regimen, the student’s guardian interrupted his admission at the PRTF and discharged him in 5/2019 back to his home in Wake County. The SBCC PRTF Liaison worked with WCPSS by collaborating with the PRTF, post discharge, requesting discharge educational records to provide to Longview so that guardian could re-enroll him in Longview Alternative School.
- Ensured that Longview Alternative School staff and embedded SBCC Alternative School Care Coordinator was aware of the supports needed to ensure that this student could make forward progress towards earning credits for graduation.
- Although he was enrolled at WCPSS in 5/2019, assistance was provided in determining an appropriate educational plan for the student since he enrolled at Longview at the end of the 2018-2019 school year.
• Following up to ensure that the student’s medical and mental health needs were being addressed and met in order to ensure that he would be able to return to Longview for summer school as planned on 07/08/2019 by coordinating the information with WCPSS.
• Despite the challenges he was presented with, this student completed summer school at Longview earning his final credits to graduate with his high school diploma from WCPSS.

### Adult Diversion Program

The Adult Diversion Program obtains referrals from WCPSS Resource Officers with the goal of diverting 16-17 year olds who commit non-violent offenses at school from obtaining charges in the adult system. Wake County adult criminal court system, WCPSS, Wake County Government, and Alliance created a program to help these students. The program continues to meet all outcomes and is collaborating with leaders in the justice system to support the behavioral health needs of youth identified for this program, as well as the changes in 2019 with “Raise the Age”.

### Referrals for Diversion:

The number of youth referred to the Diversion Program was 68, a slight increase from the year before (in 17-18, 62 were referred). Of those referred, 56 were eligible and participated.

![Referrals](chart)

### Performance Indicators and Outcomes:

Currently in NC, all youth ages 16-17 who commit offenses are automatically treated as adults, regardless of the charge or severity of offense. **This will change starting in December 2019.** The Diversion Program will continue to serve the referrals until July 1st, 2020 as the program is a 6 month diversion program. Those referred in December 2019 will complete the program in late June 2020. A key indicator of this program is connection with appropriate treatment and support services. The table below indicates the program’s achievements:

<table>
<thead>
<tr>
<th>KPIs</th>
<th>16-17*</th>
<th>17-18</th>
<th>18-19</th>
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<tr>
<td># of students who screened positive for behavioral health issues with Medicaid or no insurance</td>
<td>New for 17-18</td>
<td>21</td>
<td>18</td>
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<tr>
<td></td>
<td>14</td>
<td>6</td>
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</tbody>
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% receiving treatment within 45 days | (n=55) 16% | 43% | 50%
% diverted from adult criminal justice system | 81% | 92% | 89%

*Data does not completely reflect all youth receiving services. A new field for those screening positive for behavioral health issues was added for the 17-18 school year. % of Medicaid/No insurance referrals receiving treatment based on the number who screened positive.

**Process Data 2018-2019**

The Adult Diversion Program obtains referrals from Wake County School Resource Officers with the goal of diverting 16-17 year olds who commit non-violent offenses at school from obtaining charges in the adult system.

There were 68 students ages 16-17 who were referred to the Adult Diversion Program during the 18-19 school year. About 54% identified as African-American, Caucasian youth accounted for 36%, Hispanic referrals decreased to 7% (a decrease by 9% from the previous school year), while 3% identified as “other”.

Youth with Medicaid or no insurance made up 37% of the referrals, youth with Healthchoice made up 3%. Sixty percent of the referrals either had private insurance or insurance status was unknown.
Process Indicators and Outcomes 2018-2019

The Adult Diversion Program receives referrals from WCPSS Resource Officers. The goal is to divert 16-17 year olds who commit low-level offenses from obtaining charges in the adult system by participating in a rehabilitation program.

**Goal – Percent of youth, screening positive at intake, who received an assessment or therapeutic service within 45 days of referral to the program.**

**Results**

From July 1, 2018 to June 30, 2019, the Adult Diversion program received 68 new referrals. Of the eligible referrals, 56 chose to participate in the program. Eighteen youth screened positive on the behavioral health screening tool, indicating that the youth may need treatment services. Of these youth, 6 reported having Medicaid or no insurance. A total of 3 (50%) voluntarily agreed to engage with a behavioral health provider and received a therapeutic service within 45 days.

All students received at least one service through the following programs. Alliance does not have a way of tracking when the student enrolled to measure whether they met the 45 day benchmark:

- 100 Black Men
- 4-H Teen Counts/Youth Development
- ACE
- Carolina Strategies
- CORRAL
- First Step
- School, Community Service, Employment
- Therapeutic Services – including services Alliance does not pay for or pays for through grant-funded programs
• Sean Ingram Academy
• Teen Court
• ASCEND program – youth enrichment program to help students reach their potential

Outcome 1 - Increase number of students who are diverted from the adult criminal justice system. Measure is defined as: % of youth referred and accepted to the program who successfully complete program requirements (and are, subsequently, diverted from adult charges). Data will be calculated as: (numerator, n=) the number of youth who successfully complete the program, (denominator, d=) the number of youth referred and accepted into the program.

From July 1, 2018 to June 30, 2019, 56 youth were eligible and chose to participate in the program. At the time this report was due, 46 participants were able to be analyzed in this data as 10 students are still active in the program. The remaining 10 students are expected to complete the program in December 2019. Thus, 41 participants (d=46, 89%) successfully completed the program and were diverted from the adult criminal justice system.

Below is a quote from Wake County District Attorney, Lorrin Freeman, who is a key leader in the collaboration in the Diversion Program:

"Historically, criminal justice system outcomes have focused on the crime while often overlooking the root cause of the criminal behavior. In Wake County, however, an innovative partnership between our office, Alliance Health and the public school system refers students ages 16-18 who become involved in low level, non-violent criminal behavior to a new diversion program to help get them back on track.

Importantly, this includes identifying and providing help for behavioral health concerns that may be present. We know that children who grow up in violent homes are more likely to grow into adults who engage in violence. Moreover, childhood neglect, not just physical abuse, can have a significant impact on an individual’s likelihood to engage in criminal behavior later in life.

Stopping the cycle of repeated criminal activity requires addressing the underlying cause of the criminal behavior. When we pair accountability with behavioral health assessment and treatment, better outcomes can be achieved for the offender and for the community.

I hope lawmakers will keep the invaluable impact of this program in mind as they consider funding for our state’s public behavioral health system. One misstep in high school should not determine an entire future."

Diversion Success Story

"Student was initially hospitalized at WakeMed due to violent episodes in the home. Mother refused to pick student up from hospital and he left on his own. A CFT was held at Broughton High and in attendance was CPS, Mental Health Agency by phone, Jill Harris-Velez (SBCC) who was working with this case as a crisis referral, and SAP Coordinator. At the CFT the team was informed that this student wouldn’t be allowed to attend Broughton because one of his
teachers reported that she was scared of him. It was determined that the student’s grandparents in Rocky Mount would be the best placement for the consumer. The grandparents agreed to let him reside at their residence on a trial basis to see how he performed. The SRO referred the student to the Teen Diversion Program due to a pending Disorderly Conduct Offense. Student was admitted into the program on 6/27/18 and completed on 12/27/18. During the time the student was assigned to the program, he participated in treatment sessions and called Diversion Coordinator on a weekly basis. Grandparents report that he is doing great in school and continues to move in a positive direction. He was also active in track at his local high school. His relationship with his biological mother improved greatly and she purchased the study guide for the ASVAB test as he wanted to join the military. He graduated from High School in June 2019 with plans of enlisting in the Air Force in December 2019.”

**Family Partner Program**

The School Based Care Coordination Team’s Family Specialist/Partner provides support to other caregivers as a person with her own lived experience caring for a child with extraordinary challenges and needs. She provides assistance and support to caregivers to empower them to increase their involvement, assist the caregivers of children to maximize the supports and accommodations that are available in his or her home, school and community. The Family Specialist is able to support families with a variety of complex needs while promoting a strengths based approach, focusing on solutions rather than problems.

The Family Specialist recently created a web based Caregiver Support Group. This group provides a safe space for caregivers to share their fears, challenges, and their successes. The group provides a variety of innovative methods for participants to interact and engage with the support group: phone, computer, and in person. The group has successfully brought together a growing community of caregivers whose children share unique needs and offers an environment for individuals to participate without fear of being judged or excluded. Since its inception in April of 2019, nineteen (19) individuals have connected to the group.

The Family Specialist was recently featured in the Alliance staff spotlight, as seen below:

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**Staff Spotlight**

“**One cannot possibly care for others if they are not taking care of themselves.**”

Carla Huff, Family Specialist

Carla Huff is a Family Specialist, and she provides support to parents/guardians of children either diagnosed with or having symptoms of a mental illness/exbrain disorder. Carla states, “As a parent of a child who received services and now a parent whose child receives services as a young adult, I offer a different perspective as to the real life, day-to-day challenges that parents face. It is so much more than a child going to therapy; it is about creating an environment in which a child and family can thrive and find wellness. I help parents find their voices for their children and for themselves.” Carla also partners with families, the System of Care Coordinator, and other community stakeholders to promote a system that is both family-driven and collaborative. Carla emphasizes that she is extremely excited about starting a support group for parents in Wake County in March. This will be an opportunity for parents to educate themselves on how to help their child, while also helping themselves. It will be held on the 1st and 3rd Monday of the month, from 7-8pm.

Carla explained that her first employer was an employer was the United States Army. After getting out of the military, Carla spent some time focusing entirely on her family until she moved to Raleigh to finish her education. After graduating from NC State University, she worked at the Juvenile Court Coordinator's Office for five years, then she taught at Wake County Public Schools until she landed at Alliance in 2014.

Carla feels that her experiences give her a different perspective and allow her to connect with the people she works with on a different level. She states that, “Building relationships with the people I collaborate with is what keeps me motivated. When asked what advice she would give to others her response was I do not have advice to give to others I know it is time for me to take a vacation and practice self-care. One cannot possibly care for others if they are not taking care of themselves.”

The Alliance core value that Carla feels she embodies is compassion. Her favorite quote or phrase that she would like to share is, “You weren’t born to just pay bills and die, instead fill your life with stories and pieces you’ve been.”

Written by: Elizabeth Pritchard MHS/SAUD Care Coordinator

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Family Partner Success Stories

“This group has given me a safety net and offers me a nurturing environment that helps me take care of myself so that I can take care of my children. Our group sharing gives us a sense of togetherness and takes us out of being isolated”. –TS

“I personally enjoy hearing that there is another family going through the exact or similar issues I face on a daily basis and provided positive feedback on what I have done in the past or how I should try to improve, do something different…I really get to exhale when we have our meet ups and we are truly able to connect and bond with each other”. –SB

Alternative School Program

Longview referrals:
Per WCPSS request, a care coordinator was placed at Longview Alternative School to facilitate coordination between WCPSS and behavioral health to include children transitioning in and out of crisis facilities. In the 2018-2019 school year, the care coordinator was able to obtain releases for 50 Longview families. The releases allowed coordination between WCPSS and behavioral health to include children transitioning in and out of crisis facilities. In addition, the program provided 12 groups which focused on career planning, goal setting, interviewing skills, housing, decision-making, and volunteering. Due to success of the groups, Activate Good, a community based program that coordinates volunteer work and community service, is working with Longview Alternative School.

The Alternative School Care Coordinator facilitated middle school groups for students in the spring semester. This was a new intervention organized along with Longview staff. Furthermore, Alternative School Care Coordinator facilitated 11 men’s groups for high school students during fall semester including 2 career speakers.

Other supports that SBCC Alternative School Care Coordinator provided during the 2018-2019 school year:

- Longview’s Spring Fling (5/3/19) – educational event to prepare for EOG’s. Alternative School Care Coordinator facilitated 3 students performing a positive/inspirational script.
- End of the Year Award Ceremony (6/10/19) – Alternative School Care Coordinator organized a presentation of events and accomplishments by students and staff.

Alternative School Program Success Story

Longview School, Alliance Health, and Activate Good collaborated in “Longview Shows Love”, an event at the school on February 13, 2019. The decision to do the event during the week of Valentine’s Day was intentional. Students, staff, parents, and community stakeholders all showed love for others in the community by creating customized packages for others. The event started with Amber Smith, Executive Director and co-founder of Activate Good, giving an inspirational message about struggles during her teen years and the increased confidence and
mental wellness that resulted from doing kind deeds and volunteering. Ms. Smith also gave several examples of significant charitable endeavors begun by people under the age of 18. She emphasized that not only does helping others benefit the community, it benefits the doer in multiple ways. Middle school students made “Smile Boxes” featuring encouraging messages and drawings on the outside along with toys and art supplies on the inside. The Smile Boxes will go to children in pediatric hospitals via the local nonprofit Zach’s Toy Chest. High school students created hygiene kits that included toiletry items as well as cards with inspirational messages that will be distributed by another local nonprofit, Passage Home. Both youth and adults were actively engaged in the project, and several people noted how good they felt afterward. We all got to experience the fact that love for oneself and love for others, including our local community, are all intertwined, and increasing one increases the other.

Quote from Longview Psychologist Tracy Cannady about the event: “I am truly thankful to have collaborated with Chris Toller on showing students and families the essence of giving back and showing others that they are cared for. The Longview Shows Love event was dynamic, inspirational, and truly a school wide opportunity to give back and make a difference in someone’s life.”

Letter from Longview Dean of Students, Ms. Gloria Miranda:

October 10, 2019

To Whom It May Concern:

First, let me say Mr. Toller has been an asset to Longview School in so many ways. Mr. Toller is very innovative and thinks outside the box to meet the needs of the students, staff and families. Mr. Toller goes above and beyond to provide support by assisting with programs, greeting and encouraging students and staff, and lending a hand wherever he can. The collaboration with our school and Mr. Toller/Alliance has allowed us to provide wrap around services and discuss resources that benefit the students and family. Mr. Toller attends our Student Service Meetings and High School Professional Learning Team in which he provides initiative ideas to help support the goals of the school. On numerous occasions the counselor, school psychologist and nurse have asked for his assistance with promoting wellness and helping to solve difficult problems during challenging situations. Mr. Toller is solution focused and often can reach some of our hardest kids. His desire to make a difference is evident in the way he conducts himself. Mr. Toller’s presence has been very welcoming, and he demonstrates a continued interest and effort to provide appropriate services to our family and students. Mr. Toller is a very valuable addition to the Longview family, and we could not meet the needs of our students, staff and families without him.

Sincerely,

Gloria Miranda, MS, LPCA, NCC
Longview School
Dean of Students/ HS Counselor
SBCC Partnering with Community and Schools:

8/21/18: Spedapalooza: Presentation on Alliance IDD Services to all WCPSS Extended Content Special Education teachers (AU, ID Moderate, ID Severe, Multi-handicapped classrooms)
9/20/18: Lake Myra Elementary Community Resource Fair
9/22/18: 1st Annual Longview Family Day Wellness Fair
10/22/18: Oakview Elementary, PLT Meeting
10/27/18: Poe Center Event
11/16/18: Kaleidoscope Event
12/12/18: SBCC Team volunteered at Note In the Pocket. Note in the Pocket is a nonprofit dedicated to providing clothing to WCPSS kids in need.
12/13/18: Conn Elementary, Community Resource Fair
12/17/18: Youth Substance Use Training
1/10/19: Davis Drive Elementary, Alliance IDD Services Presentation to Parents/Special Education Teachers
1/15/19: Longview Parent Workshop
1/18/19: White Oak Elementary Resource Fair, Alliance IDD Services Presentation to Parents/Special Education teachers
2/7/19: Kingswood Elementary, Alliance IDD Services Presentation to Parents/Special Education Teachers
2/12/19: “Longview Shows Love”, collaboration with Activate Good
2/13/19: SBCC Presentation for the PLT Team at Wake Forest Middle
2/18/19: SBCC Presentation to WCPSS Psychologists at Bugg Elementary
2/21/19: “Reality of Money” (with SECU) at Longview
2/28/19: Co-facilitated career discussion with Southern Cross, Inc for Longview
3/13/19: Enloe High School, SBCC Presentation
3/16/19: Southern Wake Academy, IDD Resource Fair
4/4/19: Stough Elementary Community Resource Fair
4/12/19: East Millbrook Middle Health Fair
5/3/19: Longview School Spring Fling
5/8/19: Wakelon Elementary Resource Fair
5/17/19: South Garner High School Resource Fair
6/10/19: Longview School Student Awards
6/17/19: WCPSS Psychology Mentee Event at Powell Elementary, SBCC Presentation

School Based Care Coordination also has team members participate in the following collaborative/trainings:

- Wake County Crisis Collaborative
- Therapeutic Foster Care Collaborative
- Young Child Mental Health
- State Collaborative
- Wake County Collaborative
- Juvenile Crime Prevention Council
- Veteran/Non-Veteran CIT Support
- Gang Prevention Collaborative
- DPI Collaborative/School Based Mental Health Initiative
- ACES Leadership Steering Committee
- NAMI
- Fuquay Varina Crisis Center Community Collaborative
- Provided CFT trainings
- Family Partner is being trained to provide and train the evidence based WRAP model

Appendix 1: Methodology

The School Based Care Coordination (SBCC) team began using a comprehensive referral tracking system in September 2014 for the Traditional program. To be able to analyze trends from year to year, we excluded any data from previous school years.

For the process data, the data collected includes gender, grade, ethnicity, language, insurance, and special education status for each referral. SBCC leadership pulled the data from the SharePoint site and created graphs of the data for each referral in the categories of gender, grade, ethnicity, language, insurance, and special education status, broken down by school year using Excel. Kindergarten is separated out from Elementary school as that age group is typically overrepresented among referrals compared to the percentage of Kindergartners in elementary schools. The sample size of students for the process data includes all referrals. Data analysis is pulled from the SharePoint site which continues to be modified, as needed.

The School Based Care Coordination team documents the insurance type for each referral and whether or not a child’s family agrees to receive services after the SBCC staff contact them. SBCC leadership identified the accepted referrals for each school year and then separated out those who were in the Alliance data system because they had Medicaid or no insurance. To calculate process indicators, claims data (whether or not providers billed Alliance for services provided to any of the students on the SBCC caseload) was compared to referral or contact dates (depending on the program) of the accepted student who also appear in the Alliance Health claims database to determine if a student received services within the designated time period. Using billed claims is the most reliable way of determining whether or not a student actually received treatment.

Appendix 2: Definitions:

Accepted (into program): Family did not refuse, referral appropriate for program, etc.

Not Accepted (into program): Family refused to participate at time of referral, youth not appropriate for program, family moved outside of WCPSS district, etc.
Insurances accepted: Medicaid, NC Healthchoice, IP/RS/State, and BCBS. Schedule a routine assessment, please contact intake coordinator, Marcie Boyes at: (919) 865-8802 for routine assessments. We now also offer after-hours assessments at our clinic to accommodate families’ schedules. To schedule an C.A.R.E.S. assessment please contact Nanette Nelson at: (919) 724-1427

To schedule an C.A.R.E.S. assessment please contact Nanette Nelson at:

Saturday, that can meet with children and families in the home, community, or on-site.

Licensure clinical assessor who is available between the hours of 2pm-10pm, Tuesdays through

After-hours home or office based Assessments for Children

Ensure that the appropriate services and supports are in place.

Easter Seals UCP has improved accessibility to services when children and families need to be connected to

Community Assessment and Response to Expedite Services

Easter Seals UCP C.A.R.E.S.
High-Fidelity Wraparound

What is it?
An evidence based, problem solving process that supports families in building teams of natural and formal supports in order to meet the needs and vision of the family, while building skills so that the family can be successful after discharge from Wraparound.

The 10 Key Principles of Wraparound:

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<tbody>
<tr>
<td>1.</td>
<td>Family Voice and Choice</td>
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<td>2.</td>
<td>Team-Based</td>
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<td>3.</td>
<td>Culturally Competent</td>
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<td>Natural Supports</td>
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<td>Unconditional Care</td>
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<td>10.</td>
<td>Outcome-Based</td>
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What happens during Wraparound?

- **Engagement**
  - Build rapport
  - Assess the strengths, needs, and culture of the family

- **Planning**
  - Family prioritizes needs
  - Develop a team
  - Monthly CFTMs

- **Implementation**
  - Skill building
  - Accountability for the plan's implementation
  - Problem-solving barriers to progress

- **Transition**
  - Planning for the future
  - Discharging from services
  - Celebrating success

5/16/2018