Section A: Population of Focus and Statement of Need

A.1. Geographic Catchment Area and Populations

This application is submitted on behalf of the Mental Health and Recovery Board of Union County (MHRBUC), the behavioral health planning and funding authority (political subdivision) for Union County, Ohio. Union County, Ohio, is a relatively prosperous county of 56,741 people. The county is located in Central Ohio and is contiguous on the southern border to Franklin County (Columbus, OH). Union Co. is among the fastest growing counties in Ohio. The rapid change in the county has brought an increase in population and a widening disparity of wages and increased social concerns. The southern part of the county is dynamic and has high service-sector and manufacturing job growth. The northern part of the county has characteristics more like Ohio's Appalachian communities with limited employment, social isolation, and absence of transportation services. Overall, however, there is a fairly good quality of life, unemployment is low and there is a strong sense of community.

Growth in the county has also brought an increasing diversity of residents. Approximately 92% of county residents identify as white, 2.4% identify as African American, 2.9% identify as Asian (Union County has 29 Japanese-owned companies and is headquarters to Honda of America), and 2% identify as more than one race. While the Central Ohio region (particularly Columbus) is known to be among the most LGBTQIA+ supportive communities in the mid-west, Union County offers limited supports or connectedness for people who are LGBTQIA+, despite the fact that statistically, they are our largest "minority" population representing about 4.5% of the county (Gallup, 2018). Tragically, suicide is more common in our community than death by unintentional overdose and our community has experienced multiple suicides of young people identified as LGBTQIA+. Recent focus groups and community assessment done by the MHRBUC revealed the need for specific supportive services for youth who identify as LGBTQIA+ and their families. This need, and the expansion of the county which was largely rural just 10 years ago has left the county struggling to catch up with human services infrastructure needs, as well as deficits in creating safe, inviting relationships for people who represent non-majority populations.

We are challenging the traditional nature of our community. In traditional systems, functions are institutional or system-based, problems and funding are viewed as isolated and categorical, families and youth are blamed and seen as objects and punitive services are "done to" them. Issues of culture and strength are largely blind. Services have been focused on out-of-home placement, residential and inpatient placements, and less than two years ago, Union County had a placement rate significantly higher than the Ohio average (PCSAO, 2017). Nearly 40% of Union County Juvenile Court cases are beyond the Ohio Supreme Court disposition timeline. The MHRBUC has taken these issues head on, instituting High-Fidelity Wraparound, Intensive Home-Based Treatment (IHBT) Functional Family Therapy (FFT), expanded service coordination, funded school-based MH navigators, and convened community work groups on out-of-home placement.

The *Mosaic Project* outlined in this proposal will make a core benefits package of behavioral health services available to all children and youth ages 0-18 plus youth in transition in Union Co. (approximately 16,000 youth) through culturally competent, accessible service coordination and services. The core benefits package is designed to fulfill the Institute of Medicine's behavioral health intervention spectrum (IOM, 2009) and provides the infrastructure of care management and service coordination to ensure that all children receive access to programs and services necessary to promote well-being, intervene early, treat behavioral health conditions, and give ongoing support for children and families. Recognizing that most of the children and

youth will be served in the promotion and prevention parts of the continuum, the *Mosaic Project* envisions serving 250 children/youth at risk for SED annually through service coordination (400 unduplicated over the project). This penetration rate is based on data from Union County Youth Risk Survey, Medicaid and MH Block Grant claims data, and national trends (CDC, 2017). The *Mosaic Project* will provide coordination to help families access this continuum regardless of payer. The process will braid together funds from private insurance, the MH Block Grant, Medicaid, local levy dollars, and other funding sources to ensure that this continuum is available.

A.2. Need for Enhanced Infrastructure

The SAMHSA FOA for this project requires that a strategic financing plan be developed by the end of Year 2 and implemented in Year 3 (FOA, p.9). This application is unique in that it starts with a sustainable financing plan that links youth-serving systems, providers and public/private payers including Medicaid. The application was developed in collaboration with Partners for Kids (PFK) and CareSource. Partners for Kids (PFK) is one of the nation's oldest and largest pediatric accountable care organizations. PFK is a partnership between Nationwide Children's Hospital and more than 1,000 physicians offering coordinated care to their population. PFK acts as a bridge between four of the five Ohio Medicaid Managed Care plans for approximately 330,000 children. CareSource is Ohio's largest Medicaid Managed Care Organization and manages the care for the remaining Medicaid-insured children.

Given that many Union County families are privately insured, it would be the assumption that they have access to a coordinated system of care when behavioral health needs arise. In fact, the opposite is frequently true. When a family has a Medicaid-insured and multisystem-involved child, there is a mechanism for service coordination and access to a rich continuum of care. When a child is insured privately, the benefits are generally limited to assessment, counseling, and crisis services. While we know that these are important pieces of a system of care, they represent only a fraction of the interventions necessary to ensure the best behavioral health outcomes. Many private plans also have very high deductibles which further deter access to care. Parents of these children have no idea – and no mechanism – to be made aware of services such as service coordination, parenting education and peer support, High-Fidelity Wraparound, case management, intensive home-based treatments, and respite care. While seemingly counter-intuitive, our privately insured children are often the most under-treated and have the least access to the service continuum.

Despite the early successes of our attention to system of care implementation, there is significantly more to do. We need to establish a formal, enhanced **governance** process with representation not only from systems or providers, but meaningful co-governance with persons with lived experience who are the primary stakeholders in a System of Care. The *Mosaic Project* governance board will also include payers, many of whom have been largely excluded from the dialogue but have significant stake in ensuring the right care at the right time. We also lack effective data management. As part of the Ohio Family and Children First Council, Fidelity EHR has been provided for our Wraparound Coordinator and facilitators. Yet the data is unmined and siloed from other systems. We need a meaningful data set from which to make decisions, capture encounters, and ensure quality.

Ohio Governor Mike Dewine has promulgated multiple Executive Orders related to systems of care for children and youth, including EO 2019-02D creating the Governor's Children's Initiative and EO 2019-05D Elevating Foster Care Priorities in Ohio. These orders are reflected in the Governor's proposed budget that is currently in the legislature. The *Mosaic Project* will utilize all available state resources whether those resource funding initiatives, training and technical assistance, or policy development.

Section B: Proposed Implementation Approach

Background and Design

Service coordination for multi-system youth with behavioral health issues has been identified as a critical component of managing these chronic conditions (Pires, Fields, & McGarrie, 2016). Yet, service coordination for youth behavioral health needs is largely dependent on the reimbursement structure of the child's primary payer, managed care organization, or accountable care organization (Honsberger, Normile, Schwalberg, & VanLandeghem, 2018). Youth who experience behavioral health concerns often have limited care coordination that rarely combines services from a private payers (employer-provided or Exchange health plans), Medicaid, MH Block Grant, and local public funding – even when combinations are indicated for an individualized plan of care. This leads to service gaps in a fragmented system. Often, services are *technically* available but there is no centralized service coordination to help any family in need.

Our community became painfully aware of this phenomenon through the recent loss of two of our young people to suicide. The suicides occurred within a short period of time and our analysis of the circumstances revealed that both young people were privately insured and connected with a counselor. None of the other services or supports were available to them because there was no mechanism to bring them to the table. While they could have had service coordination, the access to such care coordination is initiated by *systems* and not the family so many have no idea of their availability.

The Mosaic Project will change that. By identifying a core benefits package for all children and then providing the coordination of payers – both public and private – we will maximize access to the IOM Continuum of Care and ensure that all children have access to the right service at the right time. Based on SAMHSA's Tiered Care Coordination model (SAMHSA, 2016), *The Mosaic Project* will begin with universal screening of all children in Union Co., provide a centralized intake portal for any family, and coordinate services across the complete continuum of evidence-based practices – from prevention to recovery supports. It will be the responsibility of *The Mosaic Project* to help the family select the correct mix and amount of services and then utilize all available benefits – private insurance, Medicaid, MH Block Grant, SAPT Block Grant, state GRF funds, funds from juvenile justice and child protection, education funding, and local levy dollars to provide the service plan seamlessly to the family.

There have been similar initiatives in other areas. One such initiative reviewed extensively for this application was Wraparound Milwaukee (www.wraparoundmke.com). However, even this unique wrap-focused public managed care entity (MCE) requires the child be engaged with a public payer (e.g. Medicaid) or be at eminent risk of removal. By ignoring the private insurance market – we leave resources on the table and families are not served with coordinated care plans.

Funds awarded under this proposal will be used to build the infrastructure including planning and policy, information technology, engagement and referral, screening, service coordination, crisis services, and a continuum of evidence-based practices across the IOM continuum. This system of care will be supported by sophisticated data management and health information exchange, and collaboration among the system payers from all levels. This will enable families to focus on wellness and recovery with an understanding of the available benefits and without the worry of understanding how to navigate the endless parade of payment systems. The result will be an unprecedented level of collaboration and coordination that ensures our kids are healthy and thriving. **Table 1** (following in Section B.2) illustrates the architecture of the Mosaic Program and the inclusion of SAMHSA required activities.

Section B: 1. Goals/Objectives

1. Goal: *Establish SOC infrastructure to improve prevention, early identification, and referral to the Mosaic Project (SOC) of children with or at risk of developing SED.*
   1.1. Establish governance board that includes Medicaid MCO/ACOs; youth-serving agencies and schools; family representative(s); local BH Authority; private insurer representative(s), and youth with lived experience to design, direct, monitor and adjust SOC.
   1.2. Create *The Mosaic Project* SOC design with core benefits (required service set) identified.
   1.3. Identify and utilize information management and data systems to ensure appropriate coordination of care, ethical consenting of participation and data sharing (SAMHSA's Consent2Share), and service utilization/outcomes.
   1.4. Ensure culturally and linguistically appropriate planning, design and service delivery with direct consumer engagement and appropriate application of CLAS Standards.
2. Goal: *Identify and remove barriers to access, engagement, awareness of and service delivery for the Mosaic Project System of Care.*
   Proposed number served: 800 youth/families annually across the IOM continuum (primary prevention through identification) 2,500 unduplicated over 4 years.
   2.1. Using health promotion, social marketing, and education, ensure that the public, private insurers, agencies, and persons seeking assistance know how to access the SOC.
   2.2. Create Centralized "one stop" engagement (central intake) for benefits package of the SOC.
   2.3. Create web portal, phone app, and other tech interfaces to give families access to their service plans, appointment reminders, and family management strategies.
   2.4. Establish care management information technology using SAMHSA's Consent2Share, Fidelity EHR, and the Clinisync (Ohio) health information exchange (HIE).
   2.5. Ensure universal screening for all children through local school districts using evidence-based screens for social, emotional, and behavioral concerns.
3. Goal: *Establish and expand evidence-based mental health interventions to fulfill the required activities and ensure network adequacy for delivery of SOC services.*
   Proposed number served: 250 SED/at risk annually, 400 unduplicated over 4 years.
   3.1. Identify gaps and needs across the IOM Continuum of Care.
   3.2. Provide training and monitoring of providers to ensure utilization of EBP's and fidelity to selected models.
   3.3. Provide staffing for service coordination, care management, and central intake.
   3.4. Develop a learning "community of practice" for SOC activities.
   3.5. Engage and expand the network of behavioral health services providers to ensure adequate network access for youth and families seeking services.
   3.6. Ensure rigorous evaluation of service outcomes utilizing behavioral health HEDIS measures, SPARS reporting requirements, clinical outcomes measures, and family/youth satisfaction.
4. Goal: *Identify and/or create community and natural supports for children/youth with SED and their families to support effective treatment and provide natural transition from services.*
   4.1. Utilize evidence-based peer support models (APG, etc.) to provide support for youth with lived experience.
   4.2. Engage the faith community in establishing or expanding support groups and positive youth engagement.
   4.3. Ensure appropriate engagement of extended families, traditional wisdom figures, and other natural supports in the service coordination to increase positive connection post-treatment.
   4.4. Create positive youth development activities (e.g. Adventure Therapy, youth leadership, life skills) to engage the youth in naturally supportive activities.
   4.5. Engage the Chamber of Commerce and local employers to assist in providing job skills and competitive employment.

Section B.2. Implementation of Required Activities

Table 1. Proposed Implementation Approach and SAMHSA Required Activities

IOM CONTINUUM OF CARE						
Promotion						
Universal	Selective	Indicated	Identification	Treatment	Intensive Tx	Supports

CHILDREN/YOUTH CORE BENEFITS PACKAGE (WHAT?)			
Prevention/Community	**Intervention**	**Treatment**	**Recovery Supports**
AOD / MH Community & School-Based Prevention Consultation Positive Youth Development Youth-Led Prevention	Crisis Line/Text Line* Crisis Intervention* SBIRT / SBIRT +* School BH Navigators	Diagnostic Assessment* Psychiatry* Ind./Family Counseling* CPST/Case Management* IHBT* Service Coordination* Wraparound*	Certified Peer Support* Parent/Family* Mentors Support Groups

ENGAGEMENT (WHEN?)						
Universal Screening (Early Childhood - Adolescence)						
Web Portal	Community Events	Outreach	SBIRT+	Diagnostic Assess.	DA + CANS	CRT + DA + CANS

CENTRAL INTAKE & ENROLLMENT	
Information and Referral	Care Management
Consent2Share + Fidelity EHR Data Management Care Coordination System + HIE	

KEY PERSONNEL (WHO?)		
Primary Care Providers Prevention Specialists Parent Educators ECMH Consultants	School Navigators Care Managers School-Based Clinicians Support Group Facilitators	Clinicians Service Coordinators Care Managers (MCOs) Wraparound Facilitators Peer Supporters/Parent Mentors

EVIDENCE-BASED SERVICES (HOW?)			
Prevention	Incredible Years PAX GBG/PAX Tools Triple P Strengthening Families Signs of Suicide (SOS)	Youth/Adult MH First Aid Youth Peer MH First Aid Alcohol Literacy Challenge Botvin LifeSkills Youth-Led Prevention	Active Parenting LGBTQIA + GSA Support Expressive Arts Coping & Support Training Girls Moving On
Problem ID	SBIRT/ SBIRT + (includes PHQ9, ACES, SASSI)* Evidence Based Universal Screening (includes SAEBRS, ASQ, SDQ)* Community Response Team Rapid Intervention (CRT) Family Check Up*		
Treatment	Child/Adolescent Psychiatry* Diagnostic Assessment* Child/Adolescent Needs & Strengths (CANS)	Intensive HB Treatment (IHBT)* Functional Family Therapy (FFT)* Hi-Fidelity Wraparound* Trauma Informed Care Dialectical Behavior Treatment*	24/7 Crisis Response* Intensive Day Treatment* EMDR Respite*
Recovery	Parent Mentoring* Support Groups Employment Supports*	Alternative Peer Groups (APG)* Therapeutic Foster Care* Transitional Youth Services*	Respite* ***SAMHSA REQUIRED ACTIVITIES**

Section B.3 Timeline for Implementation (Federal Fiscal Year Quarters)

PD = Project Director PC = Project Coordinator MCO = Managed Care Organizations SC = Service Coordinators
PRO = Provider(s) LFC = Lead Family Coordinator EVAL = Evaluator MPGB = Mosaic Project Governance Board

Year 1 Activities	**Q1**	**Q2**	**Q3**	**Q4**	**Responsible**
Establish governance board	●				PD, PC, MCO, PRO, MPGB
Hire Lead Family Coordinator	●				PD, PC
Contract - Central Intake & Providers	●				PD, PC, PRO
Contract -Marshall Univ. Eval	●				PD, PC
Design Information Mgmt/Care Coord MIS	●	●	●		PD, PC, MCO, PRO, MPG, EVAL
Develop Cultural/Linguistic Assess/Plan		●	●		PD, PC, MCO, PRO, LFC, EVAL, MPGB
Develop Promotion/Access Public Info		●	●	●	PC, PRO, LFC, EVAL, MPG
Conduct SOC Gap Analysis			●	●	PC, MPGB, EVAL
Provide Required MH Services	●	●	●	●	PRO, LFC, SC
Establish Data/Eval/CQI Committee		●			PD, PC, EVAL, MPGB, MCO
Design/Implement Required Eval Data		●	●		PD, PC, MPBG, EVAL
Develop Strategic Financing Plan			●	●	PD, PC, PRO, MCO, MPGB
Engage natural supports/recovery supports		●	●	●	PC, LFC, SC
Train in EBPs		●	●	●	PD, PC, PRO, LFC, SC
Engage State Stakeholders for sustainability			●	●	PD, PC, MPGB
Year 2 Activities	**Q1**	**Q2**	**Q3**	**Q4**	
Create/Promote Web Portal, App Access	●	●			PC, MPGB, PRO
Develop Soc. Media/Stigma Reduction Plan	●	●	●	●	PC, EVAL, Consultants
Publish Year 1 Activities/Eval/CQI	●				PD, PC, EVAL
Ensure Strategic Finance Plan	●	●	●	●	PD, PC, MCO, MPGB
Engage Private Insurers in SOC & MPGB	●	●	●	●	PC, MCO, MPGB
Establish universal screening in all schools		●	●	●	PC, PRO, SC, Schools
Create Community of Practice	●				PD, PC, LFC, PRO, SC
Ensure access to SOC MH Services	●	●	●	●	PD, PC, MCO, PRO, MPGB,
Continue evaluation of required activities	●	●	●	●	PD, PC, EVAL, MPGB
Provide Required MH Services	●	●	●	●	PRO, LFC, SC
Review evaluation YR1 and adjust		●	●		PD, PC, EVAL, MPGB
Ensure groups/recovery supports/EBPs	●	●	●	●	PC, PRO, LFC
Review Cultural/Linguistic Plan + Update			●		PD, PC, MPGB, LFC, PRO, Participants
Develop Sustainability plan			●		PD, PC, MPGB
Engage State Stakeholders for sustainability			●	●	PD, PC, MPGB
Year 3 Activities	**Q1**	**Q2**	**Q3**	**Q4**	
Publish Year 2 Activities/Eval/CQI	●				PD, PC, EVAL
Identify new EBPs and Train if indicated	●	●	●	●	PC, PRO
Continue Community of Practice	●	●	●	●	PD, PC, PRO, LFC
Convene Tiered Care Coordination Summit	●				PD, PC
Continue evaluation of required activities	●	●	●	●	PD, PC, EVAL, MPGB
Review evaluation YR 2 and adjust		●	●		PD, PC, EVAL, MPGB
Provide Required MH Services	●	●	●	●	PRO, LFC, SC
Review Cultural/Linguistic Plan + Update			●		PD, PC, MPGB, LFC, PRO, Participants
Engage State Stakeholders for sustainability			●	●	PD, PC, MPGB
Year 4 Activities	**Q1**	**Q2**	**Q3**	**Q4**	
Publish Year 3 Activities/Eval/CQI	●				PD, PC
Provide Required MH Services	●	●	●	●	PRO, LFC, SC
Publish plan for sustainability	●	●			PD, PC, MPGB
Celebration of System Transformation			●		PD, PC, LFC, SC, MPGB, Community
Complete all grant requirements/close out				●	PD, PC

Section C.1 Experience with Similar Projects

As the applicant organization, the Mental Health & Recovery Board of Union Counties (MHRBUC) is the public behavioral health authority for planning, funding, and evaluating mental health and substance abuse services in our jurisdiction. As such, the MHRBUC is responsible for the oversight and allocation of SAPT and MH Block Grant funds, Ohio General Revenue Funds (GRF), special grant funds from both state and federal sources (Drug Free Communities; Bureau of Justice Assistance; State Opiate Response), and local tax levy funds. The MHRBUC has extensive experience with youth systems of care as well as the Ohio Strong Families, Safe Communities grant initiatives. The MHRBUC serves as the administrative and fiscal agent for the Union County Council for Families, a statutory, multisystem youth system of care organization. The role of the MHRBUC will be to provide oversight and funding for the project. The Union County Council for Families, as a sub-organization will be utilized to employ and house the service coordinators for the project. The Council is the local division of the Ohio Family and Children First initiative – a cabinet-level state organization (https://fcf.ohio.gov). The project will be overseen by the Youth Systems of Care Director who will serve as the Principal Investigator and Project Director.

Partner organizations for this initiative will include the Medicaid Managed Care Organizations (MCOs). Ohio currently has five (5) MCOs managing Medicaid for recipients. Partners for Kids (PFK) manages the behavioral health services for four of the five plans and CareSource manages the behavioral health services for their plan. PFK is the nation's largest children's behavioral health Accountable Care Organization (ACO) and provides managed Medicaid behavioral health services to more than 330,000 children in 34 Ohio Counties. CareSource, as Ohio's largest MCO, has significant penetration in Union County and is also a partner in this initiative (see attached letters of commitment). These organizations will serve as *Mosaic Project* Governance Board members and provide care coordination to youth with service-intensive needs.

Nationwide Children's Hospital (NCH) is a primary pediatric hospital in Columbus, Ohio, with more than 1,379 medical staff members and over 11,909 total employees. In recent years, the hospital has been ranked as one of America's Best Children's Hospitals. NCH has a significant presence in the children's behavioral health services market in Union County which will be expanded under this initiative.

Maryhaven at the Mills is Union County's comprehensive behavioral health services provider. They currently provide school-based BH navigation, high fidelity wraparound, intensive home-based services (IHBT), psychiatry, behavioral health crisis services and most of the required behavioral health services.

The Helpline provides crisis engagement via hotline and text as well as 211 services. They handle all crisis calls and information and referral. They are staffed by licensed social workers 24/7 and will expand their client engagement and rapid access services to serve as the Central Intake provider under this initiative. They handle more than 15,000 crisis calls per year.

Marshall University will provide project evaluation. Dr. Tammy Collins will lead the evaluation. Dr. Collins works with various Centers under Marshall University's Research Corporation structure including: The Center of Excellence for Recovery and West Virginia School-Based Mental Health Technical Assistance Center and with Marshall Health on federal, state and local research and evaluation projects including projects funded through the Substance Abuse and Mental Health Services Administration and the National Institutes of Health as well as West Virginia State Government Departments.

Section C.2 Complete List of Staff Positions

Position	Role	Level of Effort	Qualifications	Funding Source
Positions at the Mental Health & Recovery Board of Union County (political subdivision, applicant agency)				
Applicant Executive Director Philip D. Atkins	Administrative and Fiscal Oversight	.1 FTE	PhD, LICDC-CS, OCPC	In kind to this project as match
Project Director/PI Carmen Irving	Oversight/management of the *Mosaic Project* (SOC)	1 FTE	MA, CFLE	SAMHSA SOC
Lead Family Coordinator TBD	Primary engagement and support for families and youth	1 FTE	Lived experience as parent of multisystem youth	SAMHSA SOC
Administrative Assistant	General support to the project	.2 FTE	Administrative support experience	In kind to this project as match
Positions via Contract with the Union County Council for Families (under administrative and fiscal agency of applicant)				
Project Coordinator Jason King	Project Coordination, Daily Operations, Supervision of Lead Parent and Service Coordinators	.75 FTE	MSW, LSW	SAMHSA SOC
Service Coordinators (2) TBD	Care coordination and management for youth and families	2 FTEs	Minimum bachelor's degree in human services field. LSW or QMHS preferred	SAMHSA SOC
High Fidelity Wraparound Coordinator TBD	Oversight and provision of High Fidelity Wrap Services	1 FTE	Masters with MH license	In kind to this project as match
Parent Educator TBD	Provision of parent support and education	1 FTE	Minimum bachelor's degree in human services field. LSW or QMHS preferred	SAMHSA SOC
Position via Contract with Marshall University				
Project Evaluator Tammy Collins, PhD Marshall Univ	Planning and Evaluation Design	.25 FTE	PhD, project evaluation experience	SAMHSA SOC

The applicant Executive Director (Philip D. Atkins, PhD) will provide in-kind support as the Executive Director of the MHRBUC. The Project Director/Principle Investigator (Carmen Irving) serves as the Youth Systems of Care Director for the MHRBUC and will be assigned to the project at 1 FTE (40 hours per week). The Lead Parent Coordinator (TBD) will be an employee of the applicant. The Project Coordinator (Jason King) is the lead direct service provider/service coordinator manager through the Union County Council for Families (under the administrative and fiscal management of MHRBUC) via contract services. This Council will employ the Project Coordinator, Service Coordinators, Parent Educator, and High Fidelity Wraparound Coordinator.

Other key functions will be coordinated as contracted services. The Marshall University evaluator (Tammy Collins, PhD) will be managed through professional services agreements as will be the Central Intake provider, clinical services providers, and other supportive services providers.

Section D. Data Collection and Performance Management

Data collection will be a combination of electronic and paper. The primary care management system will be Fidelity EHR. This EHR is specifically designed to support system of care and wraparound implementations. It was adopted by the State of Ohio for service coordination in 2017. Initial data will be entered via central intake and will be securely stored on a cloud-based server. Permissions will be HIPAA and 42 CFR Compliant by using SAMHSA's Consent2Share electronic consenting process which will be fully integrated into Fidelity EHR. Fidelity EHR has the CANS (Child and Adolescent Needs and Strengths) instrument, the Wraparound Fidelity Index (WFI-4) and several additional validated measures integrated into the system. Fidelity EHR will be customized or integrated with the SAMHSA National Outcome Measures (NOMs) Client-Level Measures for Discretionary Programs Providing Direct Services Tool (SAMHSA TOOL) Child and Adolescent/ Caregiver Combined Version for the SPARS process. The data collection and performance management will be measured at four levels: collaboration process effectiveness, utilization data, clinical outcomes, and EBP adherence. The data will be presented in a monthly dashboard format to the Mosaic Project Governance Board and key stakeholders.

Performance Measures	Data Source	Collection Frequency	Responsible Staff for Data Collection	Method of Data Analysis
Collaboration Process Effectiveness (Mosaic Project Governance Board)				
Five-Dimensions of Effective Collaboration: Joint Decision Making Administration Autonomy Mutuality Trust	Five Dimension, 17 Indicator Collaboration Scale (Thomson, Perry & Miller, 2009).	Baseline + Annually	Project Director Evaluator	Descriptive Statistics
Policy Changes as a result of the grant	Governance Board meeting minutes	Monthly	Project Director	Nominal Measurement: Policy Count
Cultural competence and programming humility	CLAS Assessment	Bi-Annually	Project Director	Assessment Results
Utilization Data (Client-level Engagement Data)				
Number of individuals contacted through program outreach	Social Media/Web Portal data; Public information reach; Central intake contacts; outreach efforts/attendance	Monthly	Project Coordinator; Social Media/Web provider; Central Intake provider; Lead Parent Coordinator	Nominal Measurement: Aggregation and count by contact type and volume
Number of individuals referred to MH or related Services	Central Intake contacts	Monthly	Central Intake provider Service Coordinators	Nominal Measurement: Number served and referral/disposition
Number of individuals receiving MH or related services after referral	Fidelity EHR, Provider utilization data; MCO Claims data	Monthly	Service Coordinators; Providers; Lead Parent Coordinator	Nominal Measurement: Number served by provider, service access time/ LOS
Number of youth/families receiving services as a result of the grant	Fidelity EHR, Central Intake data, Provider enrollment reports; MCO Claims data	Quarterly	Project Director; Project Coord; Providers; Central Intake; MCOs	Aggregate data of all grant activities by service type; Claims and dollar spend per service recipient

Performance Measures	Data Source	Collection Frequency	Responsible Staff for Data Collection	Method of Data Analysis
Clinical Outcomes (Results of Clinical Interventions)				
Clinical Engagement Diagnosis Symptomology Employment/Education Crime/Criminal Justice Housing Stability	Fidelity EHR SAMHSA Services Tool (SPARS) CANS CAFAS	Encounter-based Episode of Care – baseline, reassessment (180 days), discharge	Providers; Service Coordinators Service Coordinators	Care management review; team meetings; aggregate reports of SPARS Services Tool Child/Adolescent Functional Assess Scale (CAFAS)
Youth/Family Needs and Strengths; Social Support and Connectedness	CANS – Child and Adolescent Needs and Strengths	Encounter-based Episode of Care – baseline, reassessment (180 days), discharge	Providers; Service Coordinators	Client-level and aggregate reporting of CANS scores
Rate of Readmission to psychiatric hospitals	Claims data; Provider records	Quarterly	Providers; Service Coordinators; MCOs	HEDIS Measure: Numerator – Total readmissions within 30 days of DC Denominator – Total Population (age 6-18)
Rate of Follow Up after Hospitalization for Behavioral Health Disorder	Claims Data; Provider Records; Fidelity EHR	Quarterly	Providers; Service Coordinators; MCOs	HEDIS Measure: Numerator(s) 7 day follow up visit and 30 day follow up visit Denominator – Eligible Population
Client/Family Perception of Care	Client Satisfaction Instrument; Wraparound Fidelity Index (WFI-EZ) Client/Youth focus groups	Discharge + 30 days; Semi-Annually	Providers, Service Coordinators; Wraparound facilitators; Evaluator, Lead Parent Coordinator	Descriptive Statistics; Thematic Analysis
Evidence-Based Practice Adherence (EBP Fidelity Measures)				
Intensive Home-Based Treatment (IHBT)	IHBT Fidelity Measures Review	Quarterly	Providers; Evaluator; Clinical Consultants	Indexed Score on IHBT Fidelity Review
High Fidelity Wraparound	Wraparound Fidelity Index (WFI-4); Team Observation Measure (TOM); Annual Hi-Fi Wrap training	Case-based frequency; Annually	Wraparound Facilitators; youth/ family members; Wraparound Coordinator; Project Coordinator; Contract trainers	Indexed scores and aggregate participant data; Training data
Child and Adolescent Needs and Strengths (CANS)	CANS fidelity assessment and annual training	Annually	Praed Foundation (developer of CANS)	Completed assessments and trainings; CANS certifications completed