A. SCOPE OF SERVICES:

A.1. The Grantee shall provide all services and deliverables as required, described, and detailed herein and shall meet all service and delivery timelines as specified by this Grant Contract.

A.2. Service Definitions:

a. The Early Connections Network (ECN) is a regional System of Care (SOC) made possible with a federal grant award from the United States Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS) as part of the Child Mental Health Initiative Program. The ECN seeks to develop and implement a regional early childhood SOC in Cheatham, Robertson, Dickson, Sumner and Montgomery Counties for young children, as defined in Section A.2., with social, emotional, and behavioral needs and their families, in addition to developing a model for possible replication in other parts of Tennessee.

b. "Broad-based Governance Structure (BGS)", for purposed of the ECN, is defined as the overall governing body of the ECN. The BGS shall be comprised of representatives from various early childhood state and local agencies, local community and advocacy groups, local elected officials, early childcare centers, providers, schools, family members, youth, military service members, veterans, and military officials. The BGS will consist of the Coordinating Council (approximately twenty-one (21) members), the Full Partnership (approximately one hundred (100) members), and various workgroups as needed to achieve full SOC implementation and sustainability. The purpose of the BGS is to provide oversight of and make decisions about all aspects of ECN planning, implementation, and sustainability, including, but not limited to strategic system planning; facilitating state and local collaborative partnerships and securing Memoranda of Agreement; resolving system-wide barriers such as access to effective and age appropriate services; and family engagement in governance.

c. "ECN Principal Investigator (PI)" is the designated individual employed by the State responsible for the overall leadership, development, and guidance of ECN's theoretical framework, treatment modality, and performance with respect to goals and objectives. The PI is also responsible for fiscal and administrative oversight of the ECN.

d. "ECN Project Director (PD)" is the individual designated by the State responsible for providing leadership in all facets of the development of ECN and managing and/or supervising all key staff positions. The ECN PD oversees the day to day operations of ECN, including the development of a comprehensive theory of change and strategic plan, ensuring family involvement in all aspects of ECN and overseeing program services, evaluation, and continuous quality improvement efforts for infants and young children, as defined in Section A.2., with social, emotional, and behavioral needs and their families in the five (5) county coverage area of Cheatham, Robertson, Dickson, Sumner, and Montgomery Counties.

e. "Full Time Equivalent (FTE)" refers to the number of total hours worked divided by the maximum number of compensable hours in a work year as defined by federal law.

f. "Grant Management Team (GMT)", for purposes of the ECN, is a team of representatives from the Grant Partner agencies that meets bi-monthly or as needed to ensure the terms of the SAMHSA Cooperative Agreement are met, procurement contracts are executed in accordance with Section D.17. and in a timely manner, and grant planning and implementation activities are conducted in a collaborative and ethical manner. The GMT, under the leadership of the ECN PD and inclusive of the ECN PI, serves the ECN in a supportive capacity working in partnership with the BGS.

g. "Grant Partners", for purposes of the ECN, include the State; the Grantee; Centerstone of Tennessee; Centerstone Research Institute, and other agencies as designated by the State.

h. "Imminent Risk", for purposes of the ECN, is a term to be used when determining eligibility criteria for enrollment in ECN services. The term will be used for infants and young children, as defined in Section A.2., judged to be at risk for developing a mental health disorder as identified through a standardized measure consistent with the most recent recommendations of SAMHSA's Early Childhood Community of Practice Diagnosis and Eligibility Workgroup at the time of assessment, and approved by a licensed mental health practitioner with knowledge of early childhood development.

i. "Infants and Young Children" and "Young Children", for purposes of the ECN, means those aged birth (0) to five (5) years.

j. "Management Information System (MIS)", for purposes of the ECN, is either the Qualifacts Information System, a web-based, electronic clinical record system that was created by Qualifacts, used by Tennessee Voices for Children, and specifically designed for systems of care such as the ECN; and/or CenterNet, a web-based, electronic clinical record system created and used by Centerstone of Tennessee, and/or other electronic medical record systems designated by the State.

k. "Model of Service Provision" to be determined will be a strengths-based approach to service planning and care where a child-centered and family-driven Individualized Support Plan (ISP) is developed to guide the family in the process of accessing services and supports to promote success, safety, and permanence in the home, school, and community.

l. "Social, Emotional, and Behavioral Needs", for purposes of the ECN, pertain to infants and young children, as defined in Section A.2., who are judged at the time of assessment to be at imminent risk of developing a mental health disorder and/or meet established eligibility criteria for enrollment in the ECN.

m. "Transformation Accountability (TRAC) System" is a web-based data entry and reporting system that provides a data repository for CMHS program performance measures collected and mandated by the Government and Performance Results Act (GPRA) and the Office of Management and Budget's (OMB) Program Analysis Review Tool (PART).

A.3. Service Recipients:

a. The population of focus is young children between birth (0) and five (5) years of age with social, emotional, and/or behavioral needs and their families.

b. Each infant or young child must meet all of the following criteria to be enrolled in the ECN:

(1) Reside in Cheatham, Robertson, Dickson, Sumner or Montgomery County, Tennessee;

(2) Be between the ages of birth (0) and five (5) years at the time of enrollment and:

i. For children three (3) years of age or younger, have significant behavioral or relational symptoms identified using either the Diagnostic Classification of Mental Health Development Disorders of Infancy and Early Childhood-Revised (DC: 0-3R), including an Axis II Relationship Disorder, or the Behavioral Assessment of Baby's Emotional and Social Styles (BABES); OR be judged to be at Imminent Risk as defined in Section A.2.; and

ii. For children ages four (4) or five (5), the Diagnostic Interview Schedule for Children (DISC) or the Strengths and Needs Questionnaire will be used as an alternative to the Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition (DSM-IV) for assessing the severity of social, emotional, or behavioral problems that meet additional ECN eligibility criteria to be determined; OR be judged to be at Imminent Risk as defined in Section A.2.;

(3) Have impaired functioning at home, in school, or in the community so that he/she requires involvement in two (2) or more agencies in the early childhood arena, such as early childhood services offered by childcare centers, early childhood education, pediatric care, or family mental health;

(4) Be at risk of placement to a higher level of care, such as inpatient hospitalization, residential treatment, or state's custody for treatment; and

(5) Have a parent or caregiver willing to participate in the Model of Service Provision to maintain the child at home and in the community.

A.4. Service Goals:

a. To establish a comprehensive early childhood SOC in Cheatham, Robertson, Dickson, Sumner and Montgomery Counties, Tennessee with a reliable infrastructure for young children, as defined in Section A.2., with social, emotional, and/or behavioral needs and their families that is sustained beyond the original federal grant period.

b. To provide child-centered, family-driven services for an unduplicated total of four hundred (400) young children and their families over the course of the federal grant period.

c. To improve outcomes for young children, as defined in Section A.2., who have significant behavioral or relational symptoms related to trauma, parent/child interaction difficulties, or impaired social emotional development.

d. To reduce stigma and increase community awareness about early childhood mental health needs and the importance of responding to their needs early and effectively.

e. To provide statewide training and local coaching for providers, families, and community members regarding evidence-based practices for effectively treating early childhood mental health and social emotional needs.

f. To develop a seamless early childhood SOC using a public health model for replication in other areas of the state.

A.5. Structure:

a. The Grantee shall fill vacant staff positions, including the Project Director (1.0 FTE), Technical Assistance Coordinator (1.0 FTE), Cultural and Linguistic Competency Coordinator (0.5 FTE), and Enrollment Coordinator/Administrative Assistant (1.0 FTE) to implement ECN activities and responsibilities prescribed herein. No ECN staff will be hired until Grant Partners have agreed upon in writing relevant job descriptions, roles and responsibilities, and a time line for hiring all staff. The Project Director, Technical Assistance Coordinator, and Cultural and Linguistic Competency Coordinator positions may be hired once the candidate has been approved in advance by the ECN PD, the ECN PI, and the Federal Project Officer.

b. The Grantee shall orient staff to program policies and procedures and work with Grant Partners to develop policies and procedures.

c. The Grantee shall, in collaboration with Grant Partners, plan for the provision and maintenance of an appropriate number of Family Support Providers and Early Childhood Treatment Specialists to participate in the Model of Service Provision in a manner approved by the GMT and the State, and with oversight of the BGS and Care Review Team(s).

d. The Grantee shall participate with Grant Partners in the review of the MIS, as defined in Section A.2., to identify necessary revisions and data elements to be used for program and evaluation purposes and implement and refine the system as needed to fulfill Grantee responsibilities.

e. The Grantee shall ensure family representation and input in all phases of the ECN by engaging caregivers and family members in the planning and implementation of ECN governance and service provision where pertaining to the Grantee's overall ECN related responsibilities as described herein. The Grantee shall collaborate with Grant Partners to begin steps to ensure family representation in ECN activities is comprised of at least fifty percent (50%) non-paid staff.

f. The Grantee shall participate in all required national, regional, state, and local meetings.

g. The Grantee shall, in collaboration with the ECN Director, Grant Partners, and the BGS, ensure the establishment and sustainability of a Care Review Team comprised of family members, local early childhood partners, and other key stakeholders to facilitate the Care Review Team's ongoing involvement in the generation, interpretation, and dissemination of evaluation findings and to provide guidance for continuous quality improvement of the ECN SOC. Additionally, the Care Review Team is responsible for ensuring the services and interventions are timely, appropriate, efficacious, child-centered and family-driven.

h. The Grantee shall, in collaboration with Grant Partners, ensure the provision of relevant staff training on topics, strategies, and techniques including, but not limited to, SOC core values and principles; social-emotional learning strategies; trauma-informed care; cultural and linguistic competency; the Pyramid Model for Promoting the Social and Emotional Development of Infants and Young Children, and any other strategies or interventions as identified by families, community stakeholders and workgroups and as approved by the State.

i. The Grantee shall collaborate with the State and Grant Partners to ensure all intra- and interagency ECN staff work under the leadership and direction of the ECN PD in a manner that supports and promotes the following:

(1) Establishment of policies and procedures that clearly define and operationalize roles and responsibilities concerning supervision and oversight of ECN staff and required administrative and programmatic federal grant functions performed by both ECN staff and Grant Partners;

(2) Effective and appropriate services and supports for infants and young children with social, emotional, and behavioral needs;

(3) SOC core values and principles; and

(4) Relevant terms and requirements of the SAMHSA Cooperative Agreement.

j. The Grantee shall, in collaboration with the BGS and Grant Partners, ensure the logic model and strategic plan for the ECN is developed and implemented in a manner consistent with the time line and goals of the federal grant.

k. The Grantee shall, in collaboration with the BGS and Grant Partners, ensure the development and implementation of a needs assessment for training and cultural and linguistic competency needs of the community; and develop a Technical Assistance Plan that addresses training needs for ECN staff, BGS members, and other community stakeholders.

l. The Grantee shall, in partnership with Grant Partners and the BGS, plan for and participate in training, technical assistance and consultation activities that enhance the development of the ECN and that promote a statewide SOC for young children, as defined in Section A.2., with social, emotional, and/or behavioral needs by ensuring Grantee ECN staff attendance at required local, regional and/or national SOC grantee meetings.

m. The Grantee shall, in collaboration with the BGS and Grant Partners, ensure the promotion of cultural and linguistic competence of ECN staff, BGS members and other community and state stakeholders through supporting the creation of a Cultural and Linguistic Competency (CLC) Workgroup and development and implementation of the Cultural and Linguistic Competency (CLC) Plan. The CLC Plan will be incorporated into the overall Strategic Plan and include plans for a community and staff assessment of cultural and linguistic competence, the development of outreach activities that promote CLC values of families in the community, CLC training opportunities for staff, Grant Partners, community stakeholders, families, and monitoring of cultural and linguistic competence within SOC activities.

n. The Grantee shall manage relevant ECN activities within the approved budget by:

(1) Submitting timely federal continuation application budgets and contract budgets to the State for approval;

(2) Securing prior approval from the State for significant changes to the approved contract budget or federal continuation application budget;

(3) Implementing the Plan for Identifying, Tracking, Documenting, and Reporting Match Funds developed by the State;

(4) Securing subcontracts with outside vendors as needed to complete required ECN responsibilities as described herein and in a manner that is consistent with State policies, procedures, and guidelines for prior approval; and

(5) Ensuring the Coordinating Council, Workforce Development Workgroup, Care Review Team, Cultural and Linguistic Competency Workgroup have input in and oversight of a local budget as needed to support ECN-related activities as described herein.

o. The Grantee shall work in collaboration with the State to ensure the submission of semi-annual progress reports specific to the ECN's goals and activities in accordance with federal and State requirements. Progress report information shall be submitted in the format as required by SAMHSA-CMHS and/or the State including:

(1) Information regarding changes made during the reporting period;

(2) A description of activities and accomplishments related to goals and activities;

(3) Difficulties encountered in achieving goals and objectives;

(4) ECN related data; and

(5) Targeted activities for the next reporting period.

p. The Grantee shall plan for and participate in monitoring by the SAMHSA-CMHS and assist and participate in other federal site visits as required.

q. The Grantee shall cooperate with the State's monitors in conducting annual fiscal and program contract monitoring. In accordance with Section D.14., the State shall conduct program monitoring as follows:

(1) State monitors shall notify the Grantee of their arrival, prior to site visit inception. The Grantee shall make available all relevant personnel on the appointed day and at the scheduled time chosen by the State, unless otherwise arranged with the State. Deviations from the proposed site visit date must be approved by the State's Federal Grants Manager and/or ECN PI, no later than two (2) weeks prior to the site visit date.

(2) The Grantee shall comply with any and all requests for information as issued by the State at any time and is required to have all information slated for review present and ready for review on the appointed day and at the scheduled time of the review. All requested information is to be prepared or made available as specified by the State.

(3) Following the monitoring visit or desk review, the Grantee shall receive a Monitoring Report. If the Monitoring Report indicates that the Grantee has incurred reportable findings, the Grantee shall be required to submit a Corrective Action Plan (CAP) for the State's approval. The CAP must include the date issued, the signature of the preparer, and must address each reportable finding listed in the Monitoring Report. The CAP must also include corrective action to be implemented, person responsible for implementing corrective action, and the CAP implementation date.

(4) Grantee correspondence concerning the CAP may be submitted to the State in hard copy or electronically, as an attachment, via electronic mail (e-mail); and must include a cover letter on Grantee letterhead; and must conform to the State approved format; and must be submitted within the timeframe specified by the State. No facsimile CAP information will be accepted.

(5) If the CAP is satisfactory, the Grantee shall receive a CAP Approval Letter from the State. If the CAP is unsatisfactory, the Grantee shall receive a CAP Disapproval Letter requesting amendment and resubmission to the State. After the CAP is approved, the State shall conduct a follow-up site visit within sixty (60) days after the approval of the CAP. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.

(6) The State reserves the right to conduct unannounced program monitoring visits at the discretion of the Federal Grants Manager, and/or the ECN PI, and/or other program monitor designated by the State at any time. Sections A.5.q.(2) through A.5.q.(5) still apply when unannounced program monitoring visits occur.

r. The Grantee shall, in partnership with the BGS and ECN PD, collaborate on the development and implementation of a Social Marketing Workgroup and Social Marketing Plan to be incorporated into the overall Strategic Plan. All materials are to be reviewed and approved by the ECN PD and/or the ECN PI before dissemination to the public.

s. The Grantee shall, in partnership with the BGS and ECN PD, ensure the creation of a Workforce Development Workgroup to identify and address workforce development and training needs in the early childhood system in the five (5) counties covered by the ECN grant.

t. The Grantee shall work in collaboration with Grant Partners to ensure the development of a Monthly Operations Report (MOR) to be used as a tool for tracking and reporting ECN activities. At a minimum the MOR will include the number of referrals to ECN; specific referral sources including contact person and agency name; number of young children and families enrolled in ECN services; number of graduations; critical incidents; staff changes; trainings attended; outreach activities completed, and status updates on each SOC domain including the National and local evaluations. The MOR is due to the ECN PI on the 10th of every month for the preceding month.

u. The Grantee shall ensure the creation and implementation of a Sustainability Workgroup, which will participate in sustainability planning activities with the BGS, Grant Partners, community stakeholders, and families and develop and implement a Sustainability Plan to be incorporated into the overall ECN Strategic Plan.

v. The Grantee shall ensure all ECN staff described herein identify themselves in public as representatives of ECN employed by Grantee in a manner agreed upon by the State in collaboration with Grant Partners.

w. The Grantee shall receive written approval from the ECN PI prior to the dissemination of any ECN-related information through publication or formal and prepared public presentation, and, at a minimum, ensure all outreach and publication materials related to Grantee's activities as described herein include the ECN logo and relevant State (see Section D.10.) and SAMHSA-CMHS funding information.

x. The Grantee must, in accordance with Section D.5., obtain written approval from the ECN PI prior to executing any subcontracts with external vendors related to Grantee's activities as described herein.

y. The Grantee shall ensure an ECN website is designed and maintained for the purpose of communicating ECN activities and information with community stakeholders. The BGS shall have oversight of the ECN website and its contents.

A.6. Process:

a. The Grantee shall follow all applicable federal guidelines and State requirements related to this SOC.

b. The Grantee shall complete all activities and timelines pursuant to SAMHSA guidelines and as approved and prescribed by the State.

c. The Grantee shall complete and submit all program and financial reports that adhere to the standards, requirements, and deadlines of SAMHSA and as approved and prescribed by the State.

d. The Grantee shall collaborate with Grant Partners to ensure the implementation of a program evaluation plan pursuant to SAMHSA guidelines, and as approved and prescribed by the State, and assure the State ongoing and timely access to data.

e. The Grantee shall participate in regular Grant Management Team meetings with the State and Grant Partners and interface with the BGS in a manner approved and prescribed by the State in collaboration with Grant Partners.

f. The Grantee, with regard to formal and informal evaluations, shall not disseminate or release evaluation data about the use of ECN funded services, activities, and/or staff to any individual, agency, group, and/or institution of higher education without the review of the GMT and express written permission of the ECN PI.

A.7. Outcome – Access:

The Grantee will work with Grant Partners and the BGS as needed to ensure that all young children, as defined in Section A.2., who are referred to the ECN and who meet service recipient criteria receive an assessment and/or referral to appropriate early childhood services.

A.8. Outcome – Capacity:

a. The Grantee shall plan for and use local and national evaluation efforts to support Grant Partners' work to improve regional partnerships and service capacity level by assisting with the development of and partnering with the BGS to:

(1) Enhance the ability to address early childhood social, emotional, and behavioral needs among young children as defined in Section A.2.;

(2) Enhance collaboration among existing and potential partners through interagency agreements and/or Memoranda of Understanding regarding treatment coordination and other collaborative activities; and

(3) Provide child-centered, family-driven, community-based, culturally and linguistically competent, and coordinated services for the required number of young children with social, emotional, and/or behavioral needs and their families in Cheatham, Dickson, Robertson, Sumner and Montgomery Counties over the course of the federal grant period.

A.9. Outcome – Effectiveness:

a. The Grantee will work collaboratively with Grant Partners in their efforts to ensure that measures of child and family outcomes and interagency collaboration and services integration will be collected using standardized instruments and ECN-specific data collection forms as approved and prescribed by the State and National Evaluation and designated for use in the national and local evaluations. The following outcome measures will be evaluated:

(1) For young children:

i. Social, emotional, and behavioral problems [using Child Behavior Checklist (CBCL 1½ - 5), Child Adolescent Functional Assessment Scale (CAFAS), Devereux Early Childhood Assessment (DECA 1-18M, DECA 18-36M, DECA 2-5Y), Preschool Behavioral and Emotional Rating Scale (PreBERS), Eyberg Child Behavior Inventory (ECBI), Child and Adolescent Needs and Strengths (CANS), Behavioral Assessment of Baby's Emotional and Social Styles (BABES; 0-3), and Strengths and Difficulties Questionnaire (4-5)];

ii. Maintain home placement [MIS];

iii. Maintain childcare/daycare placement [MIS];

iv. Readiness for mainstream kindergarten class attendance [Ages and Stages Questionnaire: Social Emotional (ASQ:SE), Brief Infant/Toddler Social Emotional Assessment (BITSEA), Social Skills Improvement System Rating Scales (SSIS), Pre-School Language Scale-4 (PLS); Picture Naming (GPIC), Alliteration (GALL), Rhyming (GRHY)];

v. Health Status [Child and Adolescent Needs and Strengths (CANS)], Family Advocacy and Support Tool (FAST)];

vi. Child Strengths [Child and Adolescent Needs and Strengths (CANS)], Family Advocacy and Support Tool (FAST)]; and

vii. Services received (type and dosage), including psychiatric hospitalizations and other out-of-home placements [MIS, data from other child-serving systems].

(2) For families:

i. Monitor family functioning as reported by caregivers [Family Life Questionnaire (FLQ), Parenting Stress Index (PSI), and Caregiver Strain Questionnaire (CGSQ)];

ii. Monitor the number of referral sources of youth and their families referred to ECN from various systems as measured using the Enrollment and Demographic Information Form (EDIF and the Multi-Sector Service Contacts-R (MSSC-R); and

iii. Monitor family characteristics and history, including physical health, medication, family composition, custody status, caregiver employment, family risk factors, and traumatic event history [Caregiver Information Question (CIQ), Child Information Update Form (CIUF), Traumatic Events Screening Inventory for Children (TESI-C)].

(3) For the service system:

i. Assess service gaps, needs, and existing resources by completing a needs assessment using key informant interviews, surveys, focus groups, mental health and other systems data as well as chart review;

ii. Assess how community partners progress from networking and cooperation to collaboration, system of care linkages and services integration as measured by qualitative and quantitative analysis of key informant interviews, community stakeholder surveys and focus groups;

iii. Assess the cultural and linguistic competence of the ECN using the Cultural Competence and Service Provision Questionnaire (CCSPQ), informant interviews, and focus groups;

iv. Assess perception of care (e.g., adherence to System of Care values and principles such as cultural competence, individualized care, family voice and choice, use of natural supports, and other principles) as reported by the Transformation Accountability (TRAC) system, Youth Services Survey for Families (YSS-F), CCSPQ Surveys, informant interviews, focus groups, and System of Care Assessment Report (SOCAR);

v. Assess cost/benefits, funding sources, expenditures, and service utilization costs using agency records and archival databases; and

vi. Assess community- and state-level federal grant performance related to ECN infrastructure development and mental health promotion activities through the collection, analysis, reporting, and distribution of the following federally designated TRAC system indicators:

(a) The number of organizations or communities implementing mental health-related training programs as a result of the federal grant;

(b) The number of organizational changes made to support improvement of mental health related practices/activities that are consistent with the goals of the federal grant;

(c) The number of organizations that enter into formal written inter/intra-organizational agreements to improve mental health related practices/activities that are consistent with the goals of the federal grant; and

(d) The number of programs/organizations/communities that implement evidence-based mental health related practices/ activities as a result of the federal grant.

Position Title: Project Director
Supervised By: Principal Investigator

Duties and Responsibilities:
Responsible for coordinating all System of Care activities for young children with early childhood mental health needs and their families in the five (5)-county coverage area.. The System of Care will ensure young children and families receive appropriate child-centered, family-driven, and culturally and linguistically competent services and supports.

- Collaborate and coordinate with Principal Investigator and Broad Based Governance Structure about planning and implementation of the federal grant.
- Provides leadership and direction of all aspects of the System of Care, including day to day operations and overseeing the implementation of the Strategic Plan.
- Collaboration/coordination with the Broad Based Governance Structure, Workgroups, partner agencies, and staff in achieving goals and objectives.
- Direct programmatic supervision of the Family Support Provider Supervisor, Early Childhood Treatment Specialist Clinical Supervisor, Technical Assistance Coordinator, Social Marketing Manager, Cultural and Linguistic Competency Coordinator, Lead Family Contact, and Enrollment Coordinator/Administrative Assistant.
- Facilitate the development of Memoranda of Understanding, interagency agreements and develop coordinated policies and procedures specific to the System of Care design and goals.
- Coordinate with the evaluation team to ensure that all data is collected and submitted to the national evaluation contractor and ensure the evaluation plan meets grant goals and objectives.
- Educate the community about System of Care values and principles and evidence-based services for young children with early childhood mental health needs and their families.
- Coordinate with all local, state, and federal initiatives as required.

Qualifications:
Master's degree in social work, psychology, early childhood development or a related field required; a minimum of four (4) years experience in the field of mental health; and at least three (3) years supervisory or management experience.

Knowledge and Skills Required:
Knowledge of System of Care philosophy and appropriate clinical interventions for young children with early childhood mental health needs and their families. Values family driven participation in service delivery and system planning. Proven skills in networking among a diverse group of agencies. Effective communication skills including written and public speaking. Ability to problem solve, and work independently, be an active team member and motivate others. Ability to directly manage complex and large scale budgets.

Position Title: Technical Assistance Coordinator
Supervised By: Project Director

Duties and Responsibilities:
Responsible for assisting the Project Director, Family Support Provider Supervisor, Social Emotional Training Specialist(s), Lead Family Contact, and Clinical Supervisor in coordinating technical assistance needs to support of the development and implementation of a System of Care in the five (5)-county coverage area.

- Develops and implements the Single Coordinated Technical Assistance Plan.
- Establishes a Workforce Development Committee as part of the Broad Based Governance Structure to develop a training plan for all project staff, local agency staff, and other interested individuals and their families in the five county region, and provides ongoing staff support to the committee once established.
- Assesses technical assistance, training and consultant needs for all staff, families and community partners.
- Coordinate with all appropriate entities including the Technical Assistance Partnership to ensure all technical assistance is provided such as cultural competency training, wrap around services, sustainability, family and youth involvement, respite care training, etc.
- Maintains communications at all levels to keep current on all national and state training initiatives and opportunities.
- Assists with the coordination of the Network and Care Review Team meetings.

Qualifications:
Bachelor's Degree in a social or behavioral science preferred.

Knowledge and Skills Required:
Skills and experience in developing and training, knowledge of System of Care principles and strategies, and ability to communicate in a culturally competent manner.

Personal Qualities:
Must be able to work independently; be a self-starter; work well with groups and as a team member; and values family and youth input.

Position Title: Cultural and Linguistic Competence Coordinator
Supervised By: Project Director

Duties and Responsibilities:
Responsible for assisting the Project Director and all Network staff and partners, families, and youth in ensuring culturally and linguistically competent practices in all aspects of the System of Care.

- Development and implementation of the Cultural and Linguistic Competence Plan in collaboration with Network staff, families and youth, and community partners and contractors.
- Provide start up resources and ongoing staff support and technical assistance for the development and implementation of a Cultural and Linguistic Competency Committee under the direction of the Broad Based Governance Structure.
- Work with the Technical Assistance Coordinator and Evaluation Team to identify and assess technical assistance, training and consultant needs related to cultural and linguistic competence.
- Coordinate with all appropriate entities including the Technical Assistance Partnership to ensure appropriate technical assistance is provided to Network staff and partners.
- Maintains communications at all levels to keep current on all national and state training initiatives and opportunities related to cultural and linguistic competence.
- Serves as a team leader and facilitates the organizational development process to accomplish Network goals related to cultural and linguistic competence.

Qualifications:
Minimum Bachelor's Degree in a social or behavioral science or related field.

Knowledge and Skills Required:
Knowledge of System of Care values and principles. Experience working with diverse populations, demonstrated experience in developing educational and informational materials, experience with training, groups, knowledge of ability to communicate cross culturally, knowledge of System of Care principles and values preferred.

Personal Qualities:
Able to work independently, ability to work well with diverse groups, must be creative and innovative, enthusiastic and value working as a team member.

Position Title: Enrollment Coordinator/Administrative Assistant
Supervised By: Project Director

Duties and Responsibilities/Principal Activities:

- Field referral and service request calls and maintain log.
- Collect screening and eligibility information and complete follow up questions as needed to ensure accurate and complete information is collected in a timely manner.
- Provide information on local services and supports for children not eligible for ECN services due to age, county of residence, etc.
- Collaborate with partner agencies to identify care coordination slots.
- Work with the designated Care Coordination Provider, Clinical Director and FSP Supervisor in assignment of the family core team.
- Facilitate appointments for family visits and assessment.
- Collect information regarding eligibility status and maintain contact with referral source and caregiver regarding status.
- Notify applicants of enrollment verification or ineligibility for enrollment.
- Notify evaluation staff of enrollments within required deadline period.
- Ensures that all data and reports are properly managed, documented, and disseminated as appropriate.
- Provide general office management and administrative duties in support of the Project Director.
- Other duties and/or tasks as assigned.

Qualifications:
Minimum of high school diploma or equivalent, bachelor's in social science field preferred.

Skills & Knowledge Required:

- Excellent oral and written communication skills and organizational ability.
- Knowledge of the service area and of resources for young children.
- Desire to help and support parents of young children, with strong customer service skills.
- Excellent problem-solving/creative thinking skills.
- Computer data collection and reporting skills

Personal Qualities:
Able to work independently; ability to work well with diverse groups; must be creative and innovative, enthusiastic; and value working as a team member.

Early Connections Network

Plan for Identifying, Tracking, Documenting, and Reporting Match Funds (Match Process Plan)

Partners and Purpose

The Tennessee Department of Mental Health (TDMH) meets match requirements through collaboration with multiple agencies involved in the System of Care initiative in Montgomery, Robertson, Sumner, Cheatham and Dickson counties. As state contract agencies for the Early Connections Network (ECN) grant initiative, including but not limited to: Tennessee Voices for Children (TVC), Centerstone of Tennessee, and Centerstone Research Institute will, under the direction of the ECN Project Director, coordinate an effort to identify, obtain, track, document, and report match funds that meets federal grant requirements. Each agency, including TDMH, will contribute in-kind or cash match through both formal and informal agreements with other agencies, and/or by contributing the value of a certain percentage of staff salaries and/or indirect costs.

In order to establish processes that serve to accurately and consistently identify, track, document, and report match that meet state and federal standards, guidelines, and laws, TDMH has developed the below processes for accomplishing this task. Under the direction of the Project Director, the ECN Grant Management Team will oversee and facilitate the implementation of the Match Process Plan with input from the Steering and Sustainability Committees.

For purposes of this document, the COLLABORATING AGENCIES are TDMH, Tennessee Voices for Children, Centerstone of Tennessee, Centerstone Research Institute, and any other agency designated by TDMH.

A Match Matrix and Quarterly Match Meeting Schedule are shown on Page 8 of this Attachment.

Federal Law and Federal Audits

The following information regarding federal law and federal audits was obtained from the SAMHSA published document entitled *Building Sustainable Systems Change: A Guide to Non-Federal Match Funding For System of Care Communities That Are Part of The Comprehensive Community Mental Health Services For Children & Their Families Program* (October 2008).

Federal Law

Under federal law, each public entity that receives a System of Care grant must make available, either directly or through donations from public or private entities, non-federal contributions toward the costs incurred in carrying out the purposes of the grant as outlined by the federal government.

The fiscal rules on match reflect the underlying intentions described above. Federal funding is provided over a significant, six (6) year period of time, which is in contrast with typical federally funded demonstration projects that are often funded for three years. The federal government at no time support all of the costs of these systems; System of Care sites are expected to achieve partnerships with other state and local child serving agencies as well as with non-governmental organizations that will invest the time, energy and funding necessary to lay the groundwork for long-term program sustainability. These match requirements are a core element of the program and cannot be waived.

According to federal law, match may be either cash or in-kind and must meet certain requirements as outlined below.

Federal law defines matching funds as:

- Non-federal public or private funds;
- Funds that are not used as match for any other federal program;
- Unrecovered indirect costs
- Funds that are spent on the system of care;
- Either cash or in-kind, fairly evaluated.

Matching funds must also be spent for the same purposes as authorized for the federal funds allocated under the grant. For example, funds spent on residential treatment services that have a bed capacity of more than ten (10) beds cannot be counted as match, as this is not an expense permitted under the statutory language governing the program.

Matching funds must be funds (or in-kind contributions) that are in-hand and have been spent in the year for which they care claimed. A federally funded System of Care site may not count contributions that have been promised but not received.

Cash match can be new state or local dollars and can include:

· New state or local general fund dollars appropriated to any child serving system or agency that are spent on the system of care or children served by the system of care;
· Funds redirected from services previously offered to a child in another part of the state who is returned (or moves to) the area served by the program and is provided services through the system of care;
· Funds redirected from residential or other institutional services and spent on community services for a child who is served by the program;
· Funds from private entities, including private health insurance payments, donations from business or charity groups, etc.
· Earned income, such as a payment for site's services, training, etc.

Although match funds may not be federal funds or funds used to match any other federal program, this does not mean that funds used to supplement reimbursements under other federal programs cannot be match. For example, additional costs of a Medicaid-covered service can be funded with grant or matching funds if the Medicaid reimbursement is less than the actual cost of the service. A non-Medicaid service can also be paid for with grant or matching funds even when furnished to a child who is Medicaid-eligible.

In addition to cash, match can be claimed for in-kind contributions from any source. In-kind match:
· May be plant, space, equipment, or services;
· Must be fairly evaluated;
· Must be an allowable cost under the terms of the federal grant if the party receiving the contributions were to pay for them, and
· Volunteer services must be an integral and necessary part of the System of Care's operations.

To fairly evaluate in-kind supports sites must make certain calculations.

· Space or equipment where a third party retains title must be valued at the fair rental rate (if this is uncertain, an estimate from a local realtor is acceptable);
· Volunteer services by professional or technical personnel, family members or youth, consultants and others must be an integral and necessary part of an approved program and constitute an allowable cost if the program had to pay for them;

· When calculating volunteer rates when the grantee does not have employees performing similar work, rates must be consistent with those paid for similar work in the labor market in which the grantee competes;
· Volunteer rates can include reasonable fringe benefits;
· Supplies must be calculated at the market value at the time of the donation.

Federal Audits

All costs used to satisfy matching requirements will be documented by the collaborating agencies and are subject to audit.

To ensure that matching funds have been appropriately calculated, TDMH will strive to ensure that all matching funds from the collaborating agencies meet the following criteria:

- Are verifiable from the collaborating agencies' records;

- Are not included as contributions for any other federally-assisted project or program;

- Are necessary and reasonable for proper and efficient accomplishment of ECN's program objectives;

- Are allowable under applicable cost principles;

- Are not paid by the federal government under any other award;

- Are provided for in the approved budget of each collaborating agency.

The relevant federal auditing requirement is Circular A-133, the Single Audit Report, from the Office of Management and Budget (OMB).

Process for Identifying Match

Identifying matching sources, other than in-kind contributions from the four collaborating agencies, is the responsibility of the Grant Management Team under the direction of the Project Director. To that end, the Project Director, with assistance from members of the Grant Management, Steering, and Sustainability Committees is responsible for interfacing with state and local private/public agencies to identify and secure match funding that meets the requirements of the SAMHSA Collaborative Agreement with TDMH. It is the responsibility of the Project Director and the Coordinating Council to execute the interagency agreements needed to secure match funding.

The Project Director and Grant Management Team, with input from the Steering and Sustainability Committees, will create a Strategic Match Funding Plan which will include goals, objectives, and action steps for identifying and obtaining match funding. The strategic match funding plan will be incorporated into the overall Strategic and Sustainability Plans of the Early Connections Network. Progress on this plan will be monitored at Grant Management Team meetings at least quarterly and by other committees on an as needed basis.

The Grant Management Team will also assist the Sustainability Committee in developing and implementing a Sustainability Plan that includes goals for obtaining match funding as part of an overall strategic financial plan to ensure short and long term sustainability. The Sustainability Plan must be approved by the Coordinating Council, which will then guide and monitor its implementation.

Process for Tracking Match

Each match contribution (cash or in-kind) is tracked using a single electronic data record to be maintained by the Project Director or his/her designee and housed at the ECN office. At a minimum, the reports generated from this database must include specific information for each source of match as follows: description of meeting/event/project, date, location, number of hours, number of professionals in attendance, number of non-professionals in attendance, rental/service value, cash or in-kind value, explanation of service, and the rates for professional and non-professional time. This match tracking database will also contain information on match obtained from each collaborating agency.

It is the responsibility of the Project Director to maintain the database and complete the reports on an ongoing basis and to submit them to TDMH and the Grant Management Team for review on a quarterly basis.

It is the responsibility of members from each of the collaborating agencies to communicate obtained match to the Project Director in writing on a monthly basis. This information will then be entered into the match tracking database upon receipt. Match obtained on an annual basis will be communicated to the Project Director in writing upon receipt. The Project Director will then prorate the match on a quarterly basis to ensure the information is calculated in each quarterly report. Match that is obtained on an annual basis includes, but is not limited to, percentage of salaries, indirect costs, or annual subcontracts that include match.

Process for Documenting Match

TDMH monitors the tracking of match through the review of match reports submitted by the Project Director to the Grant Management Team on a quarterly basis (see Page 8 of this Attachment). Sources of match contributions are documented through the use of the standard Match Certification Letter, invoices, emails, and/or interagency agreements. Copies of these documents (regardless of their source) are to be kept on file at the ECN office at all times. These documents will be reviewed annually as a part of TDMH's contract monitoring process.

Documenting Professional/Non-Professional Time

The value of Professional/Non-Professional time must be fairly evaluated. This means:

- Volunteer services by professional or technical personnel, family members, consultants and others must be an integral and necessary part of an approved program and constitute an allowable cost if the program had to pay for them;

- When calculating volunteer rates when the grantee does not have employees performing similar work, rates must be consistent with those paid for similar work in the labor market in which the grantee operates.

This rate must be documented in writing (and updated/verified annually) by the professional/non-professional person contributing time using the standard Match Certification Letter to be kept on file at the ECN office and available to TDMH at all times.

The use of professional/non-professional time as in-kind match will be documented through the use of sign-in sheets at meetings, agency time logs, and Match Certification Letters. This documentation must be kept on file at the ECN office and available to TDMH at all times.

Documenting Value of Space/Equipment/Supplies

The value of Space/Equipment/Supplies must be fairly evaluated. This means:

- Space or equipment where a third party retains title must be valued at the fair rental rate;

- Supplies must be calculated at the market value at the time of the donation.

This information must be documented in writing (and updated/verified annually) by the entity contributing the space, equipment, and/or supplies using the standard Match Certification Letter to be kept on file at the ECN office and available to TDMH at all times.

Documenting Value of In-Kind Contributions

The value of all other in-kind contributions must be documented in writing (and updated/verified annually) by the entity making the in-kind contribution using the standard Match Certification Letter to be kept on file at the ECN office and available to TDMH at all times.

Process for Reporting Match

TDMH will facilitate meetings at least quarterly with the collaborating agencies and other project partners, such as the Chairs of the Steering and Sustainability Committees to discuss match and budget issues. These meetings will be held as part of the Grant Management Team meetings. At each meeting the Project Director will present quarterly match funding reports and partners will monitor progress on the Strategic Match Plan, and discuss budget issues, contract issues, and sustainability efforts as needed.

In addition to the match reporting requirements stated above, the Project Director will submit to TDMH on a semi-annual basis a report that includes information as to the source of all matching funds in a format consistent with the requirements of the Semi-Annual Grantee Progress Report as outlined below:

Source	Percentage	Cash Match	In-Kind
Child Welfare			
Mental Health			
Education			
Juvenile Justice			
Substance Abuse			
Health			
Foundations			
Other (describe)			
TOTAL	100%		

In accordance with federal grant requirements, TDMH will submit annual Financial Status Reports to SAMHSA Office of Grants Management.

Early Connections Network
MATCH MATRIX

PROJECT YEAR	DATES	RATIO	FEDERAL SHARE	REQUIRED MATCH*
1	9/30/10-9/29/11	3:1	$1,000,000	$333,333
2	9/30/11-9/29/12	3:1	$1,500,000	$500,000
3	9/30/12-9/29/13	3:1	$2,000,000	$666,666
4	9/30/13-9/29/14	1:1	$2,000,000	$2,000,000
5	9/30/14-9/29/15	1:2	$1,500,000	$3,000,000
6	9/30/15-9/29/16	1:2	$1,000,000	$2,000,000
No-Cost Extension	9/30/16-TBD	1:2	TBD	TBD

**Figures are based on the Notice of (Federal) Grant Award. However, required match is based on total annual expenditures as reported on the Financial Status Report submitted December 31st of each year.*

Attachment G
SYSTEM OF CARE AND EARLY CHILDHOOD RESOURCES
(This list is not exhaustive)

Center for Early Childhood Mental Health Consultation
http://www.ecmhc.org/index.html

Center for Health Care Strategies, Inc.
http://www.chcs.org/

Center on the Social and Emotional Foundations for Early Learning (CSEFEL)
http://csefel.vanderbilt.edu/index.html

Georgetown University Center for Child and Human Development
http://gucchd.georgetown.edu/

National Wraparound Initiative
http://nwi.pdx.edu/

Pires, S. (2010). *Building systems of care: A primer. 2nd edition.* Washington, D.C.: Human Service Collaborative.

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov/index.aspx

- Original Request for Application for Children's Mental Health Initiative FFY 2010 grants (Early Connections Network RFA)
  http://www.samhsa.gov/Grants/2010/SM-10-005.aspx

- SAMHA Financing Center of Excellence
  http://www.samhsa.gov/financing/

Technical Assistance Center on Social Emotional Intervention
http://www.challengingbehavior.org/index.htm

Technical Assistance Partnership for Child and Family Mental Health (TAP)
http://www.tapartnership.org/default.php

- TAP Early Childhood Community of Practice
  http://www.tapartnership.org/COP/earlyChildhood/default.php

- TAP Systems of Care
  http://www.tapartnership.org/systemsOfCare.php

Zero to Three – National Center for Infants, Toddlers, and Families
http://www.zerotothree.org/

Mission of Governance

System of Care Governing Structure provides a responsive and inclusive structure to be used for planning, development, collaboration and evaluation of services and supports for children and youth requiring services from more than one agency and their families. The Coordinating Council exists to promote the sharing of resources and accountability across agencies and programs serving children and youth, and to build community capacity to provide effective, community-based services and supports that are delivered consistent with System of Care principles.

System of Care Principles

- Family-driven
- Youth-guided
- Individualized
- Culturally and linguistically competent
- Child and family team based
- Collaboration
- Strengths-based
- Natural supports
- Community-based
- Persistence
- Outcomes-based and data-driven

Vision of System of Care

An integrated and easily accessible system consisting of:

- rich and diverse informal community-based supports for children, youth and families, and
- timely professional services tied to evidence-based best practices.

In order to achieve positive outcomes for children and youth, public and private agencies will:

- operate in a culture of collaborative problem-solving and shared responsibility and accountability
- build one plan in partnership with the child or youth and family,
- base the plan on the child's or youth's and family's strengths, and
- assure that the plan is put into action by one team.

At all points of decision, the team will:

- put the child or youth first,
- encourage decisions driven by the youth and the family, and

- think and act creatively to meet child/youth and family needs and achieve desired child/youth and family outcomes.

Group Norms

All committees and teams act in good faith to adhere to the following expectations:

- Work with youth and families as equal partners and encourage growth and development of local family and youth support groups
- Actively seek ways to hear and integrate youth voice
- Be sure every new member is oriented by an existing member; assign a mentor to family members joining teams in order to support their continued participation
- Make sure a youth coordinator or mentor is also assigned to any youth that are joining teams to provide support for their participation and to brief them ahead of time on the topic of the meeting and any information that will be discussed
- Reflect the cultural, racial and ethnic composition of our community.
- Make best efforts to attend every meeting.
- Any member who is absent from three consecutive meetings shall be contacted by the chair or co-chair of the respective committee or team to determine interest in continued membership.
- Strive to make decisions by consensus. Consensus is defined as a decision which every member present can support even if the decision is not every member's preference. Criteria for determining consensus: "Was I heard? Can I live with it? Does it offer an outcome I can accept? Can I represent the decision to others?"
- If consensus is unable to be reached after reasonable efforts, a two-thirds majority vote is acceptable.
- A quorum shall consist of at least one-half of the membership.
- All meetings are open to the public.
- All teams will identify a recorder, who distributes minutes of all meetings to the Coordinating Council, Partnership and staff within one week of the meeting. Minutes are made available to others on request.
- Distribute materials to be acted upon at a meeting at least one week prior to the meeting. The person presenting a topic will identify in advance the purpose of the presentation, e.g., information only, feedback, or decision; and if a decision is needed, exactly what the question to be decided is.

Coordinating Council

A. Duties

1. Serves as part of the overall governing structure for System of Care and concerns themselves with supporting the overall development of the System of Care by assuming a coordinating function with occasional System of Care decision making duties when necessary. Actively spreading decision making throughout the broad based governance structure and using the SOC values and principles to transform the system at the level and in organizations they represent as well.
    i. intentionally championing System of Care development and sustainability
    ii. owning the Mission and Vision
    iii. driving change by applying creativity, taking decisions to the *Partnership*, making decisions when necessary and overseeing implementation, particularly regarding system level issues
    iv. busting barriers as needed
    v. demonstrating a willingness to "go first"
    vi. holding each other accountable for decisions made and actions taken
    vii. Striving for a broad base of participation by youth and family members and community supports on all committees and work teams

2. Serves as a key ingredient of governance for the county's Cooperative Agreement with SAMHSA to improve the lives of youth with severe emotional disturbance and their families/

3. Participates in the development and drives an annual strategic plan to guide the development of System of Care.

4. Identifies, advances and role models community practice standards for System of Care and Wraparound.

5. Identifies and addresses training and technical assistance needs.

6. Identifies and recommends ways to bridge service gaps, such as with flexible funding, grant applications, volunteer efforts, and creative use of community resources.

7. Regularly reviews and utilizes performance data, including indicators of child, youth and family functional outcomes, satisfaction, finances, and process performance, to evaluate and strengthen the County's System of Care.

8. Appoints and delegates certain responsibilities pursuant to the mission, vision, and strategic plan to individual work teams.

9. Receives periodic reports from the work teams, and actively supports and removes barriers for the work teams as needed.

10. Hosts and attends *Partnership* meetings.

11. Works with the *Partnership* to develop priorities for the annual strategic plan.

12. Presents at least one major accomplishment or challenge to the *Partnership* at each of its meetings.

13. Seeks creative partnerships with community resources to support child, youth and family needs and to remove barriers to attainment of child, youth and family goals.

14. Contributes organizational dollars, services, time and other resources as possible and appropriate, and blends funds to maximize resources.

15. Diverts children from inappropriate DSS custody, training school, and state hospital placements, and support children in their natural environments.

16. Reviews requests for out-of-state placements and placements to special needs schools and mental health hospitals.

17. Serves as the ***Finance Team*** and supports the Administrative Team in order to consider special financial decisions, such as budgeting SAMHSA grant funds, and other funding decisions and opportunities to enhance the System of Care.

B. Membership

1. The directors/senior leaders of Youth and Family Services, Area Mental Health Authority, Schools, District Court, and Department of Juvenile Justice and Delinquency Prevention, Council for Children's Rights, and Parent organization, as permanent members.

2. Four (4) family members whose children are currently receiving or have in the past received services from the mental health and/or child welfare system.

3. Four (4) leaders of mental health provider agencies.

4. Four (4) youth.

5. Work team chairpersons may be selected from the membership described in (1-4) above.

6. All members must have fully delegated authority to make or secure decisions regarding services and funding for their respective organization if they represent an organization.

7. The Community Collaborative shall be led by a chair and co-chair.

C. Election and Terms

1. All members will serve 2-year terms, except those listed in (1) above, who shall be permanent members.

2. Individuals interested in serving on the Coordinating Council must have demonstrated experience in working within a system of care, such as having served on a work team and/or participated in System of Care training. They may nominate themselves or be nominated by existing Coordinating Council or *Partnership* members. Those individuals interested in filling the provider slots must come from provider agencies that currently have youth enrolled in the System of Care.

3. Nominations will be made in August for election by the Coordinating Council and *Partnership* in September, except for the provider slots, which shall be elected by leaders of the endorsed child and adolescent mental health provider agencies.

4. Elected members may serve up to two (2) terms before rotating off for at least one (1) term.

5. Terms of elected members will be staggered so that no more than one-half of the elected members will turn over each year.

6. Terms begin October 1.

7. The Chair and Co-Chair shall each serve one-year terms in their leadership roles. The co-chair shall be elected with the understanding that he/she is in line for election as Chair the following year.

8. Nominations for Chair and Co-chair shall come from Coordinating Council or *Partnership* members in August for election in September.

D. Meetings and Attendance

1. The Coordinating Council shall meet at least eleven (11) times a year, with a combined November/December meeting.

2. Members may decide to hold additional or extended meetings as the need arises.

3. Members may identify one alternate to attend up to two meetings a year in place of the regular member. Members' alternates will be identified in October of each year.

4. Alternates may vote.

E. Staff Support

1. Clinical Director, Project Director, and Lead Evaluator shall attend meetings as staff.

2. The Coordinating Council will secure staff support for the co-chairs, maintenance of membership roster, assistance in preparing the agenda and related materials, completing meeting minutes, and meeting facilitation for the Collaborative and the Community Forum.

Partnership

A. Purposes

1. Concerns itself with broad strategic System of Care and community strategic decisions and getting those strategic recommendations into work groups for more specific detail work and recommendations. Makes strategic decisions as it relates to the implementing System of Care components. Serves as a forum for consumer concerns, and informs the Coordinating Council, as needed, regarding these concerns.

2. Advises the Coordinating Council annually on priorities for the strategic plan, assists in the development of the strategic plan and makes community wide SOC strategic decisions.

3. Serves as a resource and sounding board for the work teams seeking advice, feedback, or support.

4. Serves as a recruitment pool for the work teams and Coordinating Council.

5. Serves as an information sharing network for member agencies among themselves and with community and family constituents, particularly regarding needs and opportunities for collaboration.

6. Participants learn about and advance System of Care principles and Wraparound practices in our community.

7. Participants information gained with colleagues at their home organizations.

B. Meetings and Attendance

1. Hosted and attended by the Coordinating Council.

2. Includes an educational or training opportunity relevant to System of Care principles at each meeting.

3. Meetings shall take place 12 (twelve) times a year.

4. There is no formal membership; family members, work team members, system representatives, including providers, and the community at large are encouraged to attend.

Administrative Team

A. Duties

1. Responsible for the day-to-day operations pursuant to the cooperative agreement with SAMHSA.

2. Accountable to and provides regular reports to the Partnership and Coordinating Council.

B. Membership

1. Leadership positions as defined by the SAMHSA cooperative agreement: Principal Investigator, Lead Family Representative, Project Director, Clinical Director, Lead Evaluator, and State Liaison.

C. Meetings and Attendance
   1. Meetings will take place weekly, or less often, as needed.

   2. Meetings will be chaired by the Principal Investigator.

Work Teams (may be standing or ad hoc)

A. Duties
   1. Established by the Coordinating Council or *Partnership* for ongoing work or for a special time-limited purpose.

   2. Undertake specific responsibilities toward implementation of the strategic plan.

   3. Accountable to and supported by the Partnership & Coordinating Council for overall direction and endorsement of work; guided and coached by the Administrative Team.

   4. Utilize the *Partnership* as a resource and sounding board for advice, feedback and support.

B. Membership
   1. Work teams strive to include at least two (2) family members.

   2. Chaired selected by members.

   3. Members are recruited by the appointed chair.

   4. Members agree to serve for duration of work team or at least one (1) year, whichever is shorter; there is no upper limit on length of service.

   5. Work team members are encouraged, but not required, to attend the *Partnership* meetings.

C. Meetings and Attendance
   1. Work teams will generally meet monthly, or as needed.

Review and Amendment
The Community Collaborative Governance Structure shall be reviewed in six (6) months after inception and the second quarter of each calendar year by the Coordinating Council and *Partnership* jointly.

Attachment I
EARLY CONNECTIONS NETWORK GRANT NARRATIVE

EARLY CONNECTIONS NETWORK: FULFILLING THE PROMISE
A SYSTEM OF CARE FOR CHEATHAM, DICKSON, MONTGOMERY, ROBERTSON & SUMNER COUNTIES

SECTION A - UNDERSTANDING THE INITIATIVE

A.1: Literature Review

Best estimates indicate that social, emotional, and behavioral problems occur in 8%-11% of young children (Michaels, 2008). Additionally, we know that somewhere between one fourth and one third of very young children are at risk for early school failure because they do not have the needed social-emotional development for school readiness (Perry, Kaufmann, & Knitzer, 2007). This lack of school readiness has been found to be highly associated with young children entering preschool unprepared behaviorally and emotionally for achieving in the academic environment (Thompson & Raikes, 2007). This important factor, combined with what research has discovered about the importance of experiences of young children during their first years of life on their brain development, a stage in which foundations for trust, empathy, conscience, and life long learning are being formed (Karr-Morse & Wiley, 1997), has led advocates, professionals, providers, and policy makers to recommend this age group in the work of systems of care (Perry, Kaufmann, Hoover, & Zundel, 2008).

Unlike the term *Serious Emotional Disturbance* that drives much of the System of Care (SOC) work undertaken on behalf of school-age youth, early childhood systems must focus on a broader construct, the social and emotional well-being of young children and their caregivers as many of these children are observed to be exhibiting behavioral problems in their first years of life (Perry, Kaufmann, Hoover& Zundel, 2008). This expansion also requires the broadening of the context of system of care work to include the important caregivers in the child's life, and those children who may be "at risk" for developing mental health problems later in life. This is a very important paradigm shift as the unique needs of young children being served in a system of care requires laying the infrastructure to provide a broad range of services and supports that encourage social and emotional development in all children, as well as identifying those in need of more targeted assistance because of familial or individual risk factors or current behavioral or social problems (Perry, Kaufmann, Hoover, & Zundel, 2008).

Since at least 1982, when the National Institute of Mental Health and the State Mental Health Representatives for Children and Youth convened to address the needs of children and youth with emotional and behavioral issues, the concept of serving children and families through an interagency "continuum of care" has been evolving (Stroul & Friedman, 1986). The federal government, initially under the auspices of the Child and Adolescent Service System Program (CASSP) and more recently through the Center for Mental Health Services (CMHS), has advanced the development and implementation of a more comprehensive concept of a "system of care" (SOC). In contrast to a continuum of care, SOCs extend to include critical structures, procedures, and policies that allow families to access services that are linked, coordinated, and provided in a family-driven, community based and culturally and linguistically competent manner (Kendziora, et. al 2001). Although models vary, there is general consensus that essential components include core values and guiding principles such as: child centered and family driven; community-based; culturally and linguistically competent; provides a comprehensive array of services**;** includes individual and unique service plans; occurs in a least restrictive and most clinically appropriate environment**;** encourages full family participation in all aspects of planning

and delivery of services; requires service integration and care coordination; early identification and intervention; smooth transitions between systems; individual rights and advocacy; and non-discrimination (Arbuckle et al, 2005). There is now fairly broad and growing acceptance of SOC as the best way to serve children with SED and their families.

However, recently, there has been a recognition that there are some very real differences in how to develop a system of care for children who have not yet reached school age (Perry, Kaufmann, Hoover& Zundel, 2008; Kaufmann & Hepburn, 2007; Perry, Kaufmann,& Knizer, 2007). The core values of a system of care philosophy as articulated by Stroul and Friedman (1986); Stroul, Blau, & Sondheimer, 2008) require services that are community based, child centered, family driven, and culturally and linguistically competent with guiding principles that require a broad array of services that are individualized and provided in the least restrictive environment, that are coordinated and are driven and guided by families and youth. They also emphasize early identification and intervention. In addition, the unique principals that are required for systems of care for younger children include being grounded in developmental knowledge, infused into natural environments and are relationship based (Perry, Kaufmann, Hoover& Zundel, 2008). Further; the early childhood experts emphasize that there must be robust interagency collaborative partnerships that will by necessity include partners that may not have previously been at the table such as early childhood centers and other natural environments where young children spend time.

They recognize that collaboration is essential to building any system of care, but they point out that to have a truly effective early childhood mental health system collaboration must take on a different form with the new partners, as well as new services may need to be included in the array, and different venues for providing the services will have to be developed (Perry, Kaufmann, Hoover & Zundel, 2008). There is also a heighted awareness as to the importance of cultural and linguistic competence since all aspects of child-rearing are informed by culture and ethnicity, including forms of discipline, health and mental health practices, and expectations about dependence verses autonomy (Huang & Isaacs, 2007; Kaufmann & Hepburn, 2007). Some reasons for mental health disparities for minority populations cited by experts are: 1) local problems in the community's self-assessment, including factors such as structures, policies, and operations, clinician and consumer biases, stereotypes and beliefs; 2) societal stigma towards behavioral health disorders; 3) lack of a culturally competent and diverse workforce; 4) lack of a data infrastructure to disentangle various factors that contribute to disparities; and 5) criminalization of mental health needs of racial/ethnic populations (Huang, Isaacs & Ida, 2004). For these reasons, cultural and linguistic competence must be incoproarated in the early childhood SOC to maximize the impact on those served (Huang & Isaacs, 2007). As a core value family driven care is highly associated with the strong family movement that is developing as a powerful advocacy force in the SOC movement, however, like many other agencies and groups, the existing advocacy organizations have not typically reached out to the families of young children (Perry, Kaufmann, Hoover & Zundel, 2008), which is a major difference in a typical SOC. This factor has to be considered in the development of a conceptual model for young children and families who are to be served in systems of care.

As more states are building infrastructures that support the delivery of a full array of mental health services and supports for young children 0-5 years of age and their families, positive outcomes are being reported associated with these early childhood SOC initiatives. For example, Connecticut and Colorado both have designed and implemented effective systems of care with

positive outcomes for families and younger children who need mental health care. Because of the positive outcomes being observed, a growing body of evidence currently supports a SOC approach to serving families and children with SED (Worthington 2001). These findings are contributing to the growing body of knowledge about the effectiveness of a conceptual model for early childhood mental health systems of care that is based on robust scientific evidence. (Perry, Kaufmann, Hoover & Zundel, 2008.) Moreover, as policy makers, practitioners, program managers, and advocates address the complex challenges of designing, implementing and evaluating early childhood systems of care, it becomes more clear that that the unique needs of young children must be central if SOC initiatives are to be successful (Stroul & Blau, 2008).

Some of these positive outcomes reported by the Comprehensive Community Mental Health Services Program for Children and Their Families include reduced costs as a result of fewer days in inpatient care, decreased utilization of inpatient facilities; reduced arrests, resulting in per-child cost savings; sustained mental health improvements; reductions in suicide-related injuries; improved school achievement; and significant reductions in placements in juvenile detention and other secure facilities (SAMHSA, 2005). From a community perspective, achievements include high levels of satisfaction and participation among involved families, increased funding for mental health services and families experiencing truly family and child-centered services. All of these outcomes speak to the importance and potential of a local SOC for children with SED and their families. As more and states are building infrastructures that support the delivery of a full array of mental health services and supports for young children 0-5 years of age and their families, positive outcomes are being reported associated with these early childhood SOC initiatives. For example, Connecticut and Colorado both have designed and implemented effective systems of care for younger children who need mental health care and their families. These findings are contributing to the growing body of knowledge about the effectiveness of a conceptual model for early childhood mental health systems of care that is based on robust scientific evidence. (Perry, Kaufmann, Hoover & Zundel, 2008.)

A.2: Population in the Geographic Area to be Served

An awareness of the mental health needs of very young children in their formative and dynamic years is critically important. Although there is limited data, the Minnesota's Center for Excellence for Children's Mental Health noted that social, emotional, and behavioral problems have been reported in 8%-11% of young children (Michaels, 2008). If we were to use the conservative estimate that 8% of young children have social, emotional, or behavioral problems it would be reasonable to suggest that at least 2,756 of children 0-5 in these five counties are affected by social emotional difficulties. It has also been found that young children who display severe behavioral and emotional problems have a 50% greater chance of continuing to struggle with mental health problems into adolescence and even adulthood (Children Youth & Family Consortium, 2002; Kaufmann & Hepburn, 2007).

The Early Connections Network (ECN) will target the contiguous counties of Cheatham, Dickson, Montgomery, Robertson, and Sumner Counties which are located north to northeast of Nashville in the Mid-Cumberland region of Middle Tennessee. According to the US Census Bureau the total population of these five counties is 398,718 with the most populated county being Montgomery. Children 0-5 make up 9% (34,338) of the total population of these counties (US Census Bureau, 2000). Currently 80% of children 0-18 in these counties are White with African American children being the largest minority group at 14%. Sixteen percent of children ages 0-18 in these counties are enrolled in TennCare, the state provided Medicaid health

insurance program, and 23% of the 0-5 population in these counties is enrolled in the WIC program (Annie E. Casey, 2009).

In addition to "typical" Tennesseans, this targeted area is also home to many United States military soldiers and families. Also, the area is home to the 110 National Guard families, the major United States Army base Ft. Campbell is located partially in Montgomery County. Ft. Campbell is home of the 101st Airborne Division (Air Assault), the 160th Special Operations Aviation Regiment (SOAR), 5th Special Forces Group and 101st Corps Support Group. The 101st participates in peacekeeping and humanitarian missions at home and abroad. Over 30,000 soldiers and 62,000 family members call Fort Campbell home. More specifically, 2,316 (16.15%) of the children in these homes are under five years old and 1,675 (11.18%) are five to nine years old. The installation manages the records of some 4,000 civilians, with approximately $2.5 billion budget per year, making it the largest employer in both Tennessee and Kentucky (Clarksville Chamber of Commerce, 2009). Unfortunately, many of these soldiers have faced multiple deployments to Iraq and Afghanistan. Recent data suggests that soldiers with three or more deployments had higher rates of psychological problems (12%) and marital problems (over 16%) (Emery, 2008). This added stress on the caregivers of young children can inadvertently cause a "trickle down" effect. Young children often feel a sense of bereavement when their parent is deployed and when the caregiver returns with psychological problems or marital issues arise the effect on the child can be quite harmful. The influence of these environmental factors can manifest in the child in the form of emotional and behavioral difficulties.

In addition to the risk factors surrounding young children who have parents in the military other risk factors that increases the chance of a young child developing mental health problems can include: maltreatment, prenatal exposure to alcohol or drugs, poverty, and poor mental health in parents, especially depression in mothers. In 2008, in our targeted counties there were 373 reported cases of child abuse with 1,281 cases substantiated as being child abuse and neglect in our five target counties. Additionally, 5,487 children 0-17 received assistance from Families First, the state's welfare program. In these counties, 7% of Tennessee's low birth weight babies were born in and 58 babies died before their first birthday (Annie E. Casey, 2009). Also of note, the Annie E. Casey Foundation Kids Count report noted that from 2000-2006 in Tennessee, 23% of children lived in poverty and 36% of children lived in families where no parent had full-time, year round employment.

Young children in their preschool years have experiences that are vital in laying the foundation for their emotional development and future social and cognitive learning (Thompson & Raikes, 2007). Service disparities exist for racially, culturally and ethnically diverse children as well as those children who live in poverty in the targeted area. The stigma associated with mental health problems continues to contribute to the reluctance of parents and caregivers to access early childhood services available for young children. Culture also strongly influences child development and child rearing beliefs, so while professionals may indicate the child may have a special need, caregivers may believe that it is typical behavior for a child. Also, if caregivers believe there is a mental health need that the child has, many will drive their child many miles to Nashville where more TennCare providers, including more racially, culturally and ethnically diverse choices, are available rather than seek help locally where there are limited resources. It is these disparities and service gaps that the Early Connections Network will address for young children and their families. The ECN will embed Family Support Providers and Early Childhood Treatment Specialists in the provider agencies and organizations that young children come in contact with such as pediatricians' offices and child care facilities to be that

link between the family and community resources as well as offer behavioral intervention. The Early Connections Network will also provide training to parents and child care centers about social emotional development of young children so caregivers and providers can have a basic knowledge of skills a young child needs to develop. Although the Early Connections Network will accept referrals from parents, it is expected that the majority of the referrals (up to 80%) will come from child care facilities and pediatricians and other primary care providers in the targeted area; the remaining 20% will come from caregivers, child welfare, mental health centers, and other community resource centers.

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- ***A.3: Current Capacity to Serve Population***

Most mental health providers in the Mid-Cumberland region offer traditional mental health services to children and their families, including psychotherapy, psychiatric care and medication, mental health case management, inpatient and outpatient treatment. All of these services for children are accessed through TennCare and Coverkids, Tennessee's SCHIP program. Included are integrated health and behavioral health services which are determined by EPSTD assessment. Additionally, TDMHDD, Office of Special Populations, through state appropriations and Block Grant funding contracts with multiple agencies to deliver education, prevention, early intervention, respite and outreach services for very young children and their families. There are several community mental health centers and other agencies in the Mid-Cumberland Region (Centerstone, Volunteer, Youth Villages, and Lifecare) that serve both children and adults with Medicaid as well as offer some programming for those without insurance, although these are usually services offered to adults. There are also numerous individual mental health providers serving those with private insurance. However, according to our workforce data report there are no child psychiatrists in any of the five counties we have targeted. In fact, of the 918 psychiatrists with a specialty designation (addictions, adult, child or geriatrics) in the state, no more than 15 (< 2 %) were located in these five selected counties (TDMHDD, Office of Statistical Research, 2009).

Overall, it has been very difficult to ascertain from the community mental health agencies serving these five counties the number of very young children who have received mental health services in the past year. Centerstone, the largest mental health provider in the five counties, estimated that they have served approximately 157 children 0-5 years old in the last two years, however, they suggest that targeting programs specifically for very young children and their families has not been a priority. From our discussions with the Tennessee Association of Mental Health Organizations (TAMHO), the mental health trade organization, they admit that they have no concrete data, but they support the idea that there is a large gap in knowledge among their providers about how to treat very young children. Because of this deficit, their providers, in general, have not done focused outreach to families of very young children who have mental health needs. Taken together, it is clear that the selected five counties have many families with risk factors associated with poor early childhood mental health, such as poverty, single parents who have low education levels, high unemployment and low literacy rates, and many parents have mental health and substance abuse issues. In sum, there are some basic mental health services available in the five counties, but there are currently *no* comprehensive, coordinated specialized mental health services that target very young children and their families, leaving many of these young children and families without the early health promotion, prevention, and intervention services they need to ensure that their young, preschool children are ready for school and life.

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A.4: Local Gaps, Inadequacies, and Barriers that Justify our Need for this Initiative

Local Gaps*:* As noted above many of the providers in these five counties offer the very basic mental health services for children and their families, yet they often are not specific to their needs. Pediatricians and other primary care providers also provide some of the very basic mental health services. Many providers throughout the state of Tennessee do not have the specialized knowledge or treat very young children with mental health needs according to providers themselves, mental health trade organizations and testimonials from parents in public forums such as the Council on Children's Mental Health (CCMH), that many providers throughout Tennessee do not have the specialized knowledge to treat very young children. Therefore, there is limited outreach by providers to the families who have very young children with mental health needs. ***Inadequacies****:* The demographics of families living in the five counties such as: rates of poverty; prevalence of low birth weight babies; number of single mothers; divorce rates; and an elevated prevalence of mental health and substance use by parents, are all risks factors associated with poor developmental outcomes in young children. Because of these risk factors, we know that there is a high need in these five counties for early childhood mental health services. Additionally, the high presence of military personnel in these counties, many of whom have been deployed to Iraq or Afghanistan once or twice, creates unique family stressors that are associated with risk factors that have negative consequences for young children's social-emotional development. Many of these soldiers have returned from active duty with PTSD, substance use issues, depression, traumatic brain injuries and other factors that increase family stress, (Emery,, 2008) all risk factors associated with poor developmental outcomes for very young children. We have already described that there is an inadequate number of providers in these counties to serve children with mental health needs, and their families. When the deployed soldiers return, their very young children will be impacted. These additional children and families place additional demands on an already inadequate system. We have some services that are beneficial for children like the Regional Intervention Program (RIP) for young children in Gallatin, Sumner County. RIP is an evidence-based program for children under six years old who have mild to severe behavior problems. Also RIP, a TDMHDD funded program, has years of data that demonstrates the effectiveness of the Program, however, the state has not been able to fund it to scale. The RIP Program in the Mid-Cumberland region which is located in Montgomery and Sumner counties combined has served 101 young children and their families in 2009. Presently, 31 children are on the wait list for this program in Montgomery and Sumner counties. ***Barriers that justify this initiative***: Most providers have worked in silos and families have not been involved in needs assessments or planning for services to meet the needs of their children. This initiative will support bringing families, providers, and other stakeholders together to assess the needs of the five counties relative to young children's' mental health needs. Another major barrier is the lack of mental health services and supports that are embedded in early childhood settings. The TDMHDD, using state and Block Grant funds, has funded a small program that trains childcare centers, upon request, the social and emotional development of children. The program, however, is not funded adequately to meet the training needs of all of the centers that request the training. The lack of coordination and planning is a tremendous barrier. The lack of skills about how to provide services for young children with mental health needs and their families is a major barrier, which this initiative will help to eliminate. There are inadequate number of providers who have knowledge about young children's mental health needs, and their families. The trainings and Early Childhood Treatment Specialists are strategies needed to improve the services for young children with mental health needs and their families.

A.5: Collaborations with other Federal, State, and Local Programs and Reforms

Federal: The Early Connections Network will leverage existing federally-funded programs by collaborating with programs such as Title XIX, Title IV-A, Title IV-B and Title IV-E of the Social Security Act, that represent TennCare (Medicaid) and Medicare, TANF, child welfare, and foster care respectively. We will also be working very closely with the Department of Health where the Title V Maternal Child Programs are located. The Maternal and Child Health Division operates a number of programs that we will collaborate with including Help Us Grow (Hugs). HUGS operates in all 95 counties in Tennessee assisting pregnant and postpartum women up to two years, and infants and children up to six years with medical/behavioral, social, and educational services. The Early Connections Network will coordinate with the Department of Children's Services (DCS) to provide services to young children at risk of entering state custody and their families, and the required TennCare Early Periodic Screening, Diagnostic and Treatment Program (EPSDT) services in the counties. EPSDT is a Medicaid mandate and an excellent method for identifying early, very young children who have physical and developmental lags according to the pediatric periodicity chart. Any lags in health or developmental stages in these children, trigger a further assessment. ***State/Local***: Since 2006, the Department of Education has implemented a very extensive voluntary pre-k program. Tennessee's Voluntary Pre-K program is a national leader in Pre-K quality, having achieved 9 of 10 quality standards from the National Institute for Early Education Research for the past three years. State-supported Pre-K programs are located in 94- of the 95 counties in Tennessee, and 133 of 135 eligible school districts. All five of the counties of concern for the Early Connections Network have a state funded pre-k program. Our Childcare Consultation program which is funded by TDMDDD and facilitated by TVC, has worked with many of the faculty and staff at a number of these state supported pre-k programs. The Early Connections Network will build on these relationships in the five counties to be served in this initiative. Tennessee Nurses for Newborns Network is a home visitation model designed to provide a "safety net" for pregnant women and new mothers with young children moat at risk for poor health and emotional-social developmental outcomes. During the home visits nurses teach pregnant women and mothers appropriate child care, provide mentoring and role modeling to mother and connect high-risk families to community resources. Nurses also provide assistance in managing crises and increasing skills at providing a health and safe environment for optimal child development. Finally, we will collaborate with the very successful Tennessee Early Intervention System (TEIS), Part C of IDEA, which is operated through the Department of Education. ***Reform:*** Tennessee Council on Children's Mental Health (CCMH) The Legislation passed in 2008 that established a Council on Children's Mental Health Care to design a plan for a statewide system of mental health care for children. It requires the Council to develop a plan for a statewide system of care where children's mental health services is child-centered, family-driven, and culturally and linguistically competent, and provides a coordinated system of care for children's mental health needs in the state. The
Council is co-chaired by the Commissioner of the Department of Mental Health and Developmental Disabilities and the Executive Director of the Tennessee Commission on Children and Youth.

SECTION B - IMPLEMENTATION PLAN

B.1: Infrastructure Development

<u>Attachment I</u>

EARLY CONNECTIONS NETWORK GRANT NARRATIVE

Multiple existing state collaborative efforts provide a sound basis for the development of a Regional SOC implementation. These collaborations are significant pieces of the infrastructure, but are not available statewide. They need to be interwoven with other services available in the region to form a complete infrastructure in the five county region addressed in this regional SOC.

❑ *Composition and Responsibilities of the Governance Body* The Early Connections Network will develop a governance body based on the collaborative relationships developed over the past ten years among the grant partners, among the leaders for the Center on the Social Emotional Foundations for Early Learning (CSEFEL/Team Tennessee), and additional early childhood stakeholders from the five county service area, including families, local pediatricians, staff from the regional Department of Children's Services office and local Department of Education representatives. This System of Care will build on the strength of these groups to form the Steering Committee, which will include representatives from the current collaboration and community leaders from the targeted area. Additionally, ECN staff will provide administrative and technical support to the Steering Committee. Other stakeholders will be engaged to participate on the Steering Committee as the System of Care develops. The primary responsibility of this Steering Committee will be oversight of system of care implementation, ensuring that services are provided in a child-centered, family-driven, youth-guided, culturally and linguistically competent manner.

❑ In order to leverage resources at the local and regional level, the Steering Committee will be supported by a large number of diverse community groups, military, and state mandated councils currently embedded in the region and will be called the Full Partnership. In collaboration with the Full Partnership, the Steering Committee will provide direction for subcommittees that will focus on specific areas of program implementation. The state mandated councils whose membership will make up the Full Partnership and that are currently active in the region are as follows: 1) **Regional Mental Health Councils** which provides citizen participation and policy planning for the Department of Mental Health and includes representatives representative of service recipients and their families, advocates for children, adults, and the elderly, service providers, agencies, and other affected persons and organizations and 2) **Community Advisory Boards (CABs)**: Established by the Department of Children's Services (DCS) established local CABs in each county in Tennessee. Each CAB functions as an independent local advisory board and is composed of local community partners committed to the well being of children and families, including local families, local public agencies including schools, health departments and other health care providers, juvenile court, district attorney general and law enforcement officials.

The ECN will be administered through the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) and will be operated collaboratively with Tennessee Voices for Children and Centerstone Community Mental Health Center. The Initiative Director, Technical Assistance Coordinator, Social Marketing Coordinator, and the Cultural and Linguistic Competence Coordinator will be employed by the TDMHDD. TVC will employ the Family Support Providers, Social Emotional Training Specialist, a Family and Youth Engagement (FYE) Specialist and the Family Support Supervisor. TVC is the state chapter for the National Federation of Families, a consistent partner in the four previously funded systems of care sites and manager of a regional system of care programs. Centerstone Community Mental Health Center will employ the Early Childhood Treatment Specialists (ECTS) and the clinical supervisor. As the mental health component of the initiative, they will work in partnership with the Family Support Providers to ensure the emotional and behavioral needs of enrolled families

and children 0-5 are met. Centerstone Research Institute (CRI), the research arm of Centerstone, will also design and implement the evaluation component of the ECN.

- *Systems & Services Integration and Interagency Collaboration:* Linked by interagency agreements and memoranda of understanding for this initiative, and guided by active participation of parents and caregivers, ECN will serve to identify gaps in service, develop a plan to address these needs in a culturally and linguistically competent manner, and build a more seamless service delivery system for families of young children. The interagency agreements outline each partnering agency's participation in the initiative, including designated representation on the Steering Committee, provision of specific services or supports, and agreements regarding information and resource sharing. Focus groups will also be held in Year One with parents, early childhood educators and community members to ascertain the services most often utilized, identify the gaps in services that exist, and to obtain feedback on what families feel they need to be successful and establish a strong foundation for their young children. This information will inform the Steering Committee about what services are missing in the targeted counties and should be priorities for service development in this initiative.
- *Care Plan Development:* Care plans will be developed through the Child and Family Team (CFT) process. During the first 30 days of enrollment, the Family Support Provider (FSP) and Early Childhood Treatment Specialist (ECTS) will assist the family in developing an agenda for their first CFT meeting and identify the formal and informal supports the family would like to have on their Team. Team meetings are held at locations and times that are convenient to the family and are initially facilitated by the FSP. Based on the family's agenda, strengths, and needs, the CFT will work with the caregiver to develop an Individualized Service Plan (ISP) that meets their unique needs. The team problem-solves around any barriers, as well as decides if the use of flex funds is necessary. All members receive a copy of the plan with their specific tasks highlighted; this plan will guide the intervention and by monitored for completion by the FSP. CFT meetings will be held at least every 90 days to update goals and track progress during the family's enrollment, although meetings may be held as often as needed to address the family's needs.

Financing, Access, and Flexible Funding: In the Early Connections Network, each Child and Family Team (CFT) will be facilitated by the Family Support Provider (FSP), a trained parent/caregiver of a child with emotional, behavioral or mental health problems. Guided by an individual service plan (ISP) which will utilize existing funding streams, such as Medicaid, private insurance, TANF and grant-funded initiatives, will enable a child and family to access necessary mental and physical health services, as well as childcare, respite and other such services. Flexible funds will be utilized to access nontraditional services that would improve the emotional and behavioral health of the child or empower the parent/caregiver to maintain a child with special needs in the home. The decision to use flexible funds will be made by the Child and Family Team in the development of the ISP and reviewed by the Initiative Director for approval and payment for the identified service.

- *Care Review*: In order to accomplish quality assurance each supervisor will conduct regular reviews of both the electronic record and the hard chart for each child and family to ensure that documentation is up to date, accurate, and consistent. The Initiative Director will also regularly conduct reviews of a random sample of records. A Care Review Team will be established as a subcommittee of the Steering Committee and will include family members, the Social Emotional Training Specialist, the Clinical Supervisor and professionals. This Care Review Team will review randomly selected ISPs each quarter, assessing for fidelity to the

wraparound process, appropriate use of flexible funding, adequate documentation, compliance with initiative policy, and adherence to cultural and linguistic competence in service provision and assess the need for further training of staff and community providers. They will follow a protocol (to be established in Year One as part of the initiative policy and procedures) of quality assurance and report back to the Initiative Director and the Steering Committee on the results of their review. Each quarter, with the exception of Year One (planning year), families will be invited to attend a meeting to give feedback on the quality of services they are receiving, ask for their suggestions for improvements, and encourage them to become involved. Information from this quarterly meeting will be reported to the Steering Committee and used to improve initiative implementation.

Workforce Development: A Workforce Development Committee will identify workforce inadequacies via a needs assessments conducted in Years One and Two. The Committee will have access to and use of information compiled by the Council on Children's Mental Health and TDMHDD as well as information from other professional organizations that have knowledge and experience with early childhood mental health. The assessment will address deficiencies in areas such as staff vacancies and turnover, cultural competence, family participation, and use of evidence-based or evidence-informed practices. The Committee will be charged with developing a strategic plan for addressing these needs in order to build a comprehensive system of services in this five county area. The Technical Assistance Coordinator will chair this committee and be responsible for investigating the training needs of the community and ways to meet those needs. Many training events provided to initiative staff will also be open to community stakeholders in order to facilitate cross-training of the workforce and to enhance the opportunity to build collaborations between service providers that will further benefit children, youth and families. The Workforce Development Committee will also engage stakeholders from regional mental health, social work, education and child care preparation programs easily accessible to targeted area.

Replication Plan: The Early Connections Network's replication plan is compatible with the state's vision as well as other state and federal initiatives in Tennessee. The EECN seeks to build upon the strengths of the four previously funded system of care sites. TDMHDD, TVC, and Centerstone have, through these sites, developed a unique model of service delivery. An innovative addition to this model will be the introduction of the ***Social Emotional Training Specialist (SETS).*** Enrolled families and their providers will have access to targeted training from the Social Emotional Training Specialist through the Early Connections Network. This individual will provide mentoring, support and training to families and caregivers of young children with mental health needs. The SETS will also provide education to providers and child care centers.

This newest implementation would enhance and accelerate the momentum of the adoption of this model replicated through four other initiatives (Nashville Connection, Mule Town Family Network, JustCare Family Network, and the K-Town Youth Empowerment Network) throughout the state. As we move toward a statewide coordinated system of care, it is the intent of the Early Connections Network to replicate and enhance this model in the Mid-Cumberland Region to further provide evidence that community based, culturally and linguistically competent and family-driven care is effective for very young children with mental health needs, and their families.

Attachment I
EARLY CONNECTIONS NETWORK GRANT NARRATIVE

Developing SOC Structure – Strategies

The Early Connections Network will develop the following structures to implement a system of care in the five county region for young children and their families:

Clinical Network: The clinical network will consist of a broad array of traditional and nontraditional services, treatments, and supports – many of which already exist within the community and some that will be developed, improved, and coordinated – to assist children with emotional and behavioral problems and their families. The framework for the clinical network already exists, where TDMHDD and community stakeholders have begun integrating system of care philosophies and structures, providing the foundation for the proposed system's network of clinical resources to be expanded and accessed by children and families enrolled in the initiative.. The initiative will explore training and technical assistance opportunities through CMHS, particularly in the area of cultural and linguistic competency and issues specific to children ages 0-5 years. The initiative will also utilize findings from the local and National Evaluations to identify and overcome deficiencies and enhance clinical services in its clinical network. During the first year and at regular intervals throughout the life of the initiative, the governing body will conduct community needs surveys and use data collected by the Care Review Group to identify and overcome disparities in access, treatment, and family involvement. Addressing all disparities found will be priority actions for the governing body.

- *Administrative Team:* The Administrative Team for the Early Connections Network will be comprised of two parts, the Steering Committee and the Grant Management Team. The Steering Committee will be formed by representatives from state and local child serving agencies, community leaders, advocates, youth, parents from the targeted communities, and core initiative staff (Initiative Director, FSP and Clinical Supervisors, Lead Evaluator, Technical Assistance Coordinator, Social Marketing Manager). The Steering Committee will reflect the racial, ethnic, and cultural groups representative of the targeted area. They will oversee the system of care model and ensure that interagency agreements are implemented, as well as facilitate solutions to barriers in access, funding, and family involvement.
- Collaborating with the Steering Committee will be the Grant Management Team which will be comprised of the Principal Investigator (TDMHDD), the Project Director, the Executive Director of TVC, the TVC Assistant Director for Programs, the Vice President of C & Y Services of Centerstone Mental Health Centers, and the Evaluation Director (Centerstone Research Institute). They will be responsible for implementation oversight and fiscal management of the initiative.
- *Training Capacity:* The Early Connections Network will use consultants and experienced trainers and our Centers of Excellence (four academic centers that provide evaluations and services for children with complexes needs including mental health needs and their families) as well as opportunities for learning within the community and surrounding areas, to ensure that initiative staff and members of the Steering Committee are informed on the system of care model, provision of wraparound services and family-driven care, and cultural and linguistically competency. The Early Connections Network will connect with various agencies and entities within the county and through the Technical Assistance Partnership to provide training on cultural competency, clinical issues related to early childhood services, and other training needs identified by the Network.
- *Performance Standards:* Early Connections Network, in collaboration with the evaluation team and through family and stakeholder involvement in the governance and subcommittees of the initiative, will identify key performance standards for measurement of success in initiative

implementation and system transformation. These performance standards will include traditional domains such as service utilization, access and capacity, and outcomes for children and families. The success of Early Connections Network will also be measured through data collected in the National and Local Evaluations. In addition to demographic information (e.g., gender, age, race and ethnicity) and measuring accessibility of network services to all participants, the local evaluation performance data will capture disparities, barriers regarding access, gaps in services, and community attitudes toward seeking and receiving social emotional or mental health care in early childhood. Both the Grant Management Team and the Steering Committee will work closely with evaluation staff to develop data collection procedures and effective reporting methods that will inform the community of initiative progress and participants' needs regarding services.

- *Management Information System (MIS):* The majority of family and initiative data will be captured by TVC's Qualifacts system, an internet based information storage/management system that is also used by other SOC grantees and initiatives in Tennessee. Additional data will be captured by Centerstone using Centernet, an internal storage/management system that is connected with Centerstone's personnel and billing systems. Both systems are accessible from remote locations and conform to all HIPAA standards.
- *Presence in the Community:* In addition to hiring qualified staff directly from the communities served and utilizing the strong relationships built through the multi-year and multi-site collaboration of the current partners, Early Connections will have offices centrally located to the targeted counties to facilitate access to families and stakeholders from all communities. Although the goal is to embed initiative staff in local pediatric offices and early childhood facilities, the partners will initially operate from their agency offices which are centrally located to the targeted counties. TVC currently has its main office in Nashville, near the offices of TDMHDD (where the Project Director, Technical Assistance Coordinator and CLC Coordinator will reside) and adequate meeting and training space. Both offices are located in an area accessible by public transportation and close to services utilized by the targeted population to provide easier access for families. Trough collaborative agreements with stakeholders and concentrated efforts to be accessible to participating families, ECN will build and maintain a strong presence in each of the targeted counties

Collaboration With Other Child-Serving Systems: Middle Tennessee has a rich history in collaboration for early childhood services. Through state and federal grants, local contracts, and mutual goals, many providers, educators, researchers, and policy makers have worked together to improve access to quality services for young children and to provide supports and education for parents and caregivers on early childhood development and social emotional needs. The Early Connections Network will draw upon the strengths of these groups to develop a more coordinated system of service delivery and supports for young children and their families. Beginning with the long standing relationships and collaborative work of the key grant partners (TDMHDD, TVC, and Centerstone), the Network will formalize the partnerships with other early childhood initiatives and initiatives in the implementation of this cooperative agreement. The following, although not an exhaustive list, are those who have agreed to work with the Network to develop a more coordinated, family driven system of early childhood services and supports. *Team Tennessee/CSEFEL is entering its third year of developing and supporting a statewide cadre of trainers and coaches and six model demonstration sites using the Pyramid Model**.** The Team TN State Leadership Group consists of statewide directors and coordinators of early childhood programs from the TN Department of Education (TDOE) Voluntary Pre-K

Program, TN Early Childhood Training Alliance (TECTA), Department of Mental Health & Developmental Disabilities, TN Voices for Children, TN Children's Trust Fund, Head Start State Collaboration Office, TN Infant and Toddler Services, TN Early Intervention Systems (TEIS), Nashville State Community College, TN Child Care Resource & Referral Network, and Early Childhood Comprehensive Systems. *The Early Childhood Consulting Program (ECCP), established in 1996 by TDMHDD and operated by TVC, addresses needs associated with serious behavioral, developmental, and environmental barriers to effective learning. Special emphasis is placed on those children at imminent risk of being dismissed from their child care or early childhood education setting. *Tennessee Parent Information and Resource Center (TPIRC), a federal DOE grant in its third year and operated by TVC, provides training, technical assistance and support to Title I schools and parents residing in low income areas statewide to improve the academic success of children and youth and parental involvement in the educational system. TPIRC has an early childhood component that supports home visitation programs and offers technical assistance around early learning strategies.

Training and Technical Assistance: Early Connections Network will partner with the Centers of Excellence (COEs), an experienced resource in Tennessee for disseminating evidence based treatments for children. Specifically, the COEs who will provide the structure and oversight for training in Parent-Child Interaction Therapy (PCIT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). These trainings will provide parents, professionals, and other community perspective additional knowledge about evidence-based treatments for young children with mental health needs. **Parent Child Interaction Therapy (PCIT)** is a behavioral, family-oriented therapy and an evidence-based practice for children with disruptive behavior problems. It is a treatment designed to improve the relationship between caregivers and their child. PCIT is also one of the most effective treatments known for children with behavior problems between the ages of 3 and 7 years (Eyberg, S.M.,2009; Eyberg, Nelson, & Boggs, 2008; *Child Welfare Information Gateway*; Kauffman Report, 2007). **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** is an evidence-based treatment for children with traumatic stress. The components-based psychotherapy addresses PTSD, depression, behavior problems, or other difficulties resulting from traumatic life experiences. **The Pyramid Model for Promoting the Social and Emotional Development of Infants and Young Chilldren** is designed to increase and sustain the capacity of child care and early education systems to promote the social-emotional development and school readiness of young children birth to age 5.

Social Marketing: Given the significant access disparity among our underrepresented but growing and underserved local populations such as the poor, of all cultural, racial and ethnically diverse backgrounds, including African American and Hispanics, and the large number of military families whose lives are very influenced by military culture, widespread social marketing that will have to be done starting at the very beginning of the Network initiative. We will have to engage credible cultural brokers such as trusted family and youth support to inform the development of programs to meet the goals of the initiative. Additionally, this initiative will have to aggressively reach out to Veterans and other military personnel recognizing that they are a unique cultural entity. The TDMHDD personnel have been engaged in a partnership with the Tennessee Veterans Task Force for two years working on issues that will be supportive of the women and men serving in the military and their families

The Social Marketing (SM) Coordinator will be hired by TDMHDD and will work in tandem with the Social Marketing subcommittee that will have representatives of all the various racial, ethically, and culturally diverse groups, including representatives from the military on the

Steering Committee to develop a strategic social marketing plan for the initiative. These collective avenues will reach all community sectors, including government, education, healthcare, social services, military and the business community. The Family and Youth Engagement (FYE) Specialist will focus on ensuring diverse family voices are present in all levels of program implementation.

Increasing Capacity and Quality of Services: The Early Childhood Network will significantly increase capacity and improve the quality of services for very young children and their families in the targeted area. The Network will use year one (planning year) to build a foundation for quality service provision based on community needs assessments, focus group data from families, providers, including child care centers and others, development of specific interagency agreements, service and training contracts, and strengthening collaborative relationships with stakeholders. As early as the fourth quarter of Year One the Network will strive to enroll up to 20 children/families. In the five subsequent years the Network will enroll up to 76-80 children/families. The Network will serve at least 400 children/families during the course of the initiative. The Cultural and Linguistic Competence Coordinator who will be hired from the targeted community will be working closely to ensure that the needs of the various culturally racially and ethnically diverse children and families are recognized and met.

Projected Annual Number of Youth Served by Key Services			
Key Service in the System of Care	**Est. # served**	**Key Service in the System of Care**	**Est. # served**
❑ Case Coordination	❑ 80	❑ Outpatient Therapy	❑ 45
❑ Mental Health Case Management	❑ 65	❑ Diagnosis and Evaluation/Assessment	❑ 100
❑ Crisis Intervention	❑ 25	❑ Intensive Home-based Services	❑ 35
❑ Therapeutic Foster Care	❑ 10	❑ Child Care/Pre-School Mental Health Consultation	❑ 80
❑ Residential Treatment/ Group Care	❑ 10	❑ Parent Training	❑ 55
❑ Speech Therapy	❑ 50	❑ Parent Support Group	❑ 30
❑ Behavioral Aides	❑ 40	❑ Respite Care	❑ 30
❑ Transportation Assistance	❑ 80	❑ Medication Management	❑ 55
❑ OT (Sensory Integration)	❑ 50	❑ Transitional Housing Services	❑ 40

Participation in Initiative Development and Implementation: The Early Connections Network will be built upon the strong collaborations developed over ten years in the targeted region by and among the grant partners who have worked closely to implement other system of care sites in Tennessee. Stakeholders, policy makers, early childhood expert, local child-serving agencies, community leaders, family members, advocates, and youth are involved in the development and the implementation of the Early Connections Network. Close attention will be paid to ensure the inclusion of diversity of the participants including, but not limited to, gender, race, disability, religion, ethnicity, culture, and sexual orientation.

❑ Others involved with the Network through MOUs and interagency agreements are local mental health providers, the regional Council for the Tennessee Commission on Children and Youth, child and family advocates, and community stakeholders. Included in this group are service providers who focus on the needs of young children and their parents, such as daycare

facilities, Head Start and Pre K programs, pediatricians, and child abuse prevention agencies. Team Tennessee, a collaboration of early childhood experts and providers operating under both state and federal funding, will provide support and training to the Network as well as participate on the Steering Committee.

Interagency Commitment of Nonfederal Match: Network partners have demonstrated their commitment to the Early Connections Network by meeting the non-federal match fund requirements for the initiative. In-kind match funds will be provided by Network partners in a number of ways, including salary allocations of staff involved in all levels of the initiative, waiving of indirect cost allocations, donation of space, materials and direct services, value of volunteer and donated time, market value discounts on training and other services, and state, local and private funding for services. Non-Federal Match Commitments have been made from current ECN partners, copies of which can be found in *Attachment 5*. Additionally, Governor Phil Bredesen has endorsed this initiative, providing a letter of assurance, which can be found in *Attachment 2.*

B.2: Service Delivery

- ❑ *Eligibility Requirements:* To be eligible for enrollment in the Early Connections Network, children must meet the following requirements: 1) Between the ages of 0 and 5 years (at the time of enrollment); 2) Children 3 years of age or younger must have significant behavioral or relational symptoms identified in the Diagnostic Classification of Mental Health Development Disorders of Infancy and Early Childhood-Revised (DC-0-3R), including an Axis II Relationship Disorder or a diagnostic impression of "imminent risk" identified through a standardized measure, and approved by a mental health practitioner experienced in early childhood development; for children 4 or 5 years of age, the Diagnostic Interview Schedule for Children (DISC) will be used as an alternative to the DSM-IV with the "imminent risk" diagnosis being identified through an intake process that includes a standardized measure that requires the approval of a mental health specialist with experience in early childhood development; 3) Impaired functioning at home, school and community so that he/she requires involvement with multiple service agencies in the early childhood arena; 4) Must reside in Cheatham, Dickson, Montgomery, Robertson, or Sumner County; 5) At risk of placement to a higher level of care (inpatient hospitalization, residential treatment, or state's custody for treatment); 6) a parent or caregiver willing to participate in the wraparound process to maintain the child at home and in the community.
- ❑ The Network will seek to target the large population of young children in the specified region that have historically been underserved, expelled from daycare settings and slipped between the cracks in transition to elementary school due to unmet mental health needs, lack of provider capacity or parental knowledge or inability to access services. Through the Network, children and families will have the opportunity to receive support and services necessary to establish a strong social emotional foundation, enabling them to remain at home and successfully transition to elementary school in the community.
- ❑ *Referral Sources and Enrollment Process:* Although referrals will be accepted from any individual in the community, it is expected that initial referrals will come from parents or family members, pediatricians and childcare centers within the community. The Network will likely also receive referrals from local Pre-K programs, the Department of Children's Services and the local mental health center. The Network will also receive referrals from daycare providers, Pre-K and Head Start programs, pediatricians and the faith-based community in the five county region

in order to reach parents of young children and those that serve young families.

- If the referral source is not the legal guardian of the child, the referral source must obtain appropriate consent prior to actually making the referral to the Network. Referrals can be made via fax, phone, or in person at the any of the partner offices. Within 48 hours of receipt of the referral, the Initiative Director will determine initial eligibility criteria; if the child meets initial criteria for the Network, the Initiative Director will assign a Family Support Provider (FSP) and Early Childhood Treatment Specialist (ECTS) to conduct an intake visit at the home or other location convenient to the family. If necessary, the FSP and ECTS will arrange for a bilingual interpreter to attend the intake and will provide the family with initiative information in its language. During this intake visit, the FSP and ECTS ensures that eligibility criteria are met, assessing the level of multiple agency involvement, detailing past and current use of services targeting emotional and behavioral problems, and asking questions designed to evaluate the level of functional impairment experienced by the child and its effect on the family. The FSP and ECTS also explain the program to the parent/caregiver and address the importance of parent participation in the wraparound process. By completing the intake together, the FSP and ECTS establish the dyad that will be the basis for service provision in the initiative.
- Based on the intake information and recommendation of the FSP and ECTS, the Initiative Director then officially enrolls the child in the Network, assigning an FSP and ECTS to work with the family. Referrals and assignments of initiative staff will be discussed in weekly meetings between the Initiative Director, FSP Supervisor, and Clinical Supervisor in a concerted effort to match families with initiative staff, taking into consideration staff's life experience and areas of expertise in regards to the needs of the family. While all families will be assigned an FSP to address support, care coordination and assistance in connection with services, every family will not be assigned an ECTS. If a child currently receives services from a site-based Early Childhood therapist/case manager through Centerstone (located in a variety of settings in the targeted region such as Pre-K programs and Centerstone's Early Childhood Center), the family would not require the services of an ECTS. In these situations, the FSP will work in partnership with the existing early childhood therapist/case manager to serve the family. However, families not currently receiving site based services in this manner will be assigned an ECTS upon enrollment in the Network. Working as a dyad, the assigned FSP and ECTS will arrange an initial visit with the family wherein they will begin rapport building and the strengths-based assessment; complete documents ensuring the family is aware of the limits of confidentiality, their rights and responsibilities in the program, and grievance and complaint procedures; and sign releases of information to allow staff to access mental health and school records and/or share data with agency partners. The family will be informed of the evaluation and provided with the evaluation consent to contact form. Enrolled families will have access to specific training from the Social Emotional Training (SET) Specialist, and the referral source (if different from the parent/caregiver) will be offered targeted training and coaching from the SET Specialist to build their capacity to address the needs of young children with emotional and behavioral problems. As caregivers of young children greatly benefit from planned "breaks" in many ways (i.e., opportunity for self-care that strengthens ability to parent difficult children, prevention of potential child abuse/neglect situations, etc.), enrollment in the Network will afford families to planned respite through the Network on a limited basis; caregivers will be informed of the process to access this essential service within the first month of service. All data on enrolled families will be maintained in an electronic record in the Qualifacts database system, and signed documents will be maintained in a hard chart in a secure location in each Network

partner office. Documentation of services rendered by the ECTS will be maintained in the Centernet database and accessed by other initiative staff according to privilege level per the existing agreement between Centerstone, TVC, and TDMHDD.

- *Service Components and Provision* Middle Tennessee has a number of services and resources, but there are significant issues in regards to access, eligibility, capacity, interagency coordination and service provision in a truly culturally competent manner. Tennessee has high rates of expulsion from daycare and Pre-K settings due to difficult child behaviors, lack of resources to address behaviors, and inadequate staff training; this leads to further hardship on caregivers who risk losing their employment when childcare is not available to them. Additionally, many caregivers and families in this region struggle with domestic violence and substance abuse that directly affects young children and their ability to develop health social emotional foundations. In the service arena, there are concerns regarding high caseloads, staff turnover, and historical mistrust between families and the child serving systems. This is especially true of young parents of children with emotional and behavioral problems who are often blamed for their child's behavior rather than supported. The Early Connections Network will address these issues at both the family and system levels to overcome these barriers.
- The following chart outlines required mental health services and supports, early childhood and optional services, and non-mental health services available in the five county region as well as key barriers:

Required Mental Health Services and Supports	**Available Services Barriers/Needs** **Services Available**	 **Barriers/Needs**
Diagnostic and Evaluation Services	Centerstone; Vanderbilt Center of Excellence/Children in State Custody; EPSDT; TN Early Intervention System (TEIS)	Need more services/options for private insured/uninsured; non-English speaking population, complex, high-need cases including hearing or visually impaired. Lengthy response times. Need evening/weekend access. Need transportation services.
Case Management/Care Coordination/ISP Development	Centerstone; TEIS; Life Care; CareNet; Mental Health Cooperative	Need more non-English speaking providers or translation options. Few resources for children with low-functioning or substance abusing parents.
Outpatient Services	Centerstone; Life Care Family Services; Regional Intervention Program (RIP); Montgomery County Child Advocacy Center (Rape & Sexual Abuse Center); Foundations; Family Wellness Center; Family Guidance Center; Vanderbilt Dept. of Psychiatry Outpatient Clinics	Lengthy response times. Expand number of providers with expertise in management of specific disorders including attachment and trauma. More services/ options for private insured/uninsured. After hours access. Services for children with impaired parents. Lack of sufficient funding.
Intensive Home-Based Services	Centerstone; Youth Villages	Lengthy response times. Need improved cultural competency and non-English speaking options. Need more training on providing specialized clinical services to families with children 0-5yrs.
Respite Care	TN Respite Network; TN Respite Coalition	Funding for respite services and more trained respite providers needed. Non-English speaking providers.
Therapeutic Foster Care	TN Dept of Children's Services	Only available to children in Department of Children's Services

Therapeutic Group Home Services	NA	NA
Transition Services to elementary school	Part B of IDEA Head Start Pre-K	Only available for children with special needs (Part B of IDEA) Income limitations for Head Start and Pre-K
Family Advocacy and Peer Support	TN Voices for Children-Statewide Family Support Network/Parent Information & Resource Center (TPIRC); NAMI; MH Association of Middle TN; Parents Encouraging Parents-TN Dept of Health	Limited funding.
Optional Mental Health Services	**Available Services**	**Barriers/Needs**
Mental Health Screening	EPSDT; TEIS	Increased attention to EPSDT/mental health domain needed. Behavior screens under EPSDT are "as needed' but not mandated in Tennessee.
Training	Team Tennessee-Center on the Social & Emotional Foundations for Early Learning (CSEFEL)	Limited funding.
Non-Mental Health Services	**Available Services**	**Barriers/Needs**
Special Education, Literacy Interventions	Team Tennessee/CSEFEL; TN Parent Information & Resource Center: 1) Love, Read, Learn 2) Better Together: School Readiness Collaborative Imagination Library	Limited funding. Imagination Library is currently available in Sumner County. It will be available to the other counties by June 2010.
Pro-social Recreational Activities	NA	NA
Vocational Counseling and Rehabilitation Services	NA	NA
Substance Abuse Prevention and Treatment	Services for adult/adolescent family members	NA
Youth Support and Leadership Initiatives	NA	NA
Protection and Advocacy	Prevent Child Abuse TN (Trauma); Disability Law & Advocacy Center of TN Stand for Children	Limited funding for Stand for Children
Health Services	TN Dept. of Health, Maternal Child Health: Children's Special Services. WIC	Income level restrictions
Transportation Services	Very limited public/community program transportation services.	Need increased public/community program transportation services.

Attachment I

EARLY CONNECTIONS NETWORK GRANT NARRATIVE

Key Service Activity Implementation The Early Connections Network will employ the following strategies to implement service activities following enrollment in the initiative.

Delivery of Clinical Interventions: Clinical intervention in the Early Connections Network will be provided by Early Childhood Treatment Specialists, Master's level clinicians with experience in early childhood interventions, behavioral planning, and therapeutic skill building. ***Diagnostic and treatment planning****:* For those children enrolled who have not had mental health assessment or treatment or that require more intense services based on their behavioral and emotional issues, the clinical staff will implement procedures for diagnostic and treatment planning that may include a thorough mental health intake that targets the mental health strengths and needs of each child and his/her family. The intake will include a psychosocial history, psychiatric evaluation including medication history and clinical assessment tools such as the CBCL. This information will be integrated into the service planning process and development of an individualized service plan for each youth and family. ***Community-Based Services****:* It is critical and most effective to wrap services around the child and family in their own environment and involve services that they can easily access in their community. All services identified in the child's individualized service plan will be provided within the targeted county/community whenever possible and in the least restrictive environment. Services will be provided in the clinic, office, early childcare setting, the home environment, domestic violence or homeless shelter or the community. Caregivers and their families will help identify the most convenient and most constructive place or system for service delivery that will facilitate follow through and success. Where gaps in services exist, the ECTS and FSP will work with network members to address those needs. Transportation barriers, severity of identified problem, and family preference will be factors in the selection of providers.

Clinical assessments: Two evidence-based assessment instruments will be used: The Child and Adolescent Functional Assessment Scale (CAFAS), and the Child Behavior Checklist (CBCL). Trained and certified clinicians will rate the CAFAS. The CBCL will be completed by the parent/caregiver and the caregiver/teacher, if age appropriate. Results, including overt risk behaviors and the evaluation of presenting problems, will be shared with the Child and Family Team members in a culturally sensitive manner during the initial meeting. The clinical assessment and treatment interventions will be culturally sensitive and employ a thorough understanding of the youth and families' preferences in treatment regarding sexual orientation, gender, race and ethnicity. The assessments will be conducted by a culturally competent mental health clinician using open-ended questions to enhance the treatment process. ***Training needs of clinicians:*** All initiative staff will receive training in the system of care philosophy, wraparound and culturally competent service delivery. Ongoing training will be provided in all levels of service delivery and in cultural/linguistic awareness and competency. Training will be provided in the assignment of diagnosis based upon the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R)* and the *Diagnostic Interview Schedule for Children* (*DISC)*. Clinical staff and community partners, including existing site-based early childhood therapists/case managers, will receive training in Parent Child Interaction, trauma informed care, and social emotional learning in order to better serve the families of young children. Since cultural, ethnic, and gender differences can influence behavior, these issues will be included in diagnostic training. Community service providers will provide input regularly regarding their additional training needs. Training needs will be addressed by the Workforce Development Committee, incorporated in the training needs assessment and plan, and resources located to provide the training as need indicates. All training

activities will be designed with input and participation of families. ***Evidence-Based Interventions:*** To effectively meet the needs of young children and their families, the Early Childhood Treatment Specialists will provide individualized and strengths based services in the community using evidenced-based treatment strategies to promote positive outcomes in children, including wraparound, Parent Child Interaction, Traumatic Focused Cognitive Behavior Therapy, and social emotional learning strategies as appropriate. Intervention strategies will be included in the Individualized Service Plan, with each unique measurable objective identified by the child/family as a means to attain the larger goal. Mental health services will be delivered from an ecological perspective primarily in the community setting and will provide a holistic approach that increases resiliency. Additional evidence-based and best practices programs will be added to the initiative as system assessments indicate specific needs. Interagency agreements will document each partnering agency's commitment to the provision of evidence-based practices as it relates to the population they serve.

Care Coordination and Individual Service Plans -- Child and Family Teams: Care coordination and developing an individualized plan for each child and family begins immediately upon their enrollment in the Early Connections Network Network. ***Family Support Providers:*** In the design of the Network, care coordination and facilitation of the Child and Family Team will be provided by a Family Support Provider (FSP). This model of service provision has been proven successful in other system of care initiatives in Tennessee and is effective in replication. FSPs will be parents, caregivers, or guardians of children with emotional and behavioral problems who live in the communities targeted by the initiative and who have successfully navigated the early child serving systems to meet the needs of their children. The FSP will be the one of the first initiative staff to interact with potential enrollees; it will be the FSP in partnership with the Early Childhood Treatment Specialist (ECTS) who conducts the intake for the Network and explains the initiative, gathers information on eligibility, and parent responsibility in the wraparound process. The FSPs will not conduct clinical assessments of any kind, and they will be supervised by a Master's level person. They will provide support, advocacy, information, case coordination, and connection to resources within the community, with the FSPs focusing mainly on the parents/caregivers. They will also facilitate the Child and Family Team meetings, modeling for parents/caregivers how to lead the Team in service plan development that meets the family's unique needs and incorporates the strengths of all team members. FSPs will also provide support and assistance in system navigation for the child's transition to elementary school from Pre-K services. While initially working from the TVC office, the initiative will embed FSPs according to an established schedule in local pediatric and childcare settings over the course of the grant, enhancing the capacity for coordinated service delivery in the targeted communities. ***Early Childhood Treatment Specialists****:* Building on the strengths of the parent-professional design utilized in system of care initiatives in the state, the FSPs will be paired with an Early Childhood Treatment Specialist (ECTS) to work with families enrolled in the program. The ECTS will possess a Master's degree (or Bachelor's degree with at least three years field experience) in psychology, social work, counseling, or related field, as well as demonstrate the ability to provide support that is individualized and in partnership with parents and caregivers. The ECTSs will be cross trained in the requirements and procedures in accessing services in the child mental health, early intervention, and Pre-K systems. The role of the ECTS will be as an active member of the Child and Family Team, to provide clinical intervention and therapeutic skill building for both the caregiver and child as appropriate and act as the liaison between the family and the mental health system and/or childcare setting. The ECTS will also assist with the

strengths-based assessment and connection with clinical assessments if necessary, as well as assist in the child's transition from the Pre-K setting to elementary school. While initially working from the Centerstone office, the initiative will embed ECTSs according to an established schedule in local pediatric and childcare settings over the course of the grant, enhancing the capacity for coordinated service delivery in the targeted communities. ***Social Emotional Training Specialist (SETS)**:* This will provide small group training services for promoting the social-emotional development and school readiness of young children birth to age 5 to administrators, teachers, support staff and family members associated with selected child care, Head Start, pre-K and other early childhood education programs throughout the five-county target area. The SETS will also provide coaching/technical assistance services focused on program-wide adoption of Pyramid Model best practices by selected programs and the building of policies and other infrastructure necessary to sustain and expand these efforts. The SET Specialist is the parent of a child with serious mental illness who has a Bachelor's Degree in Special Education and over 12 years of teaching experience in early childhood programs; she has also coordinated the Early Childhood Consulting Program at TVC for the past 7 years. She will provide caregivers with infant/toddler, preschool, and parent training modules addressing topics including creating supportive environments, social emotional teaching strategies, and individualized, intensive interventions. Early childhood providers and referring agencies will be offered the same training modules but in a direct service or train the trainer format to increase their capacity to address the needs of this population, as well as training on effective strategies for engaging and collaborating with caregivers for better child outcomes. ***Family and Youth Engagement Specialist**:* The Network will employ a Family and Youth Engagement (FYE) Specialist to develop a Youth in Action Council for older siblings of children enrolled in the Network as well as encourage family members to become more actively involved on the Steering Panel and its committees. Additionally, the FYE Specialist will work with social marketing on community and family outreach for the Network.

- *Child and Family Team Meetings and Individual Service Planning:* The Child and Family Team is the main tool for service planning. The first Child and Family Team meeting will be held within 30 days of enrollment and subsequent meetings will occur as needed by the family but at least every 90 days during the intervention. Initiative staff will receive intensive training in Year One on implementation of this approach and how to facilitate an effective Child and Family Team meeting. Upon enrollment, the dyad of FSP and ECTS will assist the family in identifying their strengths and needs, as well as potential members for their Team. During this process, information will be gathered regarding existing plans with other service providers, including behavioral plans from childcare settings and Individual Education Plans (IEP) from the Pre-K system; efforts will be made to incorporate the goals of these plans into the Child and Family Team process.
- Once the family has developed an agenda of needs to be addressed, the Child and Family Team meets to problem-solve around barriers experienced by the child and family. During the meeting, the Team assists the family in identifying short and long term goals, strengths of the family that can be used to meet those goals, and specific action steps to achieve the goals. The goals will be measurable and time-limited, and Team members will be responsible for tasks that fit their role on the Team. Safety plans will also be developed during this process for all children or family members at risk of self-harm, suicide, aggressive behaviors, or behaviors that put children's safety at risk. All domains will be addressed in each plan, including but not limited to substance abuse prevention and treatment, social-emotional learning strategies across settings,

chronic health disorders in children with co-occurring emotional and behavioral health diagnoses, and interventions targeting parenting of children with serious emotional disturbance. If the family chooses to access planned respite offered through the Network, strategies for efficient use of respite will be addressed. Also, if the child is 4 or 5 years of age, the Team will address ways to successfully transition him/her into the elementary education system with necessary supports. The result is a single individualized service plan (ISP) that addresses the unique needs of the child and family, incorporating both the formal and informal supports required to meet those needs, utilization of existing funding streams for mental health and early childhood services, and responsible use of flexible funding for nontraditional services as necessary. The FSP will be responsible for monitoring completion of the plan and coordination of services.

- The FSP, as the initial facilitator of the team meetings, will model for the caregiver and Team members how to develop and utilize this approach with the goal of the parent eventually facilitating his/her own team. The caregiver and child are at the center of the Child and Family Team process, and team meetings will not be held without the family's presence. Additionally, initiative staff will ensure that the caregiver is in agreement with the plan; if there is disagreement with any part of the plan, it will be amended to address the stated concern. Supervisors will review and approve all ISPs prior to entry in the database to ensure accuracy in format and content, as well as appropriateness of services and approval of flexible funding. The Initiative Director must sign off on the use of all flexible funding for fiscal and quality assurance purposes. In Year 1 of the initiative, procedures will be developed for appeals and grievances; these procedures will be provided and explained to families at the time of enrollment and again if they express concerns about the Network and its services at any time during their enrollment. A plan for quarterly case review by the Care Review Team will also be established in Year One. Additionally, as barriers or gaps in service are identified at the individual level, they will be brought to the attention of the Steering Committee in order to facilitate discussion and action to overcome the issue. These barriers/gaps will be an area of focus for the grant initiative to develop needed resources and build community capacity for these services.
- ***Training and Supervision of Initiative Staff:*** Building on the strength of their life experiences and knowledge of community culture and resources, the FSPs, ECTSs, and FYE Specialist will receive ongoing training focused on the elements of delivering child-centered, family-driven, youth-guided and culturally competent services. Although the training agenda for FSPs, ECTSs and FYE Specialist will differ slightly based on their roles in the initiative, training topics will include, but are not limited to system of care philosophy, provision of wraparound services, social-emotional learning and strategies, professionalism and boundaries, basic mental health diagnoses and psychotropic medications, cultural competency, early childhood support systems and special education (rights, process, and procedures), how to develop the Child and Family Team, service planning, navigation of child-serving systems, and effective advocacy strategies. The Social Emotional Training Specialist will provide components of the staff training, as well as staff from the Boling Center for Excellence will provide training on Parent Child Interaction, attachment issues and trauma informed care. The Technical Assistance Coordinator will be responsible for identifying other training needs based on initiative staff feedback and the needs of the families being served.
- The Initiative Director will be responsible for all Early Connections Network activities. Weekly meetings among the Initiative Director, the FSP Supervisor and the Clinical

Supervisor will be held to facilitate effective administration. However, the FSP Supervisor will also have a direct supervisor who holds a Master's degree in a social service field and has at least three years' supervisory experience. The ECTSs will have a direct supervisor with clinical expertise and supervisory experience, and, if he/she is not a licensed clinician, will receive consultation/guidance from a licensed clinician employed by Centerstone. The FYE Specialist and SET Specialist will both be supervised by members of the TVC Management Team who hold Master's and Doctorate degrees respectively. Any programmatic issues not resolved at the direct management level will be referred to the Principal Investigator, the TVC Assistant Director for Programs, and the Centerstone Senior Vice President of Child, Adolescent and Family Services.

- A broad array of service and support providers, both public and private, have partnered in a variety of early childhood initiatives and through memoranda of understanding for the implementation of the Early Connections Network to build a comprehensive, coordinated system of service delivery in the Mid Cumberland region. Historically, these providers have operated in silos, maintaining individual funding to provide specific services. The goal of this initiative is to begin to break down those silos and demonstrate how an integrated service system without service and funding silos would lead to improved outcomes for the infants, young children and families of Cheatham, Dickson, Montgomery, Robertson and Sumner Counties. In doing so, the initiative will be able to address the gaps identified through a community assessment, bringing together service providers, health providers, members of the faith-based community, and schools to enhance the mental health system. The initiative will begin to institutionalize partnerships and policies that incorporate family voice and choice in the treatment decisions for infants and young children.

Family Driven Care Family partnerships are critical to the success of the Early Connections Network Network. As one of the key community partners for the initiative and the family organization for the state of Tennessee, TVC has a unique understanding and passion for implementing family driven care in all service systems. Parents, youth, and families will be involved at every level of planning and implementation of the initiative. TVC is the CMHS grantee for the Statewide Family Network in Tennessee, and has implemented a system of support, advocacy and parent empowerment in all 95 counties of the state for nearly ten years. Staff from the SFN will be involved in training the initiative staff on what it means to provide family-driven care, and the established infrastructure of the SFN will be utilized to identify parents and families that would be interested in assisting with the development, implementation, and evaluation of the initiative. The model will embrace the philosophy of family driven care according to the National Federation of Families (outlined below).

Principles of Family Driven Care
1) Families are given accurate, understandable, and complete information necessary to set goals and to make choices for improved planning for individual children and their families. 2) Families and youth, providers and administrators embrace the concept of sharing decision-making and responsibility for outcomes with providers. 3) Families and youth are organized to collectively use their knowledge and skills as a force for system transformation. 4) Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.

5) Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports.
6) Providers take the initiative to change practice from provider-driven to family-driven.
7) Administrators allocate staff, training, support and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families.
8) Community attitude change efforts focus on removing barriers and discrimination created by stigma.
9) Communities embrace, value, and celebrate the diverse cultures of their children, youth, and families.
10) Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes.

By hiring local caregivers of children with emotional, behavioral or mental health problems as the lead care coordinators for the Child and Family Teams, the Network is ensuring that there is family voice and choice at the individual service level. The Technical Assistance Coordinator and Cultural and Linguistic Competence Coordinator will also be hired from the targeted community to ensure that they are entrenched in the strengths, needs, and culture of the families in those communities.

The initiative will develop a Steering Committee for governance purposes from the strong collaborations and relationships existing among the grant partners and in the targeted region; the Steering Committee will also incorporate youth and parents from the county to ensure diverse family representation is involved in the governance structure of the initiative. Parents and caregivers on the Steering Committee will be equal partners in this process with agency and system representatives, and their participation will ensure that the initiative is truly family driven.

- *Youth Guided Care:* Youth involvement is an important component in a system of care to ensure that youth have a voice in service provision and policies that directly affect them. Because the Early Connections Network will serve infants and young children, youth guided care will take on a different perspective than in other Tennessee System of Care sites that traditionally serve older youth. The network will hire a Family and Youth Engagement (FYE) Specialist who will focus on ensuring a family and youth voice is present in all levels of program implementation and policy development. The FYE Specialist will develop a Youth in Action Council for older siblings of children enrolled in the Network as well as encourage family members to become more actively involved on the Steering Panel and its committees. He/She will also reach out to older youth not associated with the Network and empower these youth to create community awareness surrounding mental health issues and the importance of building a strong foundation for mental health early in life. The FYE Specialist will provide community outreach, focusing on the importance of adopting family-driven care as THE way to serve children and families.

Cultural and Linguistic Competence: Culturally and linguistically competent services recognize and inform practice that values diversity across all facets of service delivery from service development, implementation, and evaluation to location of service provision and diversity of staff delivering services. The Early Connections Network will adhere to the National CLAS Standards for Culturally and Linguistically Appropriate Services in Health Care. Emerging knowledge from literature will help staff focus on the unique cultural needs of very young children and their families which include learning to work cross culturally with outreach, engagement, prevention, and early intervention.. These tenets equally apply to our military families that are racially, ethnically and culturally diverse, and also highly influenced by the culture of military life. Interpreters will be used as appropriate and a s much as possible, they

will be selected from the pool of interpreters who have some knowledge and experience working in school settings or mental health environments.

All initiative materials will be developed to be culturally and linguistically competent and will be reviewed by members from the particular cultural group for appropriateness. Additionally, literacy supports will be provided as necessary, and program materials (including intake materials) will be written at a 5th grade reading level and translated into other languages as needed. Flexible funding will be available to families without regard to socioeconomic status.

All initiative staff and community stakeholders will receive cultural competency training using local, state, and federal resources to develop and provide the training. We acknowledge that culture is one of the most powerful factors that shape the values, beliefs, attitudes and behaviors that families and associated environmental settings use to shape the thoughts, feelings, beliefs and behaviors of their children. Therefore, trainings will be designed to explore cultural beliefs of all groups including racially and ethically diverse peoples, religious, language, socioeconomic status, physical disability, and youth and siblings of young children who are lesbian, gay, bisexual, transgender, questioning, intersex, or two-spirit (LGBTQI2-S). This is an important issue as all treatment plans should reflect the racial, cultural, ethnic and other diversity of the young children and their families.

TDMHDD will hire the Cultural and Linguistic Competence Coordinator who will be a parent or family member hired from the targeted area and who is very familiar with the diverse populations of the communities. The Network will also hire other staff directly from the communities served; staffing will reflect the diversity of the Mid-Cumberland region and will include African American and Hispanic staff and comply with Title VI of the Civil Rights Act of 1964. Also, to ensure an understanding of the culture of the Mid-Cumberland region, cultural competence training about regional history, beliefs, values and practices and the influence of the military will be provided. Each individualized service plan will recognize and include in the planning the cultural and linguistic preferences of families and caregivers of the very young children served in the initiative. The Steering Committee will be comprised of racial, ethnic, and culturally diverse individuals reflective of the counties served, and likewise for all the subcommittees. They will serve the critical function of helping to guide development and monitoring of all aspects of the initiative, including policies and procedures and evaluation of service implementation. Through focus groups in Year One, family members and caregivers representing all racial, cultural and ethnic groups as well as other diverse groups of stakeholders will be recruited to ascertain their ideas about preferred services, gaps in services, and to identify those elements that parents/caregivers view as incentives and disincentives to seeking mental health services for their very young children.

B.3: Sustainability/linkages with Statewide Transformation Efforts and Other Relevant federally-funded programs

Alignment of primary initiative goals and objectives with state transformation:

The mission of the Early Connections Network is to develop a service infrastructure that will give caregivers, providers and others the essential knowledge, skills, resources and support they need to respond effectively to the social, emotional, cognitive, and behavioral needs of young children and their families. The Network seeks to achieve the following **goals** and **objectives:**

Attachment I

EARLY CONNECTIONS NETWORK GRANT NARRATIVE

Goals	Objectives
(1) Establish a comprehensive, sustainable System of Care with a reliable infrastructure for young children ages 0-5 and their families	Obj. A: Develop & expand partner collaboration over grant period to provide wraparound services and steering committee to include representatives across all five counties. Obj. B: Develop the Steering Committee, Grant Mgmt Team, & care Review Team Obj. C: Provide child-centered, family driven, youth-guided, culturally competent wraparound services to 400 children and their families over the grant period. Obj. D: Increased participation of family members in planning, implementing, sustaining, & evaluating the model Obj. E: Develop highly trained, culturally sensitive staff Obj. F: Increase capacity in region and other areas by providing training for partners and community agencies on social-emotional learning, strategies, Parent Child Interaction, attachment and trauma informed care. Obj. G: Implement & refine shared electronic information system accessible to Network members Obj. H: Develop strategic plan to identify & access adequate funding streams & community resources to ensure sustainability.
(2) Increase community awareness of social emotional health and early child mental health needs and reduce stigma	Obj. A: Develop and initiate social marking campaign through media coverage, public service announcements, print media, community activities & focus groups. Obj. B: Educate early childcare facilities, DHS/DCS workers, community agencies and others who have frequent contact with target population about social-emotional health and SOC values and principles. Obj. C: Educate family members within target communities about social-emotional health and OSC values and principles.
(3) Improve outcomes for young children 0-5 who have significant behavioral or relational symptoms related to trauma, parent/child interaction difficulties or impaired social emotional development	Obj. A: Reduce behavioral and emotional problems as measured by the CAFAS and CBCL. Obj. B: Increase family functioning Obj. C: Maintain 80% of enrolled children in their home setting Obj. D: Maintain 80% of enrolled children in their childcare/daycare placement Obj. E: Increase readiness for transition to kindergarten classroom for 4-5 year old children Obj. F: Decrease family stress by 80% Obj. E: Improve overall health status through increase complete EPSDT&T assessments by 50%
(4) Provide statewide training and local coaching for providers, families, and community members regarding evidence-based practices for effectively treating early childhood mental health and social emotional needs	Obj. A: Increased number of regional child care, Head Start, pre-K and other early education programs using Pyramid Model practices Obj. B: Develop and disseminate manual and related materials for replication of the ECN social-emotional development and school readiness model on a regional level
(5) Develop an early childhood System of Care model for replication in other areas of the state.	Obj. A: Conduct comprehensive evaluation including documentation of fidelity, process and outcomes Obj. B: Produce/distribute manuals, publications & presentations for replication of model, especially navigation for the early childhood years for parents.

- ***A draft Logic Model reflecting the mission, goals and objectives is in Attachment 6.***

An important step in state transformation to sustain this family-centered care delivery approach in complete alignment with the Early Connections Network is now underway. Based

on the success of previous SOC initiatives in the state, TDMHDD has finalized a certification for "Family Support Specialists," the family member/paraprofessional that is paired with a clinician to support the Child and Family Teams. This will pave the way for eventual reimbursement through the state's managed-care Medicaid reimbursement program, providing for the first time a reimbursable service as the foundation for family-driven care coordination of mental health and other services for children and youth with emotional, behavioral, and mental health needs and their families. Peer Support Specialist certification is already in place in our state, allowing for consumer-to-consumer support as a reimbursable service.

- The newly legislated statewide Council for Children's Mental Health with representatives from all the state departments, child- and youth-serving agencies, and advocacy agencies, as well as parents and youth from each grand region of the state is focusing on creating state-lead infrastructure systems of care for children statewide that is child-centered, family-focused, and culturally competent.
- *Strategies for Sustainability after Year 6:* Primary strategies for sustainability will be the Council on Children's Mental Health which is the statewide initiative that is facilitating the development of legislated statewide systems of care. Additional strategies for sustainability will be leveraging the ability to use Medicaid funding for family and youth support through the certification at the state level of Family Support Specialists. All FSPs in the initiative will go through the training and documentation required to be certified as Family Support Specialists. This will allow their services to be reimbursable through TennCare (TN's Medicaid program) even before the end of the grant period. The ECTSs will already be eligible for reimbursement under currently covered case management and therapeutic services; 2) Also, developing innovative models of practice like co-location of family support providers and ECTS's in pediatricians offices which will create innovative funding streams.
- *Coordination with other relevant federally funded initiatives:* Ensuring effective collaboration among and between the many publically funded services to young children with mental health needs and their families is vitally important to the key stakeholders of the ECN. The Early Connections Network leadership will maintain active participation in these workgroups as the initiative progresses to support sustainability and replication the Network. Initiative leaders will play an active role in the state's council on Children's Mental Health as well. All efforts to coordinate with other relevant federally funded programs for children will be taken such as Mental Health Block Grant Program, Tennessee Early Childhood Intervention Systems, and other key initiatives.

SECTION C: INITIATIVE MANAGEMENT AND STAFFING PLAN

C.1: Capability/Experience of Applicants

The collaborating entities have had previous experience with the implementation of a local, county-wide system of care. TDMHDD, Centerstone, & TVC have collaborated in several other system of care initiatives.

Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) (applicant): The TDMHDD is the state's public mental health authority responsible for system planning, setting policy and quality standards, system monitoring and evaluation, disseminating public information and advocating for persons of all ages who have mental illness, serious emotional disturbance or developmental disability. The Early Connections Network grant will be administered through the Department's Division of Special Populations which includes the

Office of Children and Youth. A primary responsibility of the Office of Children and Youth is a focus on early intervention and prevention services that require developing, expanding and monitoring a comprehensive array of services, advocacy for children, youth and their families, the prevention of youth suicide and the implementation of System of Care initiatives statewide.

- *Tennessee Voices for Children (subcontractor)*: Tennessee Voices for Children (TVC) is a not for profit agency founded by Tipper Gore in 1986. TVC is the state chapter of the National Federation of Families and acts as a statewide coalition of individuals, agencies and organizations working to improve the quality of life of children with SED and their families. The agency's experience in providing family support groups, advocacy, training, and a Respite Care Network is outstanding. TVC was previously funded by the state of TN under a similar cooperative agreement with SAMHSA/CMHS, and is currently contracted for a second, third and fourth SAMHSA/CMHS-funded system of care in rural Middle Tennessee, urban West Tennessee and urban East Tennessee. Dr. Matt Timm, Director of Early Childhood Programs, is an active participant in multiple collaboratives at the local, state, and federal level that involve services and infrastructure for prevention, early intervention, and social-emotional learning in early childhood. TVC is licensed by TDMHDD as an outpatient facility.

Centerstone of Tennessee (subcontractor): is a not-for-profit, community-based, behavioral health organization providing a full spectrum of services for individuals of all ages and their families who have mental health, substance abuse, and co-occurring disorders. Centerstone operates more than 68 facilities in 21 counties, including all target counties, reaching 39,900 individuals (30% of whom are children/youth) across Middle Tennessee annually. Centerstone maintains strong ties with diverse child-serving organizations that are deeply rooted in the culture of the target population and that are experienced in providing an array of child/family services.

The Centerstone Research Institute (CRI) (subcontractor): is a private, not-for-profit company dedicated to improving health care delivery through the marriage of research/program evaluation and information technology. Based in Tennessee and Indiana, Centerstone Research Institute (CRI) works with the community mental health centers of Centerstone and other community partners (e.g., TDMHDD, TVC, etc.) to conduct clinically relevant research studies/ program evaluations in order to provide high quality services to over 70,000 individuals with mental illness. CRI evaluators/ researchers and affiliated community mental health centers have conducted hundreds of service/treatment evaluations and clinical studies.

C.2: Qualifications and Experience of Key Personnel

All current staff and those to be hired are/will be fully qualified and have extensive experience in the mental health field, building collaborative relationships, and implementing system of care principles; front-line staff will be hired directly from the communities targeted for service to ensure an understanding of local culture and strengths. Full job descriptions and resumes are found in *Section G* and a Staffing Plan can be found in *Attachment 6*.

TDMHDD Key Early Connections Network Staff Positions

Early Connections Network grant activities will be led by staff at the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) including the following key positions: ***Principal Investigator (20% FTE): Freida Outlaw, PhD, RN, FAAN***. As the Assistant Commissioner of Special Populations for TDMHDD, she oversees the Office of Children & Youth Services, older adult services, and other underserved populations across the

state. She is the current Principal Investigator for Tennessee's other three federally-funded system of care sites, and has over 30 years' experience in providing clinical services, managing outpatient service delivery, providing culturally competent integrated primary and behavioral health services and evaluating psychiatric services as a clinician, academic, and policymaker. Given her experience and position within state government, Dr. Outlaw will also serve as the ***State-Local Liaison***. ***Project Director (100% FTE):*** A Project Director will be hired to direct all phases of planning, development and implementation of the Early Connections Network. He/she will be required to have a Master's Degree in the social sciences or a related field, have at least three years supervisory/administration experience, and be familiar with and engaged in the child-serving systems in the Mid-Cumberland region as well as be passionately invested in working with young children 0-5. The Initiative Director will be directly supervised by the Principal Investigator. The ***Technical Assistance Coordinator (50% FTE)*** will be responsible for identifying and coordinating the training needs of Network staff and initiative stakeholders, develop and implement the Single Coordinated Technical Assistance Plan, liaison with the Technical Assistance Partnership, and provide staff support for the Workforce Development subcommittee. He/she will hold at minimum a Bachelor's degree, preferably a Master's degree, and be directly supervised by the Initiative Director with oversight and collaboration from the Principal Investigator. The ***Cultural and Linguistic Competence Coordinator (50% FTE)*** will preferably be a parent or family member hired directly from the targeted community who is very familiar with the diverse populations of the community and has experience in strategic planning and a capacity to be trained in the area of cultural and linguistic competence, an extensive understanding of the issues surrounding young children and their families in the targeted, and belief in family-driven, youth-guided and culturally and linguistically competent care. He/she will hold at minimum a Bachelor's degree, preferably a Master's degree, and be directly supervised by the Initiative Director with oversight and collaboration from the Principal Investigator. The ***Social Marketing Manager (100% FTE)*** will be responsible for development and implementation of the social marketing plan and will work closely with the Initiative Director, Steering Committee and the Evaluation staff to establish the marketing needs of the initiative and the most effective means of communication of ECN's vision and goals to stakeholders, families, and policymakers. He/she will hold at least a Bachelor's degree, have connections to the communities being served, experience in marketing and development, and be a creative thinker.

Key Family and Youth Services Staff

The ***Family Support Provider Supervisor (100% FTE YRS 1-6)*** will also be the Lead Family Contact for the initiative and responsible for direct supervision of the family component of the Early Connections Network. This position requires a Master's Degree in the social sciences or a related field, at least three years' supervisory experience, and preference will be given to candidates that are parents or family members of children with emotional, behavioral or mental health problems. He/she will be an employee of TVC and supervised by the Assistant Director for Programs, participating in management of service provision. The ***Family Support Providers (500% FTE YRS 2- 6)*** will be hired directly from the communities served by the Network to ensure an understanding of the culture, strengths, and needs of enrolled families. The FSPs will be parents/caregivers of children with emotional, behavioral or mental health problems with at least a high school diploma or GED and experience successfully navigating the child-serving systems. They will receive extensive training to act as case coordinators, Child and Family Team

facilitators, and advocates for families, as well as complete the certification process for Family Support Specialists with the state. The ***Social Emotional Training Specialist*** *(100% FTE)* will be Mamie McKenzie, who will provide day to day operations oversight of the program. This will allow the clinical supervisor to focus 100% of their time on supporting the MHCs and clinical aspects of the program. The ***Family and Youth Engagement Specialist*** *(50% FTE)* will be a caregiver or family member of a child with a SED with experience in community outreach, family engagement, and group leadership. His/her primary responsibilities will include developing parent support groups in the targeted counties, participating in training for providers on effective strategies for engaging families, assisting in community outreach to parents of young children, and working with social marketing to design an approach that is family driven. ***TVC Oversight: Millie Sweeney, TVC's Assistant Director for Programs (10% FTE)***, has worked with children and families with mental health needs for over 14 years and experience in system of care implementation and management; she currently oversees all of TVC's efforts to promote system of care principles in Tennessee and will directly supervise the Family Support Provider Supervisor and the Family and Youth Engagement Specialist. ***Dr. Matt Timm, Director of Early Childhood (10% FTE)***, has extensive experience as a provider, educator and evaluator in the early childhood arena and is an active member of several early childhood initiatives at the local, state, and federal levels. He will oversee the training component of the Network and directly supervise the Social Emotional Training Specialist. Both Dr. Timm and Mrs. Sweeney will be supported by TVC Executive Director Charlotte Bryson, Executive Director of TVC, who has over 30 years of experience in both the clinical and administrative aspects of service delivery for families of children with mental health needs, including administration of both previously funded systems of care sites.

Key Clinical Services Staff

The ***Early Childhood Treatment Specialist Clinical Supervisor (100% FTE)*** will be a Master's level clinician with at least 5 years experience in the field of mental health. He/she will be responsible for oversight and supervision of all clinical activities related to planning, coordination, and implementation of the system of care initiative and the Early Childhood Treatment Specialists. The ECTS Clinical Supervisor will also supervise Network activities associated with training, family and children involvement, marketing, and other duties related to the initiative. The FSPs will work in partnership with five ***Early Childhood Treatment Specialists (500% FTE YRS 1- 6)***, who will provide clinical interventions, assessments, development of treatment plans, and skill based education for young children and their families to help parents become more effective caregivers, increase positive responses from their child, and reduce problematic behaviors. The ECTSs must have a Master's Degree in the social sciences and will be hired by Centerstone to provide the mental health/clinical component of the Early Connections Network. ***Centerstone Oversight: John N. Page, MSSW, ACSW Senior Vice President for Child, Adolescent, and Family Services, (5% FTE)*** has over 30 years of experience in the field of mental health services for children, youth and families including ten years with Centerstone, and oversees an $18 million dollar budget of specialized programs for over 10,000 children and families. Mr. Page has participated in two previous SAMHSA–funded systems of care (Nashville Connection and Mule Town Family Network). ***Service Supervisors*** at Centerstone who work as a team with the initiative include: ***Michelle Covington, MA, Director of Community Based Services for Centerstone (5% FTE)***, 13 years of experience in mental health services for children and families, oversees children's case management in Maury County;

Beth Hail, LCSW, Director of School-Based Services for Centerstone (5% FTE), a Licensed Clinical Social Worker with over 17 years of experience in mental health including school-based programs, oversees 8 counties; ***Andrea Sonnabend, LCSW, Coordinator of School-Based Services for Centerstone (10% FTE)***, with 10 years experience; ***E. Ann Ingram, M.Ed., Initiative Director for Mule Town Family Network (5% FTE),*** has over 30 years experience with Centerstone as Program Manager for Early Childhood Services, , with emphasis in early childhood education and behavior disorders, and overseeing Centerstone's Regional Intervention Programs (RIP) in three Tennessee counties. She has worked with children and families as a teacher in the school system followed by work in the area of developmental disabilities; and ***Amy Michelle Allison, LCSW, Centerstone Program Coordinator for Regional Intervention Program, (5% FTE)***.

Key Evaluation Staff

Evaluation staff (including required 1.0 PhD level FTE) consists of a team from the Centerstone Research Institute (CRI), whose members have extensive credentials and professional experience with longitudinal research, evaluation, measurement, and research methodology in areas that include children's mental health and related fields such as psychology, social work, juvenile justice, education, and primary care. Providing oversight and consultation, the ***CRI Chief Operating Officer (15% FTE), Tom Doub*, *Ph.D.*** has significant clinical research experience at Vanderbilt University, the Tennessee Department of Mental Health and Developmental Disabilities, the Department of Veterans Affairs Medical Center, and local mental health centers, psychiatric clinics and hospitals. He is published and recognized in the field of mental health and substance abuse. He received his Ph.D. from Vanderbilt University, where he received specialized training in evaluating community-based longitudinal outcomes using advanced research and statistical methods. The ***CRI Director of Evaluation (25% FTE), Kathryn Bowen*, *Ph.D.*,** has 15 years experience evaluating community-based programs and currently serves as Lead Evaluator and Co-Evaluator on two active SAMHSA CMHI SOC initiatives. She has evaluated a wide array of human service programs in mental health, substance abuse treatment, youth development, services integration, and child welfare, among others. She will assist in designing and implementing the evaluation component, collecting and analyzing data, and writing reports and giving presentations on initiative findings. ***Co-Evaluator (30% FTE), Cheri Hoffman*, *Ph.D.*,** will assist the Lead Evaluator with diverse aspects of initiative evaluation, provide consultation as needed, and support evaluation activities, including related analyses and publications. Dr. Hoffman has 4 years of evaluation experience and expertise in SOC evaluation methodologies particularly those that include participatory and empowerment approaches. She currently serves as Lead Evaluator on a SAMHSA Child Mental Health Initiative, and has expert knowledge about working with SED children in rural areas. ***Research Consultant (10% FTE,) Richard Epstein, Ph.D.,*** is a clinical psychologist and health services researcher with expertise in measurement and analysis of the Child and Adolescent Needs and Strengths instrument. He will provide consultation on issues related to analytic design, measurement and analysis. CRI will hire a PhD-level **Lead Evaluator** ***(70% FTE)*** from the Mid-Cumberland area to implement the planned participatory evaluation and supervise the Research Associate. Other evaluation positions to be hired include: ***Research Associate(s)(150% FTE)*** (*BS/BA with 2 years research experience preferred; family member*) who will assist the Lead Evaluator in implementing the evaluation system, analyzing and reporting data and evaluation results, delivering written reports and presentations for conferences, publications, etc., setting up and maintaining

hardware/software, collecting data, summarizing research activities and findings, and assisting in upgrading and modifying evaluation methods; and ***Data Manager (20% FTE Year 2-6)*** (*Master's degree preferred with 2-3 years of data management experience)* whose responsibilities will include maintaining clear and accurate records, entering initiative data promptly, assisting in the preparation of reports, and assisting with other tasks as needed.

C.3: Resources Available for the Initiative

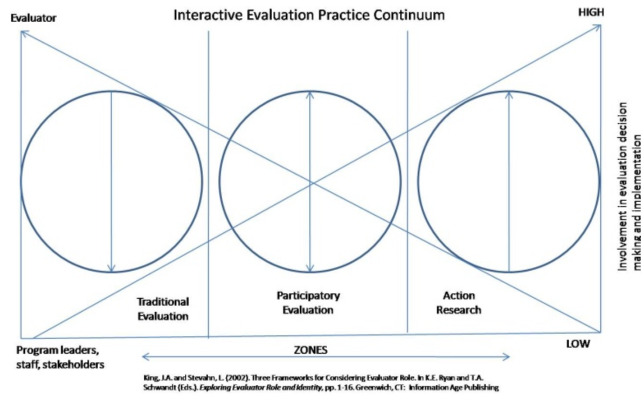
Facilities used for the initiative meet the requirements for accessibility, compliance with ADA, and culturally appropriate service locations. Staff employed by TDMHDD will be housed in the state office building in downtown Nashville. Staff of Centerstone will be housed at Centerstone's Mental Health Counseling Center in Clarksville and Centerstone's Regional Intervention Program (RIP), Early Childhood Treatment Center at 812 Greenwood Avenue in Clarksville. The facilities are conveniently located, provide appropriate accommodations for the disabled population, and are culturally appropriate. Office space for each staff member will accommodate desk, chair, bookcase, file cabinet, computer, telephone and/or cell phone, and access to printer, copier, and fax. In addition, services will be provided onsite at pediatric offices/clinics throughout the target area. The resources of CRI, including a Data Analytics unit with a data manager and senior statistical analyst, all are available to the evaluation team.

TVC's main office in Nashville, TN is situated on a landscaped corner lot. This 10,000 sq ft., fully ADA compliant interior contains an attractive reception area; single and shared office spaces; a 700 sq ft., 40 person capacity meeting/conference/training room with installed state of the art A/V equipment and wifi access; an executive conference room with maximum capacity of 8 persons; a dedicated 500 sq ft. resource library with shelved publications, computer station and large reading table; a dedicated Family Room; a dedicated 400 sq ft. administrative staff work room; well-equipped kitchen and break room; and two large restrooms..

SECTION D: EVALUATION

D.1 Procedures to Ensure Successful Implementation of National Evaluation

The Centerstone Research Institute (CRI) Division of Program Evaluation, directed by Dr. Kathryn Bowen, will lead the evaluation with guidance from TDMHDD's Principal Investigator, Dr. Freida Outlaw. Dr. Bowen has 15 years of experience using mixed methods in the evaluation of prevention, youth development and community-based treatment programs, extensive experience leading SAMHSA initiatives with national evaluation components, including a Phase V system of care grant, and additional expertise in the evaluation of interagency collaboration and services initiatives. Dr. Cheri Hoffman, Co-Evaluator, has four years evaluation experience including national evaluations involving children and youth on a Phase V system of care grant, and expertise in partnering with youth and families in participatory research and evaluation initiatives. CRI will hire a Ph.D. level Lead Evaluator to implement the planned participatory evaluation and supervise the Research Associates. The resources of CRI include a Data Analytics unit with a data manager and senior statistical analyst. TDMHDD and CRI will comply fully with all National Evaluation requirements as described in the RFA and participate in any additional cross site evaluation activities. Dr. Richard Epstein, Assistant Professor of Child and Adolescent Psychiatry at Vanderbilt University, is a clinical psychologist and health services researcher with specific expertise in measurement and analysis of the Child and Adolescent Needs and Strengths (CANS) assessment. Dr. Epstein will consult with CRI on issues related to



analytic design, measurement and analysis. Dr. Bowen's team will use a participatory, empowerment and democratic approach to evaluation where family members function as co-evaluators to set the agenda, ascertain quality, and interpret results. Participatory evaluation principles, shown in the model of the Interactive Evaluation Practice Continuum, place evaluators and stakeholders in equal partnership around evaluation decision making and implementation. Participatory evaluation also increases the validity of the information gleaned from the evaluation data and empowers families as partners in the system of care. This strategy will make evaluation findings more meaningful and empowering to families, more useful for decision makers and ultimately help strengthen and sustain the system of care. A Parent/Caregiver Co-Evaluation Team (PCET) will be established, composed of family members with experience navigating the mental health system as well as new families enrolled in the Early Connections Network (ECN). A family member will be hired as a Research Associate at .5 FTE to coordinate and oversee activities of the PCET, which will identify evaluation needs not served by the national evaluation and lead special initiatives that answer questions of interest to them, with support from the evaluation staff. Family member (e.g., biological parents, relative caregivers, foster parents, etc.) participation will be integral to the evaluation, facilitating the incorporation of family voice in the generation, interpretation, and dissemination of evaluation findings. Involvement in dissemination of findings is particularly important for sustainability efforts, as data complemented by families' stories have greater impact. All initiative stakeholders have committed to participation in the national and local evaluation as indicated in the Memorandum of Understanding provided in Appendix 1. See Section D.3 for a description of national and local evaluation measures. The local evaluation has been developed to complement National Evaluation objectives, incorporating its sampling methods, administration timelines, and core descriptive, process, and outcome measures. Drs. Bowen and Hoffman will ensure high quality data collection, entry, and secure storage using data management procedures. Participant data will be submitted according to established federal schedules. The evaluation team will participate on the Governance Board and report interim process and outcome evaluation findings to ensure that data are incorporated into initiative planning and implementation.

D.2 Use of National Data for Improving Services, Increasing Quality, Developing System of Care Policies, and Sustainability

The proposed evaluation design utilizes mixed quantitative and qualitative methods to collect data for the National Evaluation Core Studies (Descriptive, Child and Family Outcomes, Service Experience, Services and Costs etc.). An evaluation subcommittee of the initiative Steering Committee will facilitate effective use of National (and Local) evaluation data to inform initiative planning, implementation, modification, and dissemination of findings. The evaluation subcommittee will be comprised of at least 50% family members to further ensure participant involvement in evaluation. The major role of this subcommittee will be to assist with a

community needs assessment and program logic model in Year One, to oversee process and outcome evaluation activities, to interface with the PCET, and to review and interpret National (and Local) Evaluation data for presentation to the Steering Committee and other stakeholder groups that are potential sources of sustainability. A training in basic evaluation principles, the evaluation plans for the National (and Local) Evaluations and the logic model will be provided to the PCET and evaluation sub-committee members in order to improve self-efficacy of stakeholders and to facilitate ownership of the evaluation process, data collection, analysis and interpretation, thus contributing to the empowerment of families and frontline providers in the system of care. **Improvement:** The process evaluation improves the local service system through network analysis of unmet community needs, identification and strengthening of weak linkages among providers, process and outcome data to guide program development, and identifying what does and does not work within the local system of care. Focus groups during the process evaluation identify unmet needs in the community, barriers to participation, and cultural nuances that if addressed will improve attitudes toward seeking mental health services. National and local data will be used to examine service accessibility and unmet need among each racial, ethnic, and cultural group in the community. **Quality:** Early in the initiative, the evaluation will focus on training, model fidelity, cultural competence, and identification of service gaps and areas for improvement (i.e., appropriateness of referrals and service efficiency), with emphasis on using evaluation findings to inform initiative implementation. In collaboration with the Care Review Committee, the evaluation subcommittee will address family-driven content domains using record review, self-reports, stakeholder interviews, and focus groups. Process and outcome evaluation findings from the National Evaluation will be used to enhance service quality. Family measures of satisfaction and fidelity to system of care principles measured by the Wraparound Fidelity Index (WFI-4) will be used to determine areas of need. Quarterly National Evaluation CQI reports and Data Profile Reports will be used to identify program strengths and weaknesses, with findings reported to the Governance Board and its subcommittees, initiative staff, and families. **Policies:** This proposal implements a system of care that extends beyond a sample of families served and improves services across the entire network of providers and informal supports in counties supported by the initiative. As such, the MOU will evolve into a comprehensive set of policies and working agreements to streamline and improve services for youth and families. The evaluation subcommittee will work with the PCET, Governance Board, PI, initiative director, and other stakeholders to provide data guiding the development of policies to formalize the system of care. Furthermore, Dr. Bowen will collaborate with all stakeholders to provide training in evaluation of system collaboration and service integration as well as provide data guiding the development of policies to formalize the system of care state-wide. If evaluation findings suggest that existing policies are ineffective, such data will be used to develop better policies. **Sustainability:** Important to the long-term success of this proposal is the ability to influence system changes that are attractive to community stakeholders other than mental health professionals (e.g., policymakers, managed care, education, business, etc.) to secure the blended funding for a sustained system of care. While clinical outcomes are important, cost, efficiency, and service utilization are frequently of particular interest to these audiences and will therefore be a focus in the evaluation. This includes a description of service utilization, per-child costs and savings, a comparison of costs to traditional service models, and child/family prior and subsequent involvement in other systems (e.g., juvenile justice). It is not simply enough to collect and store data; effective dissemination is critical to attaining sustainability. Our initiative model includes in-kind funding for fundraising and development staff support at CRI, as well as

consultation from a PR firm. Evaluation findings will be reviewed by initiative stakeholders and carefully packaged to attain maximum impact.

D.3 Data Collection, Management, Analysis, and Reporting (compliance with Section I-2.5)

The evaluation will collect Transformation Accountability (TRAC) and any other National Outcome Measures (NOMs) as required by SAMHSA under the Government Performance and Results Act (GPRA). CRI has supervised collection of GPRA/NOMS data on 14 current and previous SAMHSA-funded evaluations, averaging greater than 90% follow-up across all initiatives. Drs. Bowen and Hoffman have extensive experience working on federal multi-site initiatives with national data components, protocols and web-based data entry procedures. Dr. Hoffman has experience with CMHI national evaluation and TRAC systems. National evaluation data will be collected at baseline, discharge and every six months for three years. Interview data will be submitted in accordance with all reporting requirements and deadlines. TRAC data will be collected at baseline, discharge, and at six-month intervals as required, and entered into the TRAC web-based system within one week. Data collection will begin in the Year 1 planning phase during which needs assessments will be conducted (including focus groups and stakeholder interviews of families, providers, and local decision makers), service system data will be collected, and Centerstone's comprehensive Management Information System will be tapped as a data source. Evaluation domains and data sources are listed below.

Key Evaluation Components, Domains and Data Sources		
Components	**Domains**	**Data Sources**
Baseline/Descriptive Information	Demographic data (age, sex, race/ethnicity)	Enrollment and Demographic Information Form (EDIF); CenterNet (MIS)
	Presenting problem, diagnostic information	EDIF; MIS
	Child and family characteristics, e.g., physical health, medication, family composition, custody status, caregiver employment, risk factors, family history	Caregiver Information Questionnaire; Child Information Update Form
	Traumatic event history	Traumatic Events Screening Inventory for Children (TESI-C)
	Service use history	Multi-Sector Service Contacts-R; MIS; chart review
Process Information	Service gaps/needs/existing resources	Year 1 needs assessments (key informant interviews, surveys, focus groups, mental health and other systems data); Community Supports for Wraparound Inventory (CSWI); chart review
	Services received (type and dosage), including psychiatric hospitalizations and other out-of-home placements	MIS; data from other child-serving systems
	Cultural and linguistic competence	Cultural Competence and Service Provision Questionnaire (CCSPQ); key informant interviews, focus groups; Cultural and Linguistic Competence Self-Assessment
	Satisfaction with services	Youth Services Survey for Families (YSS-F)
	Perceptions of care (e.g., adherence to system of care principles such as cultural competence, individualized care, family voice and choice, use of natural supports, etc.)	Transformation Accountability (TRAC), YSS-F, and CCSPQ surveys; informant interviews; focus groups; System of Care Assessment Report (SOCAR)
	Fidelity to Wraparound principles	Wraparound Fidelity Index - 4 (WFI-4)
	Interagency collaboration and systems integration	Key informant interviews, focus groups; CWSI
Key Outcomes	Non-mental health referrals	EDIF; MIS
	Family functioning	Family Life Questionnaire (FLQ)

	Behavioral and emotional problems	Child Behavior Checklist (CBCL 1 1/2-5); Child and Adolescent Functional Assessment Scale (CAFAS); Devereux Early Childhood Assessment (DECA 1-18M; DECA 18-36M, DECA 2-5Y); (Preschool Behavioral and Emotional Rating Scale (PreBERS); Eyberg Child Behavior Inventory (ECBI); Child and Adolescent Needs and Strengths (CANS)
	Maintain home placement	MIS
	Maintain childcare/daycare placement	MIS
	Readiness for mainstream kindergarten class attendance	Ages and Stages Questionnaire: Social Emotional (ASQ:SE); Brief Infant/Toddler Social Emotional Assessment (BITSEA); Social Skills Improvement System Rating Scales (SSIS); Pre-School Language Scale - 4 (PLS); Picture Naming (GPIC); Alliteration (GALL); Rhyming (GRHY)
	Family stress level	Parenting Stress Index (PSI); Caregiver Strain Questionnaire (CGSQ)
	Health status	CANS
	Child strengths	CANS
Costs/Benefits	Funding sources, expenditures	MIS; Agency records
	Service utilization costs	Archival databases; MIS

The Wraparound Fidelity Assessment System (WFAS) includes the Community Supports for Wraparound Inventory, which can be used for needs assessment, as well as the Wraparound Fidelity Index 4.0 (WFI-4), Documentation of Wraparound Process, and Team Observation Measure. The WFI-4 is an excellent fidelity assessment that captures perspectives of caregivers, youth, and Wraparound facilitators, addressing fidelity to the four phases of Wraparound (engagement, planning, implementation, and transition) as well as ten nationally accepted Wraparound principles. **Tracking and Follow-up:** Data quality depends upon effective staff recruitment, training, and supervision. The evaluation team understands the vital importance of family engagement in evaluation, rapport building, gathering extensive contact information, using tracking databases to plan and schedule interviews, reminders and thank you notes, and other strategies for recruiting and maintaining families in longitudinal evaluations. Individuals recruited for the Parent/Caregiver Co-Evaluator Team will have had children with social, emotional or behavioral problems and/or experience navigating the mental health service system. Dr. Hoffman will use a highly effective MS Access tracking database that organizes key participant information, prompts interviewers when tasks are required, and reports interviewer activities and success rates by week, month, and overall. Data collection personnel (family members are preferred) will reflect the target population in terms of ethnicity and background and be well connected to family, children, and local communities. Participants will receive a $20 monetary incentive for follow-up assessments. Families will be asked for input on appropriate types (e.g., cash, gift cards) and amounts. **Data Entry/Security:** Participant data will be collected on laptops via software provided through the National Evaluation. Research Associates will be trained to collect data on paper if families are uncomfortable with computerized data entry or if technical problems arise. Local evaluation data (e.g., fidelity) will be collected and verified using laptops with MS Access data entry forms to minimize waste, expense, and security issues inherent in paper-based data collection and storage. This also provides the opportunity for "real time" data cleaning and maximizes data availability for use in CQI. In previous research efforts, computerized data collection has provided a 99% or higher rate of completion and accuracy. ID numbers will be assigned according to National Evaluation requirements and identifying information will be encrypted. Any data collected on paper will be entered into the

national web-based system within one week, and records kept in a locked filing cabinet inside locked offices. All forms will be identified with ID numbers to ensure confidentiality. Databases will be converted to statistical formats for analysis. Variables will be coded based upon the specific data element, sample, and time point. Local data codebooks will be generated to enhance capacity to share data. CRI's computer network exceeds HIPAA compliance standards and is adequate to ensure confidentiality. **Analyses and Interpretation**: The proposed SOC model has program capacity to ensure sufficient sample size based on planned analyses and anticipated statistical power. The evaluation plans to enroll 20 families in the last quarter of Year 1, 60 families with children in Year 2 and 80 families with children in Years 3 through 6 for a total of 400 over the course of the initiative. A variety of statistical techniques will be used to assess client outcomes and determine program impacts on behavior, clinical symptoms, family functioning and satisfaction with services, among others. Hierarchical linear modeling takes full advantage of all data collected over time, unlike traditional repeated measures techniques which need to be complete at all time points, and can model interactions between individuals and internal or external characteristics to assess differential outcomes by culture, age, gender, or other variables. Any bias resulting from dropouts will be assessed and statistical corrective techniques used.

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❑ ***D.4 Using Data to Manage and Ensure Initiative Quality Improvement***

To monitor, measure, and improve fidelity to system of care and wraparound principles, we will use a combination of chart review (in collaboration with the Care Coordination committee), observational ratings (using strengths-based coaching), informant interviews, focus groups, and locally selected fidelity measures such as the WFI. These efforts will focus on key principles, including cultural competence, individualized care, family voice/choice, and natural supports. Development of these measurement systems will be a major focus of the planning year. Involvement from families and the Governance Board will be central to this effort. To assist program implementation and ensure achievement of goals and objectives, the evaluation will create monthly reports on system- and child/family-level performance indicators outlined in this proposal and those identified as part of logic model development and strategic planning. Key performance data, such as timeliness of services, will be captured electronically to ensure that any challenges are identified quickly enough to implement timely solutions. National Evaluation CQI and Data Profile Reports will be reported to the Governance Board and its subcommittees, initiative staff, and families and youth. Specific recommendations will be based on a collaborative process involving transparent data reporting and interpretation. The Lead Evaluator will participate in monthly initiative oversight meetings with program managers to provide feedback on program implementation and fidelity. Any deviation from fidelity will be addressed through targeted training, appropriate program modifications, or technical assistance as necessary. Reports will be generated using a visually-oriented dashboard model, enabling managers to easily identify problems amidst the large amount of data at their disposal. Ad hoc reports can be developed in coordination with program staff, families, and other key stakeholders to provide additional context for data interpretation and CQI efforts.

D.5 Performance Assessment Plan and Ability to Conduct the Assessment

Timeline: Preparation and training for data collection will begin during the planning phase. Process and outcome data collection will begin in Year 2 and continue throughout the remainder of the 6-year funding period. **Engagement:** In five previous SAMHSA-funded evaluations, CRI

has attained an average follow-up rate exceeding 90%, and it is expected that the proposed study will be comparable. High participation rates reduce threats to validity based on self-selection bias. All primary caregivers will be invited to participate in the evaluation if they are capable of informed consent. If individuals express an interest in participating, the Research Associate (RA) will verbally present the Parent/Caregiver Consent form (see Appendix 4). The RA will also complete a comprehensive locater form (see Appendix 3). **Tracking and Follow-up:** The evaluation will implement comprehensive tracking strategies, such as hiring personnel with whom the target population can identify, who have a track record for developing rapport with families, and are connected in the community. Program and research staff will maintain flexible schedules to accommodate families. Parents/Caregivers will receive gift cards or cash incentives for follow-up assessments. RA's will work closely with program staff to facilitate tracking. **Local Evaluation Activities:** In Year One, local evaluation questions will be reviewed and further developed in collaboration with stakeholders, including families, county officials, partner agencies, and others. Development of the logic model and strategic plan will also inform local questions. Local measurement timelines have been fully integrated with requirements for the National Evaluation with assessments at six-month intervals up to 36 months to document change over time. The local evaluation efforts will supplement the measures used in the National Evaluation by utilizing measures tracking the effectiveness of activities specific to the approach of the ECN, such as Parent-Child Interaction Training. The local evaluation will utilize the Eyberg Child Behavior Inventory, developed by the founder of PCIT, to determine its impact on child behavior symptoms. The local evaluation will also include the Traumatic Events Screening Inventory for Children (TESI-C), to enhance focus on trauma-informed practice. Furthermore, the local evaluation will include measures of readiness for kindergarten with language, picture naming, alliteration, and rhyming assessments administered directly to children beginning at 3 years of age. The local evaluation will leverage existing state infrastructure by assessing child and family needs and strengths using the Child and Adolescent Needs and Strengths (CANS), used by the Tennessee Department of Children's Services as part of its standardized assessment, service planning and outcomes management process. Activities of the local evaluation will be overseen by the Evaluation Sub-Committee and the Parent/Caregiver Co-Evaluator Team. These family-driven bodies will determine any special studies of importance to them and guide the design, implementation, analysis, interpretation and dissemination of the results. Family members will be directly involved as Research Associates, responsible for data collection, analysis, interpretation and dissemination of the National Evaluation study results. **Institutional Review Board**: CRI has an active IRB (Federal Wide Assurance #00000648), which will review the IRB application and monitor human subjects protection throughout the study. In addition, a Certificate of Confidentiality will be obtained in order to ensure confidentiality for children and families. Participant protection issues are further discussed in Section H, "SAMHSA's Participant Protection (SPP)."

Attachment I
EARLY CONNECTIONS NETWORK GRANT NARRATIVE

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