Wraparound "Lite" is NOT a Thing: Let's FOCUS

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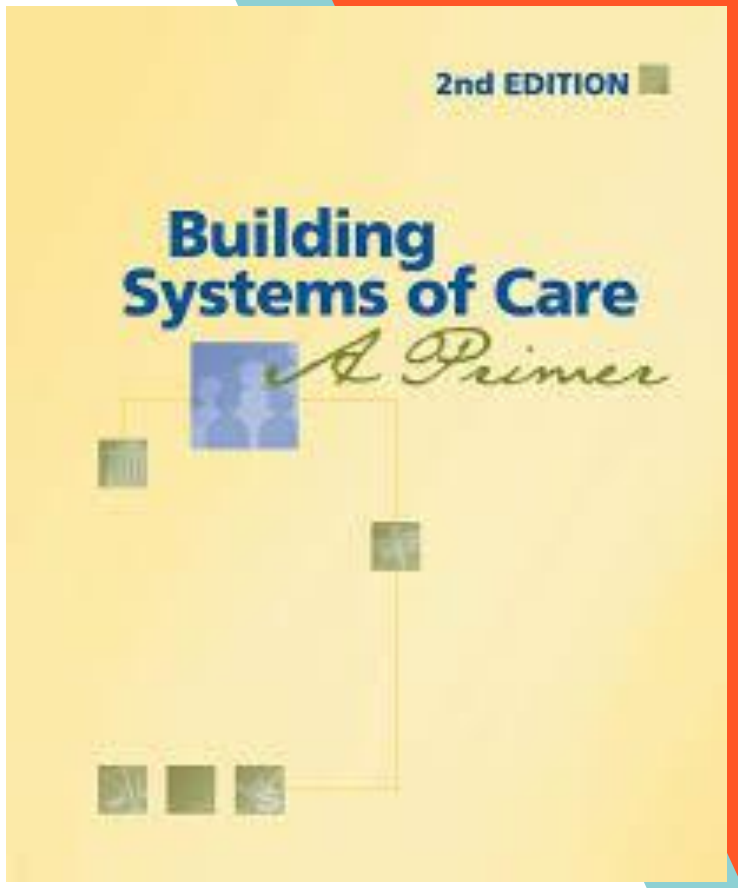
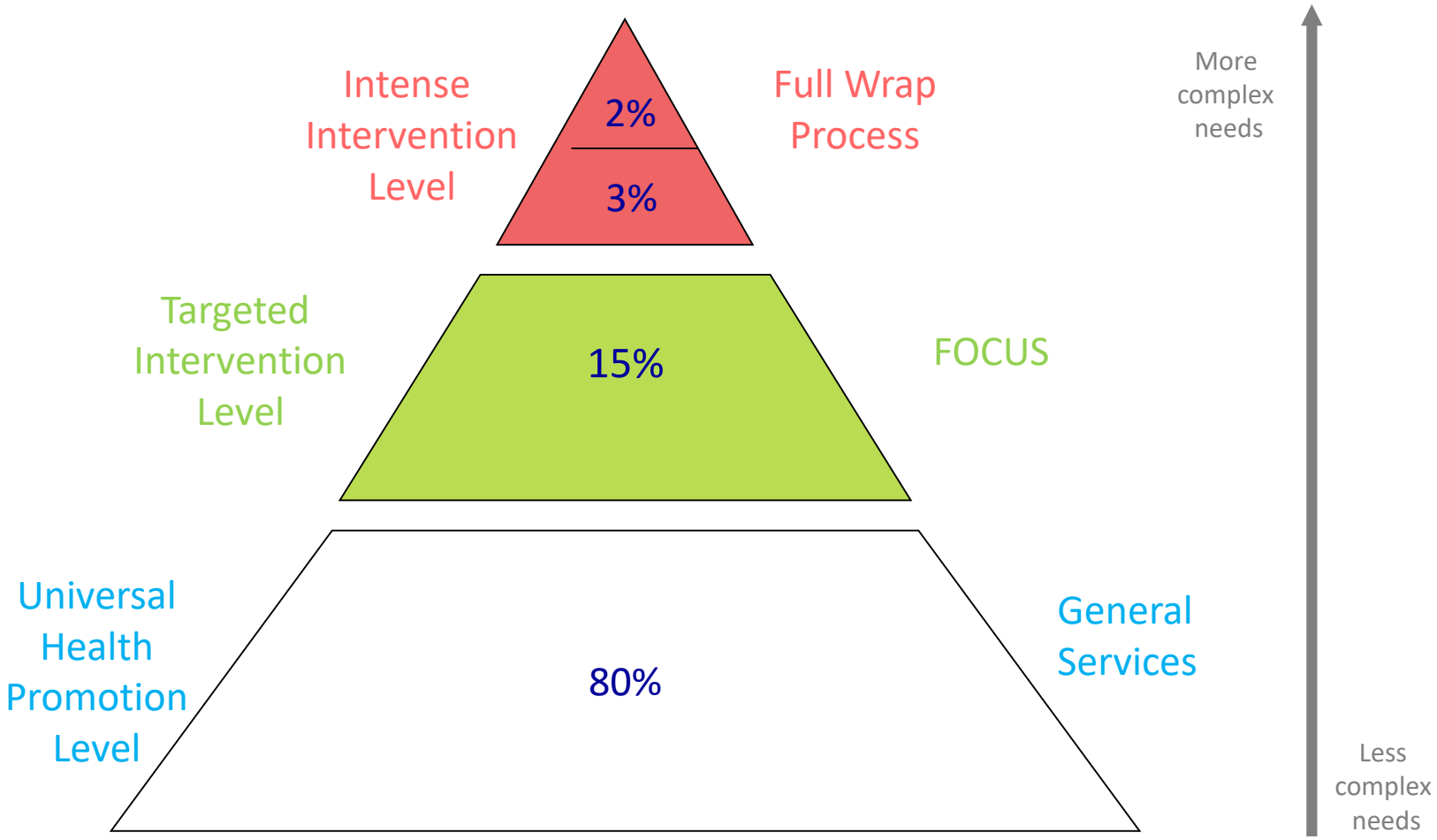
System of Care



A broad, flexible array of effective services and supports for a defined population(s) that is organized into a coordinated network; *integrates services/supports planning*, *service coordination* and management across multiple levels; is culturally and linguistically competent; builds meaningful *partnerships with families and youth at service delivery*, management and policy levels; and has supportive management and policy infrastructure.

System of Care



Risk Factors are Different

Intermediate Care Coordination

- Behavioral Health Needs
- Social Determinants of Health
  - Economic Stability
  - Education
  - Social and Community Context
  - Health and Health Care
  - Neighborhood and Built Environment
- Developmental Delays
- System Involvement

Wraparound/Intensive Care Coordination

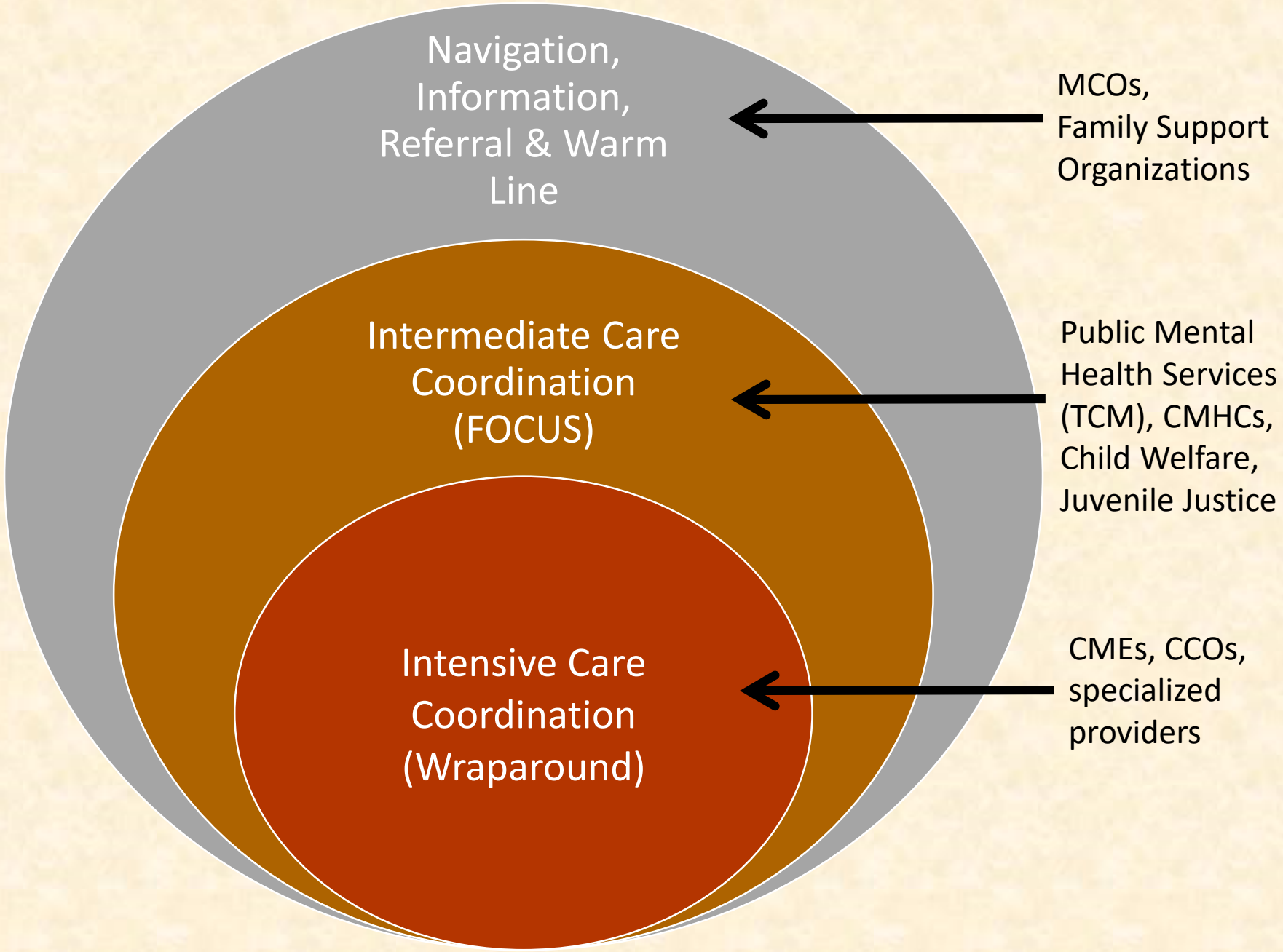
- Multi-System Involved
- High risk of OHP
- Complex Behavioral Health Needs

May be compounded by:

- Social Determinants of Health
- Developmental delays

Challenges in Applying Elements of Wraparound Across Lower Levels of Need

- Shifts in funding streams and rates of reimbursement
- Limited by regulation or policy across child serving systems
- Certain elements of Wraparound create barriers to care for families with lower levels of intensity of need
  - Teaming
  - Eligibility requirements
  - Intensity of support
- Values are not enough
- Wraparound is ineffective when pulled apart

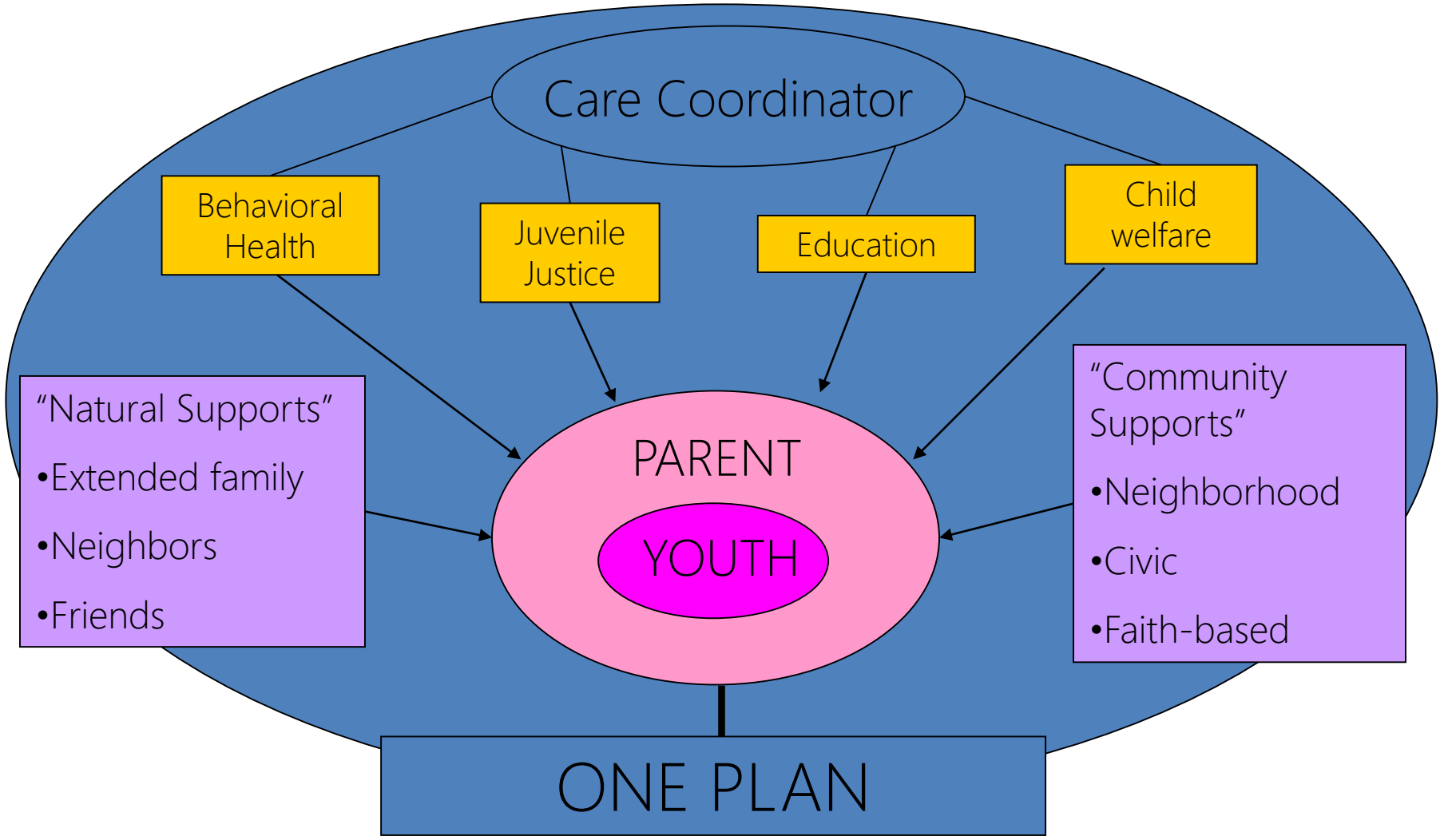


Building Skills, Transforming Communities, Improving Lives
NWIA

Wraparound


Wraparound Team
Values, Services, Supports
Underlying Needs

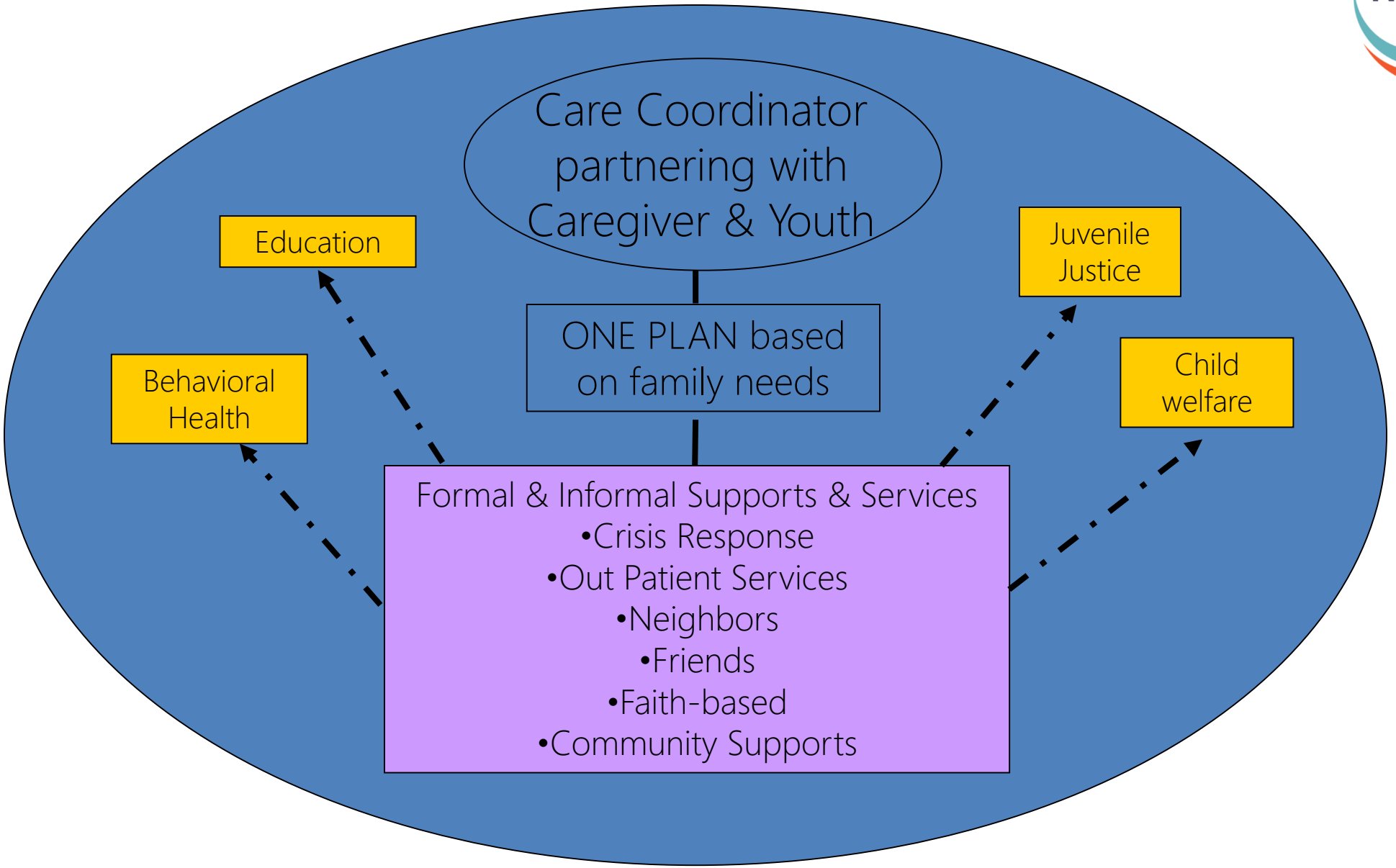
A Care Coordinator integrates the work of system partners and other natural helpers so there is one coordinated plan



FOCUS


Services & Supports
Family & Care Coordinator
Services & Supports

A Care Coordinator coordinates the work of providers & informal supports to ensure coordination & accountability of all services and supports



Values around Care Coordination within a System of Care

- Time limited: Youth grow and learn best from meaningful relationships not systems
- Unconditional positive regard: We engage by assuming the positive
- Family driven: Access, Voice & Ownership
- Culturally competent: We find supports and services to fit families, we don't fit families into services
- Community based: Families deserve to be connected

Evidence Informed Practice

Research

Investigation of subject to discover, inform, or revise

Professional Wisdom

Collective wisdom of the profession

Family Insights

Families experiences, preferences, & satisfaction

Context

Systems in which the practice will be implemented

FOCUS

- Created to operationalize values within a SOC framework around a care coordination model for youth with lesser complex needs, but who still are system involved, at risk of deeper system involvement, and who's challenges exceed the resources of a single organization

- FOCUS should be time-limited and support decreased involvement with systems while working to build connections and supports for the family through community based resources.

The care coordinator should FOCUS their efforts and work to ensure:

Families are experiencing meaningful connections – positive relationships are necessary for healing

Outcomes – are things getting better

Coordination – Is everyone working together toward a common goal

Unconditional Positive Regard – genuine acceptance no matter what

Short-Term process – working to build community resources with a commitment to empowerment and sustainability with minimal system reliance

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Family's own ideas

Monitoring if things are getting better

Building hope

Common factors leading to positive outcomes!

4 Key Components to Care Coordination

Individualized 	Comprehensive 
Accountable 	Family Anchored 

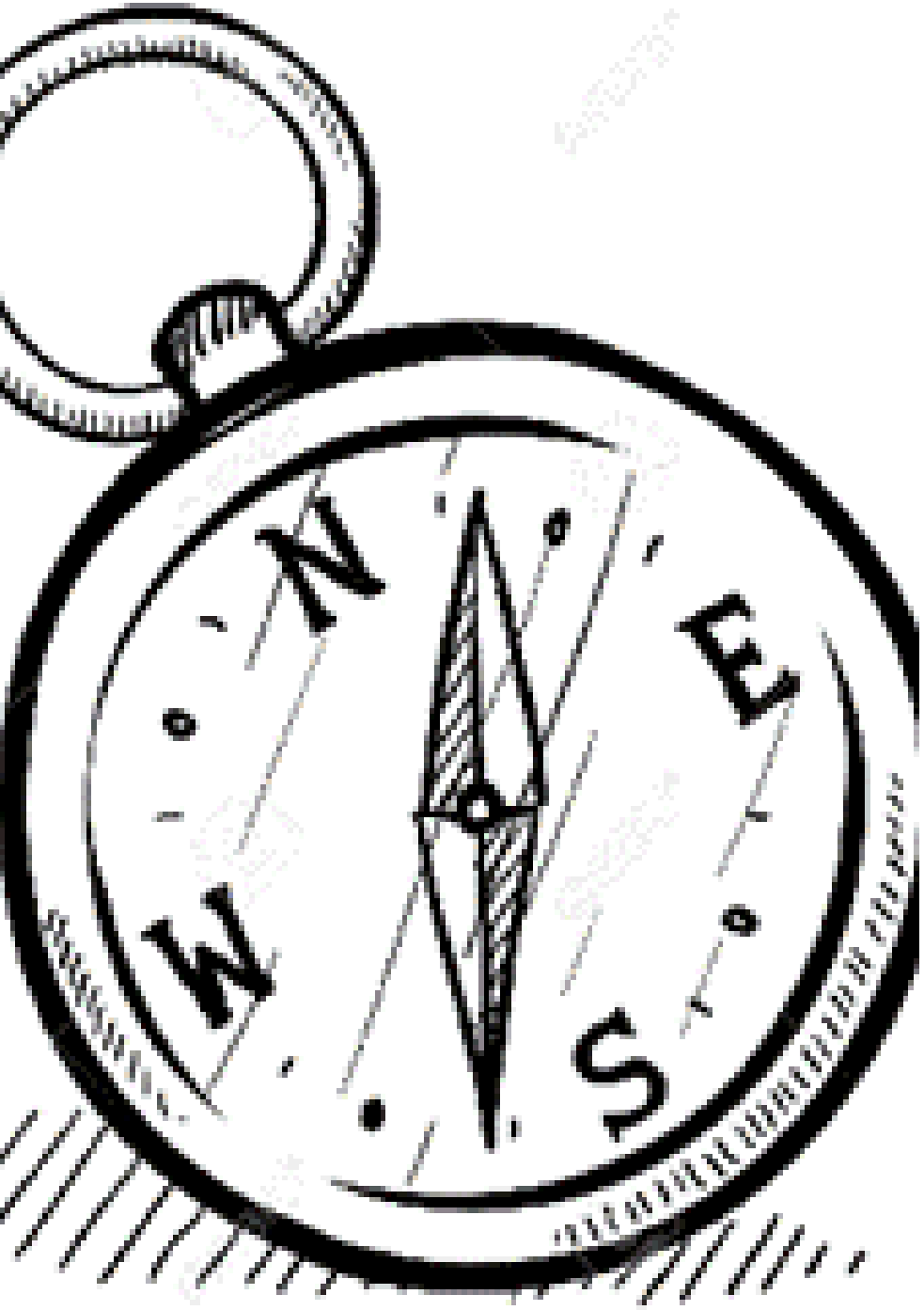
Only considered fidelity & quality practice when <u>all four</u> components are present

Individualized

- The Care Coordinator should have an orientation to, and appreciation of, the uniqueness, skills, interests, hopes, and desires of each person in the family.
- Strengths for all family members needs be incorporated into the planning to build on assets.
- Brainstormed options should align with the family's preferences and include creative solutions.

Comprehensive

- The Care Coordinator should be knowledgeable about community options and evidenced based practices and support the family in accessing those supports.
- Planning should center around all environments and encompass all areas of need including medical needs.
- Context should include multiple perspectives and information gathered should be incorporated into the planning process.
- The Care Coordinator is the locus of accountability responsible for overseeing or guiding care and outcomes across systems and environments.



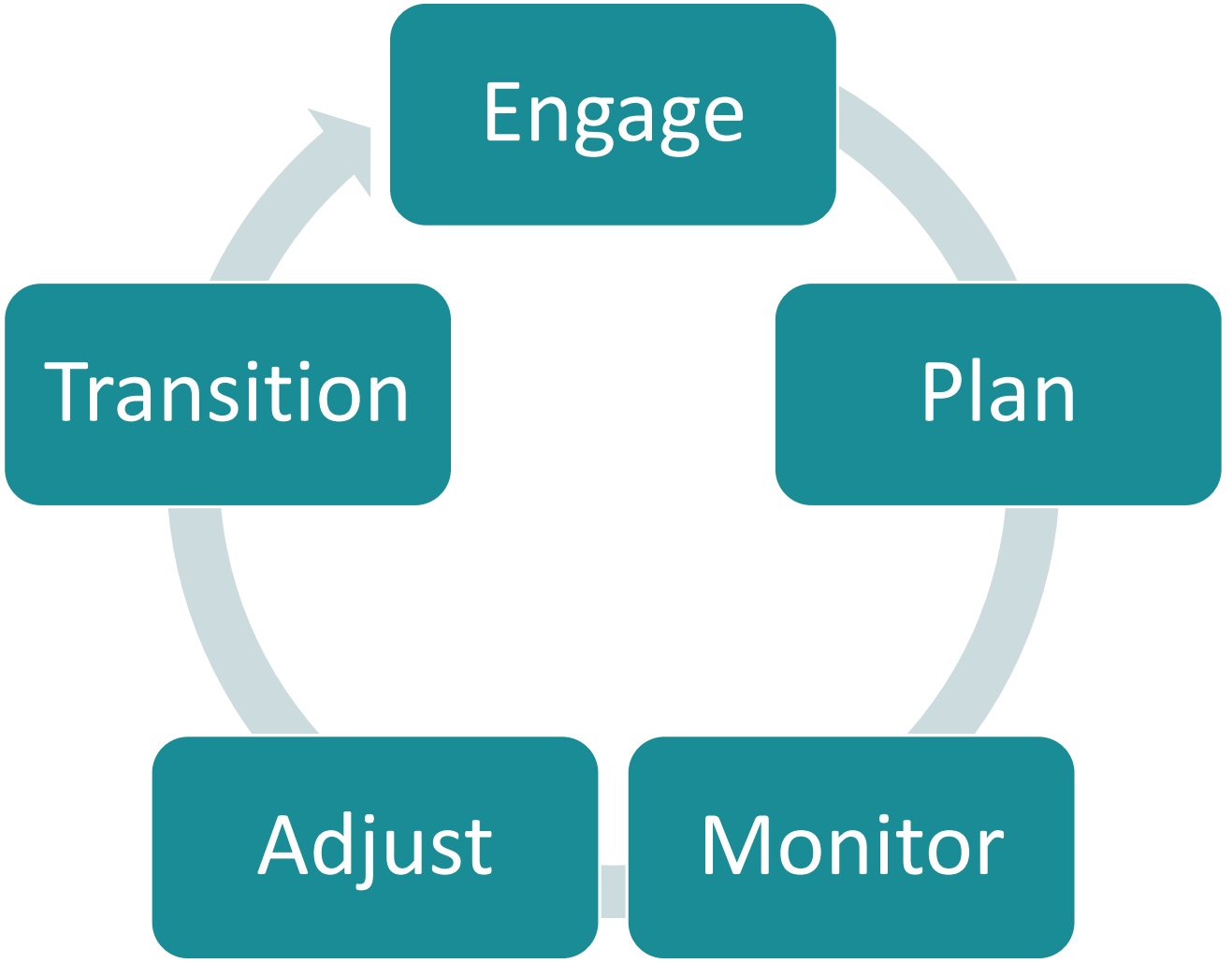
Accountable

- The Care Coordinator monitors services and supports for completion as well as impact and satisfaction.
- Progress around the reasons for referral needs to be openly discussed with the family. The plan is reviewed and adjusted often if things are not getting better.
- This is a time limited coordination process and it is the care coordinator’s duty to ensure that the plan serves the family’s needs responsively and effectively.

Family Anchored

- The Care Coordinator should establish a partnership with the family and ensure they are seen as the expert of their lives.
- Families partner with the care coordinator in the planning process which includes reporting out of need being met, satisfaction with care, and modifications to the plan.
- The care planning process allows opportunities for the family to share what they feel will be helpful and what has been proven to work in the past based on their unique history.
- Care plans should also be ‘right sized’ based on information aligning with the families preferences.

The Process of Care Coordination



Role of Care Coordinator

Understand all the components of a family's life related to the reason for referral that incorporates the family's history, culture, relationships and other relevant information to address their challenges and formulate possible solutions.

Partner with the family in the development of a POC resulting in the best fit between the reason for referral, family choices, family strengths and strategies through a proactive and reactive planning process that is inclusive of a connected crisis plan.

Collaborate with all of the services and supports comprised within the POC to ensure the strategies are being delivered aligned with the family's own ideas and specific needs.

Monitor and adjust the plan based on family feedback as well as tracking if the behaviors are getting better.

Care Coordinators…

Make referrals & schedule appointments

Research multiple options & provide them to families so they can make informed decisions regarding 'best fit'

Are knowledgeable about available services, community resources and supports & able to link families to these

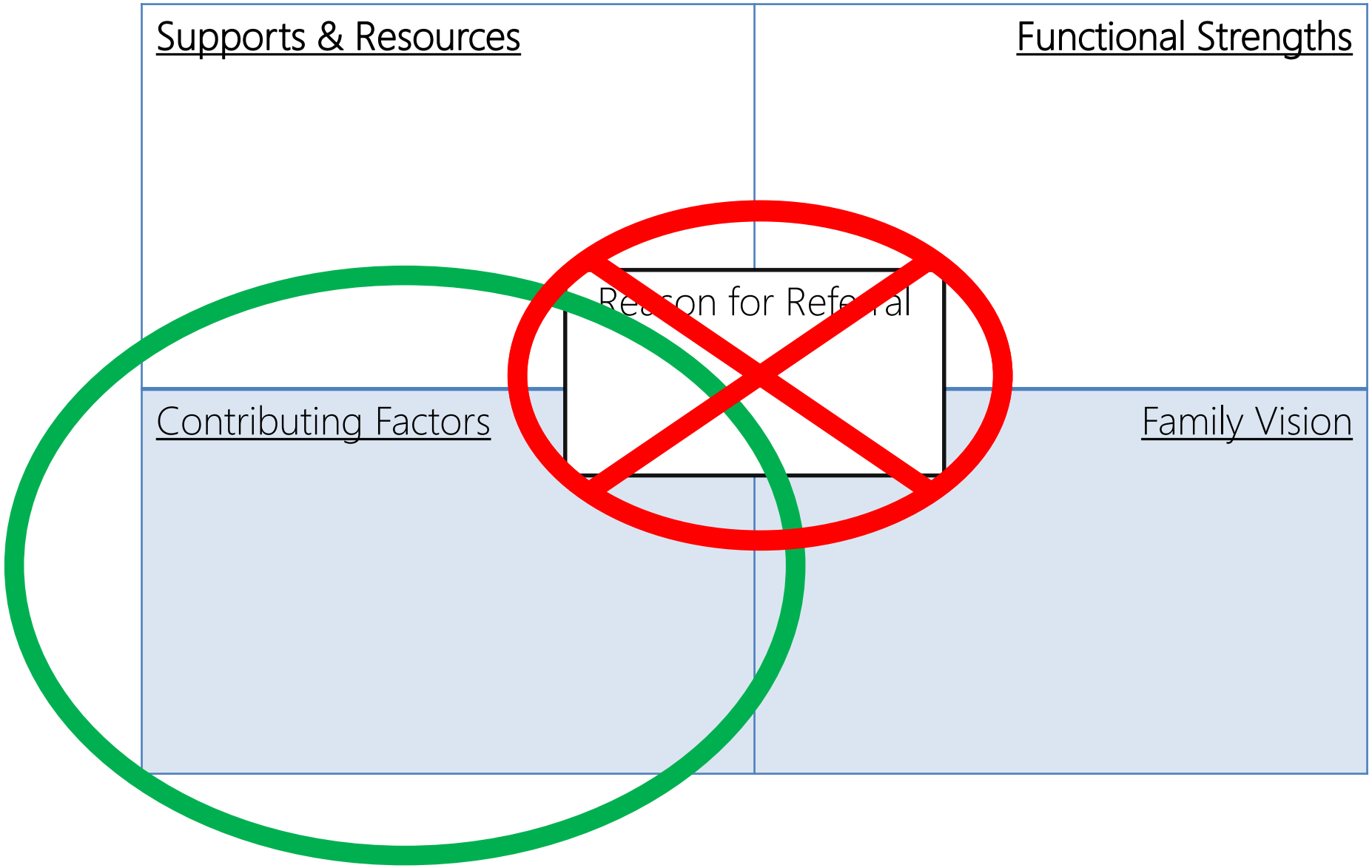
Assist with development of the service array & maintaining that information for the organization

Work to address & incorporate information from relevant people involved with the family around the reason for referral

Collect & maintain data around utilization of supports and services, behaviors changing, & family satisfaction

Serve as the hub of information gathering, sharing & dissemination.

Basics of Planning



Are things getting better?

Family Vision:	How close are we to reaching the vision?				
	1	2	3	4	5

Outcome 1:	
Base-Line:	Start Date:
Current:	End Date/Duration:
Contributing Factors:	

Connected to the reason for referral – Are the challenges that brought them in getting better?

Strategies	Family Satisfaction				
	1	2	3	4	5
	1	2	3	4	5

Strategies are connected to contributing factors NOT outcomes

Monthly POC Reviews

As the plan is being reviewed, remember the 3 C's:

- **Celebrate Successes** -- review things that have worked, services that have been effective, and any positive changes around the reason for referral

- **Check Progress** -- check in for task completion, are we closer to meeting family vision & outcomes, the impact of the interventions, and family satisfaction

- **Consider**
  - **New strategies --** if things didn't happen or didn't work, ask why, address barriers, change providers, and adjust the strategies accordingly
  - **Transition** -- if things are getting better, how will we know when the end is near?

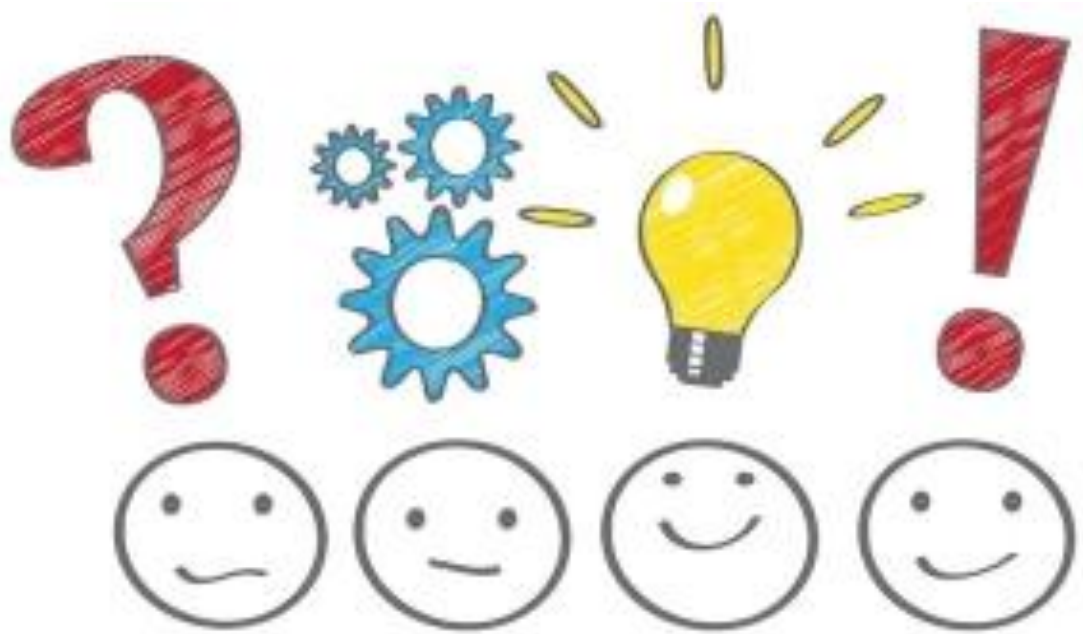
Workforce Development & Oversight

FOCUS Quality Review

- Organized around 4 phases of help
  - Information gathering and engagement
    - 23 items
  - Plan development
    - 11 items
  - Monitoring and adjustments
    - 11 items
  - Aftercare
    - 4 items

Sample Quality Review

Caseworker:	Supervisor Completing Checklist:		
Type: Documentation Review___ Supervision Session___ Field Observation: Engagement Session ___Monthly Review ___ Other (explain)_____			
Engagement with the Family/Information Gathering-Completed within 30 days			
Activities	Yes	No	Comments
<u>Behaviors placing youth at risk</u>			
CM understands the behavior that led to the referral			
CM understands how long the behavior has been occurring and when help was first received			
CM is able to discuss the risk behavior openly without shame or blame			
<u>Strengths</u>			
Identifies coping skills, preferences/exceptions and relational strengths			
CM communicated a sense of acceptance and appreciation for the family			
Quad is written in a respectful strength-based manner			
Provides an understanding of who the family is (culture, traditions, values)			



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