2019

Ain't It Hard Keeping It So Hardcore?

The Difference between Holding Wraparound Expectations and Coaching Skill

Building Skills, Transforming Communities, Improving Lives

National Wraparound Implementation Academy

Participant Manual

Baltimore Marriott Waterfront Hotel
Baltimore, MD

The National Wraparound Implementation Center (NWIC) supports states, communities, and organizations to implement Wraparound effectively. NWIC uses innovative approaches grounded in implementation science and incorporates cutting-edge strategies to support Wraparound implementation. NWIC provides support that is intensive yet affordable. The work is focused on building sustainable local capacity to provide model-adherent, high fidelity Wraparound, thereby increasing positive outcomes for children, youth, and their families.

NWIC is a partnership among the three leading universities involved with Wraparound implementation: The University of Washington School of Medicine; Portland State University School of Social Work; and the University of Maryland School of Social Work. These three universities collaborate to ensure sites have access to comprehensive support for implementing model-adherent, high quality Wraparound for children and youth with behavioral health needs and their families.

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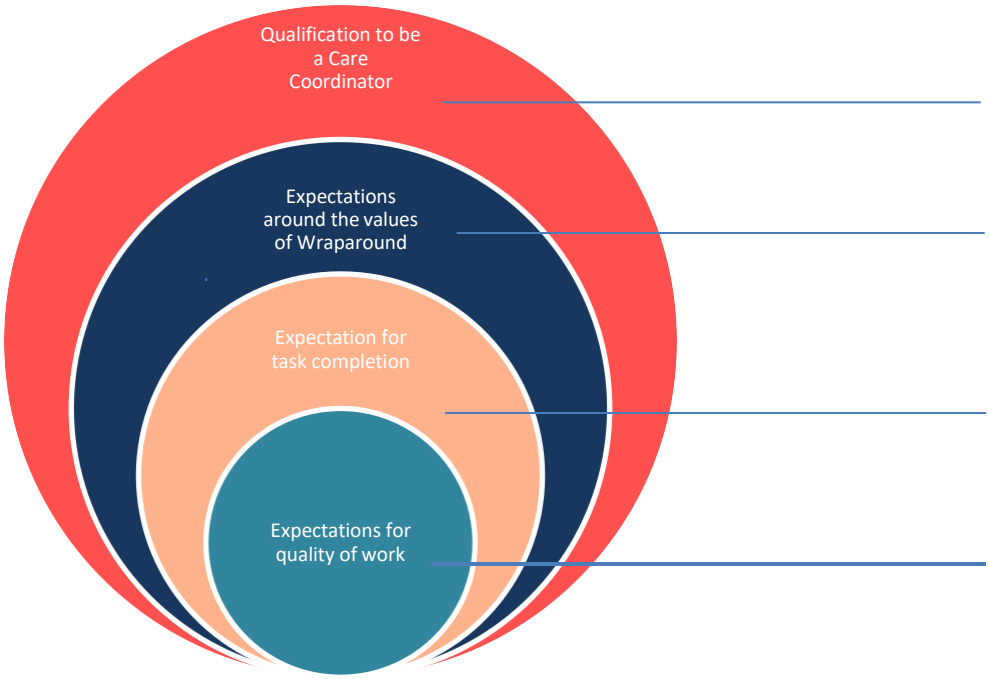
The Institute for Innovation and Implementation

Portland State University

Objectives for today's session:

- Participants will recognize the importance supervisory oversight and supportive coaching plays in getting quality practice and differentiating between the two.
- Participants will learn the expectations that should be held to all Care Coordinators when they start partnering with families in Wraparound.
- Participants will develop techniques for ensuring Care Coordinators complete their tasks in a timely and quality manner.

Expectations help to understand the bigger picture.


Qualification to be a Care Coordinator
Expectations around the values of Wraparound
Expectation for task completion
Expectations for quality of work

Notes……

CARE COORDINATOR QUALIFICATIONS

1. Wraparound Care Coordinators must possess a minimum of B.A or B.S. degree in social work, psychology or related field with extensive experience in human services. Experience can be substituted for education.

2. Ability to create effective relationships with individuals of different cultural beliefs and lifestyles.

3. Effective verbal and written communication skills.

4. Strong interpersonal skills and the ability to work effectively with a wide range of constituencies in a diverse community.

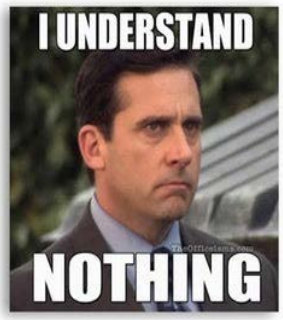
5. Ability to analyze complex information, and to define and solve.

Expectations around behavior to uphold values

There are expectations around the_____of Wraparound. This is related to how we_____ inside and outside of the office.

Notes…..

Layout the Basic Expectations for Wraparound



Think about a time where the expectations were unclear, how did you feel?

Think about a time where the expectations were clearly laid out, how did you feel?

Supervision Tool for Care Coordinator Responsibilities

Engagement and Team Preparation Phase 1

Expectation	Coaching Required?
Review the referral to identify the reason for referral and stakeholders involved.	
Call the family within 3 days of the receipt of referral to schedule the initial face-to-face meeting at a time and location convenient to them within 7 days of the initial referral date	
Explain wraparound to the family and define your role and the family's role	
Contact referral source to confirm receipt of referral, and gather additional information on the reason for referral	
Start the Family Story Timeline from the birth of the caregiver through the date of referral using the initial information gathered	
Meet with the family to gather information for the family story, this may require multiple meetings to fill in the gaps of the timeline and gather the initial conditions which include: 1) Reason for referral 2) When the family first noticed something was wrong 3) First system contact	
Distinguish between a crisis and a non-crisis situation upon initial meeting with family	
a) Provide stabilization resources for crisis situations only b) Communicate a time limit on stabilization resources to assure that the next phase is fully engaged. Keep a copy and leave a copy.	

Identify strengths for everyone in the family including the important people in their lives	
Identify functional strengths connected to the initial conditions	
Listen to the story to identify potential team members and get releases of information signed to contact them	
Develop a family vision statement about the entire family that is future-oriented, strengths-based and in the family's language.	
Gather information on who the family is (culture, values, traditions)	
Contact identified team members to explain the Wraparound process, gather their perspective on strengths and needs and invite them to be a team member	
Summarize the family story in a narrative which includes strengths, relationships, family culture and the context around the initial conditions	
Share the story with the family for review and agreement	
Develop potential underlying need statements for each family member that reflect the root cause for behavior, represent a future orientation.	
Bring the needs statements to the family to review and prioritize	
Coordinate a time and location that works for the team to hold the initial CFTM. Ensure that formal and informal attendance can occur in addition to the family.	
Meet with the family to prepare them for the initial Child and Family Team Meeting including establishing ground rules	
Prepare visual aids with the information already gathered and outlining the full initial CFTM process	
Create an agenda and sign in sheet and follow up on any additional CFTM logistics	

Development Phase 2

TASK	Coaching Required?
Meeting is held with a team that includes members living outside of the home and outside of Wraparound staff	
Meeting begins with introductions	
Ground rules are established and used to mediate conflict	
Includes a written and distributed agenda	
The family is prepped for the meeting	
Team members are also prepped for the meeting	
If team members cannot attend a meeting, were updates obtained and shared with the rest of the team	
Post it notes or other visuals have been prepped	
All team members understand the family story	
Functional strengths were reviewed	
All team members (including the family) are addressed by name and not by role	
Blaming and bias are redirected by the CC	
Youth is actively involved	
Safe space is created to talk about challenges and “tough” topics	
Strengths are being added	
Family vision explained to the team and reviewed	
Team Mission is explained to the team and developed to represent all team members inclusive of the family focused on what everyone is willing to accomplish	
New strengths are added for everyone on the team	
Underlying Need Statements are discussed and prioritized by the team for planning that are future oriented and reflect the root cause of behavior	
Underlying Need Statements are prioritized for more than just the youth	
Outcome statements connected to the reason for referral or behaviors placing the youth at risk and a baseline is established for how often those behaviors are currently happening	

Brainstorming is utilized for strategy development with a focus on community-based options	
Family selects strategies that work for them that are a balance of formal and informal supports and services	
Tasks are assigned to all team members, including informal supports	
Strengths are reviewed when assigning tasks	
Crisis Plan is reviewed and updated to include any additional risk and safety concerns. The Crisis Plan is written in the families language, built from strengths, reflective of culture and includes proactive and reactive responses	
Team members understood and left the meeting with clear direction around their tasks	
The Care Coordinator will facilitate the process to ensure the plan is the best fit between vision, strengths, needs and strategies	
Sustainability and community resources are discussed with the team and included in planning	
Additional informal and formal team members are discussed for future attendance	
Next meeting scheduled and documented	
Plan of Care is written after the meeting and sent out within 7 business days	

Implementation Phase 3

TASK	Coaching Required?
Schedule team meetings every 30 days at a minimum at a time and location convenient for the team	
Ensure the team is balanced; comprised of formal and informal supports	
Check in with team members regularly to follow up on assigned tasks, progress towards outcomes and get feedback on what is working and what is not	
Summarize and bring successes, new strengths and concerns back to the team at the CFTM	
Meet with the family a minimum of one additional time in between CFTMs	
Respond to crisis situations to stabilize within 24 hours and update the crisis plan if needed to ensure safety	
Convene a crisis CFTM within 72 hours of a crisis event	
At each Subsequent CFTM:	
The meeting begins with introductions	
Ground Rules are reviewed and revised as needed	
Successes are reviewed and celebrated	
Identify new strengths for each team member	
Family vision is reviewed and progress is recorded	
Team mission is reviewed and progress is recorded	
Progress towards each underlying need statement is reviewed and measured on a scale	
Progress towards each outcome statement is measured	
Strategies are reviewed and any barriers are addressed	
Task Completion is tracked and adjusted	
Sustainability and Community Resources are discussed	
Crisis Plan is reviewed and revised as needed	
Team members understood and left with clear direction around their tasks	
Additional formal and informal team members are identified to be invited	
The next CFTM date is scheduled	
Plan of Care is revised and sent out to all team members within 7 days	

Transition Phase 4

TASK	Coaching Required?
Continue with the tasks associated with the Implementation phase until transition	
Document results including: • What has worked • What didn't • Key accomplishments	
Increase participation of family members and natural supports	
Discuss and practice crisis plans	
Identify links to other resources who can be accessed after wraparound	
Develop a transition plan at least three months prior to a planned discharge	
If requested write letters for the youth and family to use with future team members	
Lead the team in discussion of a life without formal Wraparound including having each team member list their hopes and fears for the family	
Summarize and reflect behavioral successes of the youth and family (i.e. decreased hospitalizations, community-based care, etc.) to the team	
Forecast future needs that might come up and plan with the sustainable resources that have been developed	
Develop an after-Wraparound check in schedule including who will check in, how often and using what means	
Lead the team in selecting an event or celebration to mark the ending of formal Wraparound	

The_____Rule

Have the expectations around timeliness and quality been laid out?

The_____Verification Rule

Has training been provided to carry out the activity and has that person been observed to have the skills to carry it out on their own?

The_____Rule

Is there transparent and consistent oversight of the task to ensure it is being done in a quality and timely manner?

Fazzi Associates. *How to Hold Staff Accountable*
http://www.fazzi.com/tl_files/documents/Consulting/How_to_Hold_Staff_Accountable.pdf


"I THOUGHT THAT I WAS HERE TO DO THE JOB. I NEVER KNEW THAT I WAS HERE TO DO THE JOB RIGHT!"
CartoonStock.com

How can you hold staff accountable?

The task that I need to supervise around is:

In order to clarify this expectation to my Care Coordinators I will:

The training or support they may still need to understand the job is:

I will track this task by:

The rewards I will provide for meeting a goal around this task are:

The Consequences for not meeting this task will be

I will know if my plan is working if: