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WRAPAROUND DEMONSTRATION PROJECT

RECOMMENDATIONS FOR THE EXECUTIVE COMMITTEE

Prepared on behalf of the:
Wraparound Demonstration Project Steering Committee

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SECTION 1: INTRODUCTION AND BACKGROUND

The Need for Change

Counties across the nation and around New York State are discovering that youth with complex needs and their families can often be better served in the community through wraparound models than through out of home residential care. Programs such as Wraparound Milwaukee in Milwaukee County, Wisconsin; Children Come First in Dane County, Wisconsin; Kids Oneida in Oneida County, New York; and the Youth and Family Partnership in Monroe County, New York have been successful in serving youth at risk of out of home placement. Employing strength - based, family-focused service delivery approaches, multi-disciplinary teams, flexible funding strategies, and other wraparound practices and principles, these counties have served high need youth and their families in the community, reduced out of home placements, and expanded the availability of effective community based alternative services. Both Dane and Milwaukee Counties have also used the wraparound model to shorten lengths of stay of youth already placed in residential care.

There is no clear evidence that residential care is more effective than community-based care in treating the long-term needs of youth and their families. Out of home placement is extremely disruptive to both the child and family and often focuses primarily on the child's issues without addressing underlying family problems. Children frequently have difficulty reintegrating with their school, community, and family life after lengthy placements in group and institutional care.

Out of home residential care is also costly. Erie County estimates that the annual cost of institutional placement in a Residential Treatment Center is approximately $86,000 annually. With Erie County's average census of approximately 235 youth in Residential Treatment Centers, the cost of out of home placement in institutional level care is nearly $20 million per year. Placement in less intensive levels of congregate care can also be expensive. The annual cost of placement in an agency boarding home is approximately $67,000; in a group home $60,000; and a group residence approximately $50,000. In 2002, the average census of

youth in these three types of congregate care was approximately 80.[1]

Recognizing the success of wraparound approaches in averting residential placements or shortening lengths of stay for high-need youth, Erie County identified the development of a Wraparound Demonstration Project as one of its priorities for the Blueprint for Change Initiative. The Blueprint for Change seeks to recommend organizational and service delivery improvements that will result in more cost-effective, integrated, and outcome-focused services to children and families.

Key features of the Demonstration Project

This paper proposes a new way for Erie County to serve youth with serious emotional disturbances who are also involved in either the child welfare or juvenile justice systems. During the first year of implementation, the initiative will serve up to 50 youth and their families and give priority access to youth, with serious emotional disturbances, who are:

- adjudicated as a PINS and likely to be placed outside of their homes;
- freed for adoption or are very close to becoming freed for adoption and whose emotional, behavioral, or mental disorder is jeopardizing their adoptive placement; or
- able to return to the community earlier due to the availability of wraparound services.

The recommended Wraparound Demonstration Project includes the following key features:

- ***Care coordination provided by a family advocacy organization and/or community agency that does not provide direct services,*** to serve as the primary contact for the family and be responsible for ensuring quality service planning and delivery.

[1] These figures represent the average daily census of youth in different levels of congregate care from January – June 2002. A study of the census of youth in congregate care on June 19, 2003 indicated that there were 248 youth in institutional care and 89 youth in other forms of congregate care.

- ***Formation of child and family teams,*** involving professionals, informal supports, and, most importantly, family members themselves in the process of identifying strengths, resources, needs, and goals and priorities.
- ***Family advocacy services,*** through the newly forming Family Voices Network Inc. and other family support organizations.
- ***A flexible funding approach,*** that will include Medicaid and child welfare funding to provide the flexibility to purchase the services and supports needed to maintain youth at home and in their communities.

This Demonstration Project has clearly been informed by the progress, experience, and lessons learned by Erie County government and community agencies in their efforts to provide individualized, culturally competent, family-centered, and strength-based services to youth with complex needs and their families. Some important building blocks include the County's: Task Force on Integrated Systems of Care, Hard to Serve Committee, and Single Point of Accountability (SPOA) for Intensive Community Services and its current four care coordination programs: Home and Community Based Waiver, Intensive Case Management, Intensive Case Management Plus, and RESPECT.

In addition, two efforts underway hold great promise to advance Erie County's goal of creating one integrated and highly flexible system of care for high need youth and their families. First, Erie County is seeking state approval to be one of four demonstration counties that will be allowed to increase the flexibility of the four care coordination programs identified above. Second, Erie County has recently submitted a multi-year grant proposal, *Erie County Family Voices*, to the federal Substance Abuse and Mental Health Services Administration, which, if awarded, will enable Erie County to achieve systemwide reform and significant expansion of care coordination, individualized services, and natural supports.

Contents of this Paper

This paper contains the recommendations of the Steering Committee to the Executive Committee on each of the core elements of the Wraparound Demonstration Project. It represents the culmination of five months of work by the Steering Committee, facilitated by CGR (Center for Governmental Research Inc.) reviewing alternatives, identifying the advantages

and disadvantages of each option, and selecting an approach for serving the target population. The Steering Committee believes that this paper sets forth a clear path and direction for the County.

The remainder of this paper is organized into three sections: Design Process; Recommended Approach; and Next Steps.

SECTION II: DESIGN PROCESS

As a first step in advancing the Wraparound Demonstration Project, Erie County formed an Executive Committee to oversee its development and implementation. This Committee includes the Commissioners of the Departments of Social Services, Mental Health, and Probation; the Coordinator and the Director of Contract Compliance of the Council on Children and Families; the Supervising Family Court Judge; the Superintendents of the Buffalo City School System and Erie 1 BOCES; and a family advocate. The Commissioners of the Departments of Health and Senior Services serve as ex officio members of the Executive Committee.

The Executive Committee defined the target population for the Project as a whole and specific eligibility criteria for the first year of operation. It then determined that a broad-based Steering Committee should be formed that included individuals with more direct experience in serving complex youth and their families. A 26-member Steering Committee was established, including family advocates and representatives of provider networks; County Departments of Probation, Social Services, Mental Health, Health, Senior Services, and the Council on Children and Families; Buffalo City and suburban school districts; Family Court; and State Regional Offices. The Steering Committee was charged with developing a plan for a wraparound model and presenting recommendations to the Executive Committee.

CGR facilitated both the Executive Committee and Steering Committee meetings as part of its responsibilities as the County's Blueprint for Change consultants. To guide the discussions, CGR used a framework that includes eleven core elements that need to be in place at the system and service delivery levels for an effective integrated system of care. CGR staff identified these eleven core elements after reviewing successful model programs in New York State and nationally for the New York State Conference of Local Mental Hygiene Directors. The core elements include:

Core Elements

Systems Level

- Clearly Defined Target Population
- Shared Vision and Principles
- Strong Leadership
- Broad-Based Oversight Body

Service Delivery Level

- Effective Structure for Care Coordination
- Strength-based Child and Family Teams
- Flexible Funding
- Adequate and Accessible Community Services

Needed at both Systems and Service Delivery Levels

- On-going Evaluation
- Meaningful Family Involvement
- Staff Development on New Service Delivery Approaches

The Steering Committee generally met twice a month, from late February 2003 though the end of June 2003. In addition, task groups were formed on an as needed basis to process issues and bring recommendations to the full Steering Committee. A central tenet guiding the work of the Steering Committee was to keep what is best for the customer - the children and families of Erie County in need of government services - in the forefront of all discussions. All decisions reflected in this document were made by consensus except one - which entity should provide the care coordination. This decision was made by a majority of Steering Committee members since a consensus could not be reached.

SECTION III: RECOMMENDED APPROACH

Target Population

The Executive Committee decided to focus the Wraparound Demonstration Model on serving youth who need mental health services and are also involved in either the juvenile justice or child welfare systems. These youth are among the most difficult and costly to serve. The Executive Committee elected to further limit the target population to youth at imminent risk of out of home placement, youth already in placement who are at risk of moving to a higher level of care, and youth in residential care able to return to the community earlier through wraparound services. Targeting wraparound services to these individuals has the greatest potential for cost avoidance or cost savings.

The full definition of the target population is contained in the graphic, below:

Target Population for Wraparound Demonstration Project

Youth who:

- Are under age 18;
- Have a diagnosable emotional, behavioral, or mental disorder, excluding 'V' codes, substance abuse and developmental disabilities;
- Demonstrate severe functional impairments;
- Are currently in the child welfare or juvenile justice system;
- Are a) at imminent risk of out-of-home placement; b) at imminent risk of placement in a higher level of residential care, such as a group home, residential treatment center, residential treatment facility, or inpatient psychiatric unit or facility, or c) returning to the community from residential placement; and
- Have an available caregiver home setting.

It is anticipated that during the first full year of operation, the Wraparound Demonstration Model will serve up to 50 youth and their families. The Executive Committee set, as a first year priority, providing wraparound services to:

- Youth adjudicated as a PINS and likely to be placed outside of their homes. *(The Department of Probation estimates this involves approximately 100 youth annually).*

- Youth who are freed for adoption or are very close to becoming freed for adoption and whose emotional, behavioral, or mental disorder is jeopardizing their adoptive placement. *(The Department of Social Services estimates that this involves 50 to 60 individuals).*

- Youth whose return to the community can occur earlier due to the availability of wraparound services. *(No estimated number at this time.)*

The Steering Committee reviewed this target population and first year priorities and agreed that was an appropriate starting point for the Wraparound Project.

Client Flow

Before presenting the Steering Committee's recommendations on the remaining core elements, it is important to get an overall picture of how the model will operate. The following chart illustrates how a youth and his or her family will move through the system of care established by the Wraparound Model, from intake to discharge.

Proposed Client Flow

Referrals made by Erie County Department of Social Services, Erie County Department of Probation and Youth Services, service providers, or family members to the Single Point of Accountability (SPOA) for the Wraparound Demonstration Project. SPOA accepts referrals and gathers any additional information necessary to determine eligibility for Wraparound Project.

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Child determined eligible for Wraparound Demonstration Project by SPOA Screening Committee. A member of the Care Coordination Agency participates on the SPOA Screening Committee to facilitate the referral process.

↓

SPOA forwards referral to the Care Coordination Agency. Agency assigns care coordinator to family.

↓

Care coordinator makes initial contact with the family to review the Wraparound Demonstration Project and determine: who the family would like as members on their child and family team; when and where they would like the first team meeting to occur; and whether they would like the assistance of a family support advocate. The family decides whether the child should attend the first meeting; however it is essential to engage the youth – particularly older adolescents – as early as possible. Care coordinator also informs the family about the Project's grievance policy.

↓

Face-to-face meeting held of child and family team to: conduct a strength-based discovery; develop a preliminary plan, including a safety plan; and initiate service provision as quickly as possible. Plan includes measurable goals and is signed off by all members of the child and family team, including the child. Grievance process reviewed by care coordinator with all team members.

↓

Child and family receive traditional and non-traditional services and supports in accordance with the plan.

↓

Care coordinator meets face-to-face with the family at least twice a month and maintains regular phone contact with the family and team members to monitor progress. The full child and family team meets at least quarterly to review and modify plan as needed. Care coordinator notifies SPOA of any recommendation to serve a child in an out-of-home placement, including hospitalization.

↓

Child and family team determines when goals have been met and when the child can be discharged from the Wraparound Demonstration Project and/or stepped down to a lower level of care. Anticipated average length of enrollment in the Wraparound Demonstration Project is 12-18 months. Care coordinator notifies SPOA of discharge plan.

Guiding Principles

A clear statement of the guiding principles for the Wraparound Demonstration Project will serve as a beacon to ensure that implementation of the Project is on course and consistent with the needs and aspirations of family members and county and community stakeholders. To ensure fidelity to the Project, the principles must be embraced at all levels, from top leadership to frontline workers, and embodied in policy statements, program guidelines, and staff development and training.

In developing the principles for the Wraparound Project, the Steering Committee considered the vision and principle statements of the federal Child and Adolescent Service System Program, Erie County's Single Point of Accountability, and those adopted by each of the County's service systems. After reviewing these examples, the Steering Committee proposed that the Wraparound Model be developed and operated with the following principles in the forefront:

- ***Child-centered:*** Services will meet the individual needs of the child, consider the child's family and community contexts, promote stability, and be developmentally appropriate, strength-based, and child specific. Children and youth will be ensured a smooth transition to a supportive adulthood.
- ***Family-driven:*** Services will recognize that a family is the primary support system for the child and participates as a full partner in all stages of the decision-making and treatment planning process.
- ***Safety-focused:*** The safety and rights of children and all family members will be protected.
- ***Community-based:*** Whenever possible, services will be delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. The community will share responsibility for advocating for children, youth, and families and needed system improvements.
- ***Accessible:*** Children will have easy access to a comprehensive array of services when they need them and at the level of intensity that is needed. Children and their families will be provided every

opportunity to succeed and not be ejected or rejected because of behavior or past perceptions of their willingness to participate.

- ***Cross-system Commitment and Accountability:*** Services will be planned in collaboration with all the child-serving systems involved in the child's life and delivered in an integrated fashion. All partners, including youth, will have a clear understanding of roles and responsibilities and be held accountable for achieving positive outcomes.
- ***Culturally Competent:*** Services will recognize and respect the behavior, ideas, attitudes, beliefs, customs, language, rituals, ceremonies and practices characteristic of the family's culture.
- ***Least Restrictive/Least Intrusive:*** Services will take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and least intrusive available to meet the needs of the child and family.

These principles echo many of the values incorporated in best-practice models that have demonstrated results in reducing out-of-home placements, reducing the length of stay in residential care, improving child and family functioning, and increasing cost effectiveness. They should guide every aspect of the Wraparound Model and be an integral part of the training for all staff involved in this system of care.

Structure for Care Coordination

Strong care coordination must be an essential component of the Wraparound Demonstration Project because the targeted youth and their families will have complex needs, requiring multiple services and supports from different systems. Care coordinators will be the primary contact for the family, serve as the link to the various community services, and be responsible for ensuring quality service planning and delivery. The coordinators must also be skilled in working with a multi-disciplinary child and family team to craft a service package based on a family's strengths and needs rather than simply on what services are available.

For this core element, the Steering Committee addressed two major questions: 1) What responsibilities should the care coordinator assume? 2) What organizational entity should assume responsibility for care coordination?

In response to the first question, the Steering Committee recommends that care coordinators assume responsibilities in five areas: assessment of needs; service planning and delivery; linkage; advocacy and empowerment; and monitoring. Specific tasks are outlined in the following chart:

Care Coordinators: Recommended Responsibilities

Assessment of Needs

- Work with the child and family team to conduct a strength-based discovery.
- Identify family strengths, needs, and resources to customize services.

Service Planning and Delivery

- Assist the family in identifying who should be part of their child and family team and reinforce the family's comfort with team selection.
- Facilitate the child and family team process.
- Coordinate the team's development of a service plan and safety plan, including periodic review and modification of either plan as needed, while meeting regulatory and legal stipulations.
- Broker and clarify roles and responsibilities among team members regarding service delivery.
- Assure cultural competence in all aspects of service planning and delivery.
- Oversee transition and discharge planning.

Linkage

- Refer the child and family to services and supports identified in the service plan.
- Serve as the primary contact for family and service providers.
- Ensure accessibility to services.
- Ensure that required records and materials flow to the appropriate people in a timely fashion.

Advocacy/Empowerment

- Assist the family in clarifying and articulating their strengths and needs and in reaching their desired outcomes.
- Coach the family to manage their needed services.
- Let the family know they should maintain veto power.
- Advocate for the family and for service accessibility.

Monitoring

- Hold all team members, including the family, accountable for their part in the service plan.
- Help the family monitor their plan and budget.
- Track provision of various services provided monthly.
- Monitor the family's satisfaction with services and team process.
- Make sure there is a grievance process in place and that the family knows how to access it.

The Steering Committee then addressed the second question: which organizational entity should have responsibility for the Wraparound Model care coordinators. The Committee considered a range of options, including care coordination being provided by: the County, community agencies that deliver direct services, community agencies that deliver no direct services, family advocacy organizations, or a member of the child and family team.

The Steering Committee had a lengthy discussion of the various options and assessed the advantages and disadvantages of each alternative. Since a consensus could not be reached, the Steering Committee members voted for the preferred option. The overwhelming majority of the Steering Committee endorsed the following option: **Care coordination be provided by a family advocacy organization and/or an independent agency that does not provide direct services.** This direction reflects a departure from the current practice, where care coordination for SPOA programs is provided by agencies that also deliver direct services. By moving in this new direction, Steering Committee members felt that care coordinators would have the most independence and objectivity and the opportunity to focus solely on care coordination, enabling them to excel at this function and not be drawn into direct service. Family advocacy organizations were included as potential care coordination providers since they are experts at empowering families and able to address core issues - like cultural competence – head on.

Because of the demonstration status and relatively small size of the population to be served in year one, it is recommended that one care coordination agency be selected. This approach would be the most efficient and ensure consistency of care coordination during this formative period. The selected agency could be the sole provider of care coordination, or it could develop sub-contract relationships with several agencies but retain overall responsibility.

Strength-based Child and Family Team

The Steering Committee expects that the care coordinator work with and through a child and family team to respond to the service and support needs of youth served in the Wraparound Project and their families. Each child and family team will be customized, based on the individual circumstances and preferences of the

family. The care coordinator will help the family determine the composition of their child and family team and will then convene the team. A team may consist of family members; family-identified supports (e.g. extended family, friends, clergy, coach, teacher); existing and prospective service providers; a care coordinator; and a family support advocate.

The Steering Committee identified the following responsibilities for the child and family team:

- ***Conduct Strength-based Assessment:*** Assess the child and families' vision for the future, strengths, unmet needs and problem areas, priorities, and naturally arising family supports.
- ***Engage, Empower, and Support the Family:*** Engage and empower the family in the service planning and delivery process and support them in meeting their goals.
- ***Develop a Service Plan, including a Safety Plan:*** Based on assessment, develop a plan that builds off of the child and family's strengths, needs, and priorities and incorporates assistance from both formal services and family-identified supports. The plan should include clear goals and objectives and assign timeframes and responsibilities for child and family team members.
- ***Monitor and Update the Service Plan:*** Periodically review the service plan, assess satisfaction with the plan and effectiveness of strategies, and modify service plan as needed.
- ***Prepare for Transition:*** From the outset, openly discuss what should happen after service involvement and explore ways to step-down the intensity of services.

Meaningful Family Involvement

As described in the guiding principles and woven throughout all of the core elements, families are at the center of this initiative and should drive service planning and delivery. Key to family involvement is the availability of family support advocates. The Steering Committee recommends that all families participating in the Wraparound Project have the opportunity to partner with a family support advocate. The formation of Family Voices Network, Inc, an independent, not-profit organization, designed, created, and directed by family members, is near implementation and will facilitate the linkage of families to advocates. Family

Voices Network's mission is to ensure access to needed support, information, and services to all families in Erie County raising children with emotional, behavioral, and/or social disabilities.

Family support advocates will have the following responsibilities:

- Meet with the family with the primary understanding of learning about who they are.
- Present accurate information and options based on the needs of the family.
- Empower the family as a key decision maker. This is their plan.
- Mentor families to become their own advocate or care coordinator.
- Link families with community-based family supports.
- Attend child and family team meetings as a support/advocate to the family and not as a substitute for the family.
- Understand the wraparound process and promote it to the child and family team.
- Represent the voice of families in the design, delivery and evaluation of services.

Additional responsibilities for family support advocates may include: 1) conducting training and educational workshops; 2) facilitating family support meetings; and 3) providing care coordination.

To be considered for a family support advocate position, the Committee recommends that an individual be the parent or primary caretaker of a child who has received services in at least one of the following systems: mental health, Family Court, foster care, special education services, developmental disabilities, social services, juvenile justice. He or she must also have demonstrated the ability to navigate the system(s) they have received service from; have good verbal and written communication skills; and have an understanding of, and demonstrated ability to, work in partnership with parents, natural supports, and human service professionals.

Flexible Funding

Based on the costs of Kids Oneida, the Monroe Youth and Family Partnership, and Wraparound Milwaukee, the annual cost of serving 50 youth and families through the Wraparound Demonstration Project is expected to be approximately $1.6 million to $2.0 million, excluding Medicaid. These costs include the staff and administrative expenses of the care coordination agency and the community services provided to the 50 youth served through the model. The projected cost presumes that: 1) service coordination will be staffed at a ratio of one care coordinator per nine youth/families and 2) the Demonstration Project will not directly fund any residential or inpatient services provided to the 50 youth during its first full year of operation. Appendix A provides a sample budget for the Wraparound Demonstration Project.

The Wraparound Demonstration Project will be supported through child welfare funding and Medicaid funding. The child welfare funding will be used flexibly to purchase whatever services and supports are needed to maintain youth at home and in their communities. Medicaid funding will be restricted to support Medicaid eligible youth and services. However, Erie County will take advantage of any new flexibility in Medicaid services and eligibility afforded to counties through the restructuring of the Home and Community Based Waiver, currently under consideration by New York State. The care coordinator will authorize expenditures for services based on a plan developed by the child and family team and signed off by the family.

Adequate and Accessible Community Services

One of the guiding principles set forth by the Steering Committee is that "Children will have easy access to a comprehensive array of services when they need them and at the level of intensity that is needed." With the aid of flexible funding, system of care models like Wraparound Milwaukee and Kids Oneida have adopted a "whatever it takes" philosophy to serve a child at home and in their community and have expanded their service continuums to include non-traditional services and supports, including mentoring, respite services, in-home services, community supervision, youth development services, and discretionary funds. These programs

also support more traditional behavioral health treatment and residential services.

After reviewing the service menus of Wraparound Milwaukee and Kids Oneida as well as service gaps identified through the Blueprint for Change stakeholder interview process, the Steering Committee generated a list of services that members felt were especially needed in Erie County to be able to effectively respond to youth and their families in the Wraparound Demonstration project. These are presented in Appendix B.

Staff Development on New Service Delivery Approaches

The successful implementation of this Demonstration will require the County to place a priority focus on staff development. Policy makers and program managers will need to understand and fully support the implementation of the guiding principles and the core elements of the Wraparound model. Care coordinators, family advocates, county staff and service providers that are most closely associated with serving high need youth will require more in-depth training to implement the core elements. Key topics that will need to be covered include: implementing strength-based and culturally competent approaches to assessment and service delivery; creative service planning that truly embodies the "whatever it takes" philosophy, working effectively as child and family teams; and shifting the paradigm of professionals as "experts" to professionals as "partners."

The County's training approach for the Wraparound Demonstration Project should go beyond "one-shot" exposure events to include a more sustained, intensive, and experiential model. The training approach for the Demonstration Project should also be developed and implemented in tandem with the County's staff development plan for the other SPOA care coordination programs.

Ongoing Evaluation

An evaluation strategy is needed for the Wraparound Demonstration Project so that the Executive Committee can determine the success of the initiative and have solid data to inform expansion decisions. The Steering Committee identified four areas that should be incorporated into the evaluation strategy:

- ***Customer Satisfaction:*** The Project should assess both the child's and the family's satisfaction with services and the child and family team process.
- ***Child and Family Outcomes:*** The Project should also track changes in behavior and functioning. Baseline data should be gathered at enrollment and then at discharge. It would be ideal to continue tracking child and family outcomes at 6 and 12 months post discharge. The following measures were suggested:
  - out of home placements and length of stay in care;
  - inpatient hospitalizations and length of stay in care;
  - emergency room visits;
  - school attendance;
  - drug and alcohol use;
  - child and family functioning;
  - finalized adoptions for those children whose goal is adoption; and
  - violations of probation for those children on probation.
- ***Service Utilization and Cost:*** The Project should track and analyze the number and type of services used by families and the frequency of utilization by service type. In addition, cost data should be gathered, including information on monthly and total costs for serving children in this initiative.
- ***Adherence to Guiding Principles:*** The Project should examine tools to assess adherence with the guiding principles among care coordinators and service providers participating in the initiative.

Leadership and Oversight Structure

The Steering Committee endorses the continuation of an Executive Committee to provide oversight and management of the implementation of the Wraparound Demonstration Project. However, the Committee recommends that the membership of the Executive Committee be expanded to include representatives of provider coalitions to set a partnership tone and incorporate the insight of providers during implementation and operations.

The Steering Committee also recommends that an Implementation Team be formed to assist with the implementation and initial operation of the Wraparound Demonstration Project. Membership of the Implementation Team should include a core set of the individuals on the Wraparound Steering Committee and members of the County's Tier II structure to ensure continuity from the Wraparound conceptualization and effective coordination with on-going SPOA operations. In addition, the Wraparound Demonstration Project should be included in any enhancements to the current SPOA care coordination programs, such as additional training, technology improvements, and evaluation tools. The goal is to have one Erie County system of care for high need youth and their families.

The graphic below illustrates the organizational structure for the Wraparound Project during its implementation:

Organizational Structure for Wraparound Demonstration Project

Executive Committee

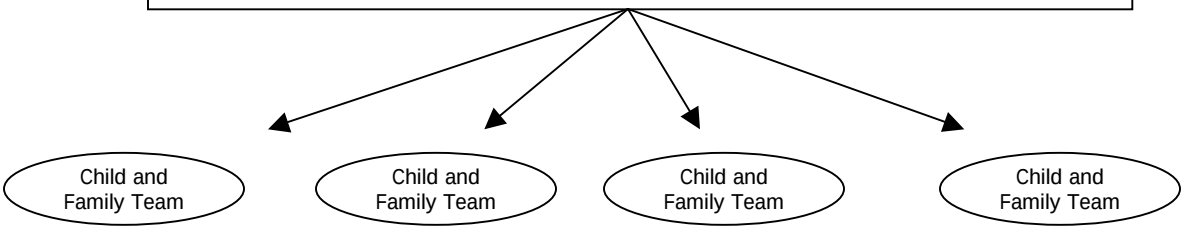
- Making senior level policy decisions related to implementation of the Demonstration Project.
- Monitoring the overall implementation and operation of the Project and making adjustments and improvements as needed.
- Reviewing and authorizing recommendations from the Implementation Team.
- Pursuing needed system, policy, and fiscal reform at the County, State, and Federal levels.
- Identifying and addressing service gaps.
- Monitoring the adequacy of fiscal and staff resources and identifying public and private funding sources to sustain and expand the initiative.
- Establishing an evaluation strategy to assess the impact of the Wraparound Demonstration Project at both client and systems levels.
- Determining whether to expand the initiative and establishing a strategy for expansion, if needed.

Implementation Team

- Develop the Request for Proposal for selecting the care coordination agencies.
- Establish the mechanisms for paying the care coordination agencies and vendors for services.
- Ensure staff are trained in wraparound principles and approaches to service delivery.
- Create reporting requirements and accountability standards at all levels.
- Identify evaluation strategies.
- Monitor implementation and troubleshoot problems.
- Resolve cross-system issues affecting implementation.
- Publicize the implementation of the Wraparound Model and the benefits of the Wraparound approach.
- Convey major issues and successes to the Executive Committee.

SPOA Screening Committee

Designated Care Coordination Agency



SECTION III: NEXT STEPS

This paper lays out an exciting and new direction for Erie County for serving a cohort of high-need youth and their families that is grounded in best practice research on integrated systems of care and wraparound approaches to service delivery. While substantial work has been done in reaching agreement on the core elements of an Erie County model, more work is needed to bring this model to fruition. The Steering Committee recommends the following next steps:

- Meet with the Executive Committee to present the Steering Committee's recommendation and discuss any modifications to the approach.
- Secure funding for the Wraparound Demonstration Project.
- Form an Implementation Team to prepare the specific policies, procedures, and strategies needed for implementation.
- Ensure alignment and coordination of the Wraparound Demonstration Project with other County initiatives aimed at high-need youth and their families.

With sustained leadership and focus, the Steering Committee anticipates that the Wraparound Demonstration Project could be up and running and serving youth and families by the second half of 2004.

Appendix A
Sample Budget for Wraparound Demonstration Project

Cost Item	Assumptions	Cost
Service Package (excluding Medicaid funded services)	$2,000 - 2,500 per month X 12 months X 50 youth	$1,200,000 - 1,500,000
Care Coordination Agency: Staff	6 care coordinators and one supervisor; 9 to 1 ratio of care coordinator staff to youth/family	$280,000 - 350,000
Care Coordination Agency: Administration	Includes space, training, equipment, travel, utilities, phone, etc.	$120,000 - 150,000
Total		$1,600,000 - 2,000,000

Appendix B
Services Identified by Steering Committee as Needing Additional Capacity

Steering Committee members identified the following services as needing additional capacity to respond for the Wraparound Demonstration Project (not listed in any priority order):

- Discretionary Funds
- Mobile Crisis Services
- Foster Family Homes
- Therapeutic Foster Homes
- Crisis Respite
- Crisis Home Beds
- Respite (e.g., planned and overnight)
- Life Coaches
- Mentoring (especially male mentors)
- Recreation/Camp
- Child Care
- Truancy Interventions
- Intensive Supervision, including evening reporting centers
- Vocational/Technical Services for older adolescents, including job coaches
- Parent Aide/Housekeeping
- Parent Skill Building, especially capacity to provide in-home support and feedback on parenting
- Group Therapy
- Individual and Family Therapy

- Specialized Therapy (i.e. for sex offenders, dually diagnosed)
- Child Psychiatric Services, including assessments, medication reviews, second opinions
- Medication Trial
- Partial Hospitalization
- Translation Services
- Hours of services to meet the needs of working parents