FOCUS: Operationalizing Systems of Care Principles and Bringing Case Management into the 21st Century

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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

- **Universal Health Promotion Level**: 80%
- **Focused Intervention Level**: 15%
- **Targeted Intervention Level**: 3%
- **Intense Intervention Level**: 2%

- **General Services**: Less complex needs
- **FOCUS**: More complex needs

#LEADINGCHANGE
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
Wraparound

Underlying Needs

Child & Family Team

Child & Family Team

Child & Family Team

Child & Family Team

#LEADINGCHANGE
A Care Coordinator integrates the work of system partners and other natural helpers so there is one coordinated plan.
A Care Coordinator coordinates the work of providers & informal supports to ensure coordination & accountability of all services and supports

- Care Coordinator partnering with Caregiver & Youth
- Behavior Health
- Juvenile Justice
- Child Welfare

ONE PLAN based on family needs

Formal & Informal Supports & Services
- Crisis Response
- Out Patient Services
  - Neighbors
  - Friends
  - Faith-based
- Community Supports

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13 GUIDING PRINCIPLES FOR SOC

FOCUS was designed to support achievement & operationalization of these 5 principles:

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports that address emotional, social, educational and physical needs, including traditional and nontraditional services and supports.

2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based perspective and an individualized service plan developed in true partnership with the child and family.

3. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services.

4. Provide care management at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner.

5. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of goals, quality, effectiveness, and outcomes at the practice and child and family level.
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
FOCUS

Created to operationalize values within a SOC framework for 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.
Intermediate Care Coordination

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

- **Families** are laughing – we must look for ways for families to have fun and build connections and relationships
- **Outcomes** – crucial to monitor if things are getting better
- **Coordination** – Is everyone working together toward a common goal
- An **Unconditional Positive Regard** for families – genuine acceptance
- The commitment to a **Short-Term** process – working to build community resources and commitment to empowerment and sustainability with minimal system reliance
What are the common factors leading to positive outcomes?

- Family’s own ideas
- Monitoring if things are getting better
- Building hope
What Makes Care Coordination Unique?

<table>
<thead>
<tr>
<th>Individualized</th>
<th>Family Anchored</th>
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<tbody>
<tr>
<td><img src="image1.png" alt="Person Icon" /></td>
<td><img src="image2.png" alt="Anchor Icon" /></td>
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<table>
<thead>
<tr>
<th>Comprehensive</th>
<th>Accountable</th>
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<tbody>
<tr>
<td><img src="image3.png" alt="Circular Arrows" /></td>
<td><img src="image4.png" alt="Compass Icon" /></td>
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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 should 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 informants and information gathered should be incorporated into the planning process.
• The Care Coordinator is the locus of accountability responsible for managing care and outcomes across systems and environments.
Accountable

• The Care Coordinator should be monitoring the services and supports for completion as well as impact and satisfaction.

• Progress around the reasons for referral should be tracked overtly with the family. The plan should be 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.

• Families should drive the care planning process which includes reporting out of need being met, satisfaction with care, and modifications to the plan.

• The care planning process should allow 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

Engage

Plan

Monitor

Adjust

Transition
Role of Care Coordinator

1. 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.

2. 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.

3. 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.

4. Monitor and adjust the plan with the family when they provide feedback on what is working and not working as well as tracking if the behaviors are getting better.
Care Coordinators should also...

• Serve as the hub of information gathering, sharing & dissemination.
• Work to address & incorporate information from relevant people involved with the family around the reason for referral
• Be knowledgeable about available services, community resources and supports & able to link families to these
• Research multiple options & provide them to families so they can make informed decisions regarding ‘best fit’
• Make referrals & schedule appointments
• Assist with development of the service array & maintaining that information for the organization
• Collect & maintain data around utilization of supports and services, behaviors changing, & family satisfaction
Basics of Planning

Supports & Resources

Reason for Referral

Functional Strengths

Contributing Factors

Family Vision
Are things getting better?

<table>
<thead>
<tr>
<th>Family Vision:</th>
<th>How close are we to reaching the vision?</th>
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<td>1</td>
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Outcome 1:

<table>
<thead>
<tr>
<th>Base-Line:</th>
<th>Start Date:</th>
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<tr>
<td>Current:</td>
<td>End Date/Duration:</td>
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Contributing Factors:

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Family Satisfaction</th>
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Monitoring and Adjusting

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, and adjust the strategies accordingly
  - **Transition** – If things are getting better. How will we know when the end is near
### Sample Quality Review

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<tr>
<th>Caseworker:</th>
<th>Supervisor Completing Checklist:</th>
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**Type:** Documentation Review | Documentation Review  
**Supervision Session:**___| Supervision Session  
**Field Observation:** Engagement Session | Engagement Session  
**Monthly Review:**___| Monthly Review  
**Other (explain):** | Other (explain)  

#### Engagement with the Family/Information Gathering:
- Completed within 30 days

<table>
<thead>
<tr>
<th>Activities</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Behaviors placing youth at risk</td>
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<td>CM understands the behavior that led to the referral</td>
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<tr>
<td>CM understands how long the behavior has been occurring and when help was first received</td>
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<tr>
<td>CM is able to discuss the risk behavior openly without shame or blame</td>
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#### Strengths
- 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) |     |    |          |
Contact Information

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