Private Provider & Wraparound Flexibility

Doug Crandall, COO
(provider in Washington State)

Catholic Community Service Family Preservation System

Family Preservation is a system within Catholic Community Services of Western Washington (CCS), a private non-profit agency that provides a range of social services including mental health, housing, long term care for older adults, child care, and other treatment and supportive services. The Family Preservation System provides services through contracts with mental health and child welfare authorities, is licensed as both a community mental health agency and a child placing agency, and is accredited by the Council on Accreditation.

Catholic Community Service's Family Preservation System operates from an unwavering belief that children need their families and families need their children. Since 1974, with the inception of the original "Homebuilders" program in their Tacoma, Washington (Pierce County) location, Family Preservation has continued to explore and develop innovative approaches that promote safety, stabilization, child and family well being, and permanency. As the Family Preservation System evolved, incorporation of Wraparound principles and approaches was very natural and exciting.

Early Wraparound Efforts and Experiments (1990 – 1993)

Wraparound efforts in Washington State and in Pierce County really got under way in the early 1990s when several initiatives came together. Washington State was implementing the Child and Adolescent Service System Program

(CASSP) initiative; the state Legislature mandated that local mental health authorities develop an integrated plan for mental health services to children, including those administered by other child serving systems; and the state level Mental Health Division had staff in the children's unit who had climbed on board the wraparound wagon and were bringing experts in the field to Washington to help whip up excitement. On a local level, Pierce County had just finished a broad community planning process to assume local administrative control of the publicly-funded mental heath system, and had just lost control of unrestricted access to one of the state's children's long term psychiatric facilities. This moved local leadership in mental health and other child serving systems into a closer partnership. Pierce County's child serving systems (mental health, child welfare, developmental disabilities, juvenile justice, public health and education) came together in the spirit of shared responsibility for children and began experimenting with the Wraparound framework by serving a few select children and their families. An interagency administrative team was formed for the purposes of planning and oversight of this initial wraparound effort.

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Catholic Community Services first became involved through a contract with the local mental health authority (under the oversight of the interagency team) to hire the first wraparound facilitator for a pilot project for ten children and their families. This individual was to facilitate child-and-family-team development, planning and implementation. Individual plans were to be funded with each system contributing staff resources, services or payment. CCS was the fiduciary/administrative agent. Services were expected to be available from existing community providers, including CCS, through categorical funding streams. Flexible funds were available to assist with any needs that could not be funded with categorical dollars. There was no dollar limit established or allocated for flex funds and expenses were paid on a cost reimbursement basis by the mental health authority.

Child and family teams were convened with much care given to educating team members about the principles of this novel approach and the process that would be employed. Systems began behaving differently – with more flexibility and creativity. For example, a child on probation for fire-setting behavior performed her community service hours washing trucks at a fire station. Sex offender treatment specialists began writing reports that contained statements of hope for youth, balancing the warnings of risk. This creativity was in part due to the newness and excitement of the approach, measured with a challenge to come up with the most innovative strategies possible. Systems were also beginning to trust each other and recognize the shared benefits of success.

Successes were immediate and exceptional. "Angie" was a 16 year-old with an extensive history of self harm and assault, often self-mutilating to the point that she required surgeries to repair the damage. She had received outpatient treatment for nine years, had experienced multiple psychiatric hospitalizations as well as nearly two years in a long term psychiatric facility. Due to past arson and assault charges, she was involved with juvenile court and probation. Each of the schools she had attended since 6th grade reported multiple behavioral issues and were quite reluctant to accept her back, citing concerns for student safety. She was released from a long-term psychiatric facility to her mother and siblings. In order to get a fresh start they moved to a rural community where staff accompanied the mother and daughter as they introduced themselves to neighbors. Work with the school resulted in Angie's attending on a limited basis while she attained her GED, and she participated on the school swim team. She was also assisted in getting an afternoon job with

a children's party planning business. Self-harm and assaultive behavior was essentially eliminated, being replaced with a sense of belonging and purpose. At the system level, administrators were astounded at the relative ease with which children and families experienced success.

Mental health was by far the largest provider of services, with child welfare a distant second. Other systems provided direct treatment or support services minimally and only occasionally. This was mainly due to the population of children being selected for this pilot, which tended to have extensive outpatient and institutional mental health histories.

Catholic Community Services proved to be both a highly capable administrative entity and direct mental health service provider. They were extremely flexible and creative in both capacities, developing supports and resources to meet needs and simplifying administrative issues such as immediate payment for goods and services. Quickly, CCS became the primary provider of mental health treatment and support, while other mental health agencies struggled to create responsive, immediate and flexible services. CCS also had the benefit of being a licensed child placing agency, and therefore had the capacity to utilize specialized foster homes for brief respite stays.

Second Generation Wraparound Efforts (1993-2000)

In the early to mid 1990s, the community context changed. The state mental health system was granted a 1915 (b) waiver to Title XIX of the Social Security Act, allowing implementation of managed care through capitated arrangements with local mental health authorities (called Regional Support Networks or RSNs in Washington). The mental health benefit design, under the rehabilitation option, was fairly broad and included a treatment modality for High Intensity Treatment. This modality included the full range of mental health services available in the Medicaid State Plan, and twenty-four-hour-per-day and seven-day-per-week access provided through a multi-disciplinary team in the community. Shortly thereafter, child welfare initiated a behavioral rehabilitation service (BRS) option utilizing Title XIX funds for those children who lived in group care or therapeutic foster care settings. Funding for this service included coverage for routine mental health care. Both the state mental health and child welfare authorities indicated that Medicaid mental health funding could not supplement this service since it would be viewed as "double dipping." The end result was that while mental health had achieved greater flexibility in funding, child welfare had created a categorical funding stream that inhibited blended funding.

When child welfare put out a bid for BRS services, CCS responded as the lead agency for an alliance of providers and was awarded the contract. This forced mental health and child welfare to evaluate how they would continue to partner in response to high needs children and families in the community. In evaluating the children identified as meeting criteria for either wraparound or high-end BRS (essentially the same criteria as wraparound), the number was about the same from each system. Given this, a decision was made to have mental health fund their share through wraparound and child welfare through BRS. The systems had abandoned the "it's your kid' mentality and were motivated to demonstrate such through collaborative funding arrangements, yet this solution seemed the most streamlined and administratively simple. They agreed to jointly monitor service utilization and expenditures with the expectation that things would change if the data presented the need.

During this time, a majority of the services and supports provided to "wraparound" children and families was being delivered directly by CCS. They had developed a cadre of skilled facilitators, clinical professional staff, psychiatric services, paraprofessional support, respite homes and parent partners. The function of the facilitator was

integrated into the role of the lead clinician from the agency. This was in part a financial decision. Since clinical work at CCS was always delivered nontraditionally, absorbing this role into that of the primary clinician seemed less confusing to both the family and staff.

At this point, the local mental health authority and CCS were invested in moving from a fee-for-service model to a case rate payment. An initial analysis of aggregate costs showed that a surprising percentage of expenditures fell into the clinical indirect category, which would not be considered reimbursable under a fee-for-service arrangement. These costs included higher levels of supervision, coordination between CCS staff, two-to-one staffing and travel. This was also a new way of doing business for CCS and the agency had not fully explored how to account for all activities to maximize direct billing. This was somewhat alarming to senior county mental health administrators and further analysis was requested.

Rather than pursue a retrospective study, it was decided to build a case rate based on the actual cost of plans. Catholic Community Services facilitators developed individual plans of care for each child/family served. Local mental health and CCS administrators "negotiated" the type and frequency of services, including flex funds, and established a cost per plan. Services were costed on a fee-for-service basis with hourly rates established by staff position and service type (e.g., therapist at $82/hr; parent professional staff at $11/hr; parent partners at $9/hr; etc.). Plans were funded for three months with a monthly reconciliation of actual expenditures to the budgeted amount. CCS could request additional reimbursement after the fact up to an established maximum consideration. Individual monthly plan amounts varied greatly, ranging from around $1,000 up to $14,000.

This process proved a real test of the strength of the relationship between the funder and provider. Arguments occurred, accusations of micromanagement abounded, and a few tears were shed. After 15 months, the RSN and CCS agreed to a monthly flat rate ($3,200). Funding came from a combination of state/federal Medicaid and state-only dollars administered by the local mental health authority. This rate would be authorized for up to one year, with decisions about authorization and re-authorization falling to the local mental health authority.

CCS had established itself as a niche provider for children and families presenting with the most challenging behaviors and complex needs. They helped the RSN achieve the lowest utilization of children's long-term inpatient care in the state. They also contributed greatly to the local child welfare system's success in keeping children in their own community and out of institutional and group care settings.

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This was an exciting as well as challenging time for CCS. It was a period of rapid growth, and while service provision was sailing along smoothly, there was a need to convey clinical and administrative issues to two different funders. It was necessary to shield staff and practice from bureaucratic and funding rules so they could focus on being creative, flexible and responsive. Fortunately, the relationship with funders continued to be strong, nurtured through participation in regular staff meetings, trainings and celebrations.

Present Arrangements

The current structure for providing wraparound within CCS has matured and been integrated into all aspects of the agency. Services have expanded throughout southwestern Washington and into Oregon replicating results experienced in Pierce County. Funding in Pierce County continues through a contract with mental health, with the all-inclusive flat rate and an expected "target" number of individuals served per month determining the contract's upper payment limit. Services are reported to the RSN through the use

of a per diem "wraparound" code, with CCS maintaining individual encounter data for management purposes.

Services are provided through a team of CCS staff in concert with the child and family, staff from other systems involved with the family and natural supports. Decision making is driven by families within a team context, with resources readily available when and where they are needed. Lead clinicians have the authority to bring other CCS staff resources (paraprofessional support, parent partners, psychiatric services and respite) to the team and authorize the use of flexible funds (up to $250) with only front-line supervisory authorization. Authorization for expenditures above that amount are made by managers and directors who are available on a 24/7 basis. Specially designated client needs checking accounts and agency credit cards are readily available to cover costs whenever and wherever they occur. Expenditures are tracked by client and fund source through an integrated clinical and fiscal management information system. Resource utilization is managed carefully by supervisors and managers through a host of management reports that include flex fund use, resource utilization, staff productivity and client outcomes.

Maintaining a competitive pricing structure has allowed CCS to stay in business even as some communities have reduced capacity. This reduction in capacity has been in large part due to a move to what is basically a Medicaid-only service delivery system in Washington State. Previously, up to twenty-five percent of children and families served did not have Medicaid and were covered with state-only funding. Economy of scale is another factor that has allowed CCS to maintain a fairly priced capacity.

Challenges

- *Conflicting Interpretation of Federal and State Financial Rules.* Federal and state communications often present contradictory viewpoints about what is allowable under Medicaid. At the federal level there is support for medical model care under a fee-for-service arrangement. Although Washington's Medicaid state plan modality does not mention wraparound by name, it includes an intensive treatment service allowing for a team-based flexible approach. However, state structures make implementation a challenge. For example, when the state was revising their coding rules, they took the position that two-to-one staffing was allowable only when there is a risk of safety to staff in a crisis situation. Wraparound relies on a team approach and may include two staff working with a family in a variety of other situations, including team meetings, family outings, and for the safety of the client or others. Under our per diem reporting structure, this is not a problem; however, questions abound as to whether this "bundling" of services will continue to be permitted.
- *Managing To the Practice Model: Keeping Fresh.* There is an inherent challenge in balancing creativity and flexibility with

adherence to process. While these are not mutually exclusive, they can cause friction, and when process takes priority over innovation and responsiveness, families may be left behind. This also includes attention to fit, so that the right response is truly tailored to specific needs. The danger is that without logical decision making it may be more expedient to just plug in the same thing or follow the same procedures in the name of fidelity.
- *Managing Perceptions of "Entitlements."* This may originate within systems and be-

tween families. It may interfere with the planning process when a specific direct service or flexible funds are viewed as a need instead of a planned strategy in response to one. For example, one family may be stretched and exhausted and receive frequent respite care. Other families may hear of this and feel they should receive the same. Referring staff in other systems may also communicate to the family or team the need for a particular response prior to the planning process. This sets families up for disappointment and makes the process of engagement and trust building more difficult.

- *Balance Between Planning and Doing*. The wraparound process, by its nature, is a balance between providing interventions and facilitating teams. Staff must be skilled, flexible and comfortable with this dual role. A challenge for any provider is creating the ability to implement "just in time" interventions, services or supports while maintaining a capacity to lead an ecological team in reaching agreement.

Lessons Learned for Providers and Funders

1. *Ensure that Mission and Values Drive Practice*. This may sound simple but should be the significant driving message of leadership of the provider agency. This requires constant self-reflection as well as organizational sophistication in reviewing the desirable characteristics of all staff and how decisions are made and how services are delivered and evaluated. Likewise, the funder has to be tolerant and supportive of a mission focused provider.
2. *Balance Provider and Larger System Issues. Providers have to accept that they can't change the whole system*. A provider becomes an option within the system. Funders have to continually manage the system change issues within the larger system. Funders should avoid making the provider responsible for system change.
3. *Regularly Re-evaluate your Commitments*. In Pierce County, the system-level outcomes have been so successful that there is a risk is that the provider is taken for granted. What were previously seen as monumental successes are now commonplace. As the bar rises from year to year, the provider runs the risk of no longer being seen as essential. It's a good idea to formally build in commitments at regular intervals over the years.
4. *Build Continuous Partnerships with Funders*. Providers have to partner with funders continually. Don't take supportive funders for granted. Leadership changes and as a provider one must to be prepared to continually demonstrate worthiness. Funders have a right to this. Strategies for identifying value and worth include identifying outcomes and results for the right price.
5. *Take the Broad and Deep, Long and Short View*. Providers must pay attention to all things at all times. The skilled administrator of a private agency has to attend to practice issues to ensure the work force stays innovative. The administrator must consider local, state and federal funding issues as well as legislative issues. Funders who are attempting to be supportive of a private, non-profit that is operating wraparound must attend to the possibility of mixed messages from other sources of the bureaucracy including contract management, accounting and certification. Housing wraparound in a private non-profit doesn't mean the funder only has to execute a contract, but must also be prepared to create supports and structures to insure the contract stays fresh, flexible and innovative.

Author

Doug Crandall has been involved with wraparound implementation and funding since its inception in Washington State in the early 1990s. He was the Children's Manager for the local mental health authority in Pierce County for 17 years and is currently the Chief of Operations for a provider

agency delivering Wraparound services in Washington and Oregon. Doug has been involved in all aspects of wraparound development in Washington, including standards, rate setting and outcome monitoring.

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