

Supporting Wraparound Implementation: Chapter 5b.2

Family Voices Network of Erie County: One Community's Story of Implementing System Reform

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Our community has a rich tradition of providing resources to individuals and families in need. As our service infrastructure developed over the years, however, the service delivery model for families and children in need of behavioral health services resulted in restrictive and categorically funded programming. During the late 1990s and early 2000s, our county government went through a period of innovation, which, in hindsight, we consider the beginning of the implementation of a new way of doing business with youth and families requiring mental health services. Through collaboration with our system and community partners, we have implemented a culturally competent wraparound service delivery model within and across our county's child-serving systems of care for children by infusing values and principles of strength-based assessments, individualized service planning, increased use of natural supports, and partnerships with families and youth at all levels. The effective use of practice and outcome data has been a key ingredient in our system reform efforts.

This chapter describes our community's journey toward implementation of wraparound and system of care, and the role that the use of data has played in that journey. According to the National Implementation Research Network (NIRN), "Implementation is defined as a specified set of activities designed to put into practice an activity or program of known dimensions" (NIRN, 2009). Our community's experience in implementing system reform efforts can best be described using the six stages of implementation as described by NIRN. These are: 1. *Exploration and Adoption*, 2. *Program Installation*, 3. *Initial Implementation*, 4. *Full Operation*, 5. *Innovation*, and 6. *Sustainability*.

I. Exploration and Adoption

Erie County is a mixed urban, suburban and rural area in western New York State with a population of approximately 950,000. It includes Buffalo, the second largest city in the state, with a population of nearly 260,000. According to U.S. Cen-



sus figures, Buffalo is the third largest poor city in the nation, behind Detroit and Cleveland. In 2007, 28.7% of the city population was living in poverty, including 39% of children. A number of factors set the stage for our community's development and expansion of reform efforts for our system of care for children with serious emotional or behavioral health conditions and their families.

A Blueprint for Change

A Blueprint for Change initiative by county government in 2000 changed the mindset of human services delivery. The county executive, elected on a mandate for change, sought to make organizational and service delivery improvements that would result in more cost-effective, integrated, and outcome-based services to children and families. As a result, joint demonstration projects across mental health, juvenile justice and child welfare services were implemented to provide limited flexible wraparound services to children at high risk for out-of-home placement. A pilot model that used blended funding through New York State Office of Mental Health for high-need children culminated in the creation of a "Single Point of Accountability" (SPOA), simplifying the referral process.

Systems Collaboration

A needs assessment conducted with 134 direct service providers, and 32 parents found that children with serious emotional or behavioral conditions who had similar needs and challenges were represented across all child-serving systems (Kernan, Griswold, & Wagner, 2003). Data was collected about youth receiving services from various systems including foster care, juvenile justice and mental health. This data included diagnosis, service history, needs, gaps, and barriers to services. Additionally, focus groups were held with families and youth in preparation for submission of a proposal for a grant funded by the Center for Mental Health Services (CMHS). Table 1 shows that youth in placement and at risk of placement had similar needs. Recommendations to the county were to integrate child-serving systems and expand community-based and individualized services for children, youth and families. The Departments of Social Services (SS), Juvenile Justice (JJ), and Mental Health (MH) collaborated with each other and with families, and this helped build the trust and relationships that were crucial to our request for federal funding through CMHS's Comprehensive Community Mental Health Services for Children and Their Families Program.

II. Program Installation and III. Initial Implementation

When federal funds were awarded in 2004 to Family Voices Network of Erie County, our goal of cross-system cultural change for children with serious emotional disturbance and their families could be realized. The initial management team had been known as the 'Implementation Team', and included representatives from the county's child-serving agencies, service providers, and the family organization who met bi-weekly. Once the CMHS funds were awarded in 2004 this team became the 'Management Team,' and expanded to include social marketing, evaluation, and the youth director. Within a year, we had a cultural competency consultant on board part time. Our cross-system governance structure began to build collaborative relationships with families, family court, Social Services, Juvenile Justice, and youth. Our Executive Committee, which includes representatives of family and youth, as well as city, state and county

Table 1. Needs Assessment Range of Services Needed

	Children in Placement Need Service (N=64)	Children at Risk of Placement Need Service (N=70)
After-school programs	48%	46%
Mentoring	48%	31%
Respite in-home/overnight	46%	34%
Respite (mental health)	19%	29%
Parent training and education	27%	39%
Skill building	28%	24%
Transitional case management	22%	13%
Intensive case management	18%	46%
Mental health advocacy	20%	14%
Sexual trauma treatment program	17%	13%
Integrated treatment and case management	22%	26%
Vocational education	20%	9%
Psychiatric evaluation	8%	23%
Medication management	6%	20%
Child and family recreation	11%	29%
Parent support group with family	20%	27%

commissioners, makes policy decisions which affect the Management Team, which is the working group that implements the decisions made by the Executive Committee. Because our Management Team is so large—with as many as 45 attendees representing all child-serving agencies, family members, care coordination supervisors, cultural competency, and youth—we have sub-committees making recommendations to the Management Team on specific issues. For example, the cultural competency committee will look at data broken out by race/ethnicity or socio-economic status, identify disparities, and make recommendations for improvements to the Management Team. The

Management Team subsequently decides by consensus of the group to make changes in service delivery or training based on these recommendations.

Family-Run Organization and the Youth Coordinator Position

With the CMHS grant award in 2004, the family organization Families' Child Advocacy Network, was able to receive funding to hire family support partners and jump-start activities. Family members began to attend the Management Team meetings. They took part as full members, and were

compensated for their time on an hourly basis. Our Youth Director had input at each level of governance including the Executive Committee. There were monthly Roundtable meetings that allowed

family members to become full participants in the evaluation design, data collection, data interpretation, and decisions made regarding presentation and use of the data.

An example of family input was the decision to track how many days it was taking from the referral date to the start of services. Families complained that weeks would pass before services started or they heard about their status regarding services. Another issue that was important to families was transition planning. Both of these family priorities became focused areas for improvement and are monitored regularly. (Relevant data collec-

tion is discussed later in this chapter.) A working committee of family members, youth, the social marketing director, and the evaluator began to meet monthly to work on the website, newsletter, and family-friendly reports. This working group became the social marketing and evaluation team (S.O.M.E.) and was recognized by SAMHSA with a Silver level award for ‘Involving Family Members and Youth in Evaluation’ in 2008.

Strategic Planning Process and Logic Model Development

Within the first year of grant funding, a core group of individuals from our community of stake-

holders—the project director, evaluator, family director, youth coordinator, clinical director, and social marketer—met weekly over the course of four months to create a first draft of our logic model, which encapsulated our strategic plan to affect change in our system of care. Conference calls with consultants Mario Hernandez and Sharon Hodges at University of South Florida were instrumental in putting our ideas to paper. We used our grant to develop our understanding about our target population, challenges, assets, goals and outcomes. We provided regular feedback on our progress to our Management Team.

Our logic model has become our central strategic tool for planning, evaluation, and continuous quality improvement, with short- and long-term outcomes reviewed quarterly by the Management Team. By reviewing our logic model regularly, new team members become familiar with our goals and indicators of progress and more experienced members can bring up issues that need to be addressed. Changes to our logic model are made by consensus of the Management Team. For example, we recently agreed to an additional family, youth and child-level outcome, namely “increased family participation and empowerment.” Our logic model is a living tool, reflecting the dynamic changes in our community with our families and partners. Our logic model is featured as an exemplary model on the University of South Florida’s website (University of South Florida, 2009), and in the System of Care Handbook (Stroul & Blau, 2008).

Critical Data Dashboard and Fine-tuning the CQJ Process

Data management and reporting was a priority for the early leaders of system reform efforts. The county invested in an online, web-based system and required all agencies serving youth enrolled in Family Voices Network (FVN) to utilize this system, CareManager ©, for documenting care coordination activities consistent with wraparound practice, and, eventually, billing and invoicing. As our system of care developed and the county placed appropriate priority on ensuring that the model was achieving the desired outcomes, it became clear that we needed to monitor not only fidelity to practice but also outcome performance. Earlier efforts found us chasing “fires” with little

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ability to track the effects of corrective actions, or to truly gauge the size of the “fire.”

Reporting at this time was somewhat unfocused and untargeted, difficult to sustain, and lacking in transparency. As a result, in 2007 the county developed a ‘critical data dashboard’ which reports key practice and outcome metrics. Table 2 shows this dashboard, which was designed to be visually simple, provide a snapshot assessment of critical performance indicators, and be readily accessible to each care coordination agency and the county. The report format was designed so each care coordination agency (currently there are six) would receive its own monthly and year-to-date (YTD) data, as well as data providing a comparison with the system as a whole. For example, Table 2 shows ‘slot utilization’ for the month of August 2009. ‘Enrolled days’ are the number of days that families are in services, while ‘allocated days’ are the number of days that the agency is contracted to provide services. In the example shown for ABC Agency, there was an average of 40.1 enrolled days in August, which was 91% of allocated days. For the year to date (YTD), there was an average of 42.4 enrolled days which was 96% of days allocated. Looking to the right at the ‘overall Family Voices profile’ for the current month, 79.4% of allocated days were used, down from the year-to-date figure of 84.8%. Hence, ABC Agency is performing better than the FVN overall average for slot utilization. This information can be used by the agencies as benchmarks and to measure themselves against the overall average.

The county established quarterly dashboard meetings with individual agencies to discuss and review performance. In addition, the Management Team regularly communicates and resolves dashboard issues which are broader in nature. From early on in this process, meetings were not focused solely on specific measures of agency performance but rather on practices that would support proactive management and supervisory techniques. As the dashboard meetings began to reveal that agency supervision and clinical practices and outcomes were improving, the quarterly dashboard meetings were moved to once every six months for all agencies.

During calendar year 2008, the county contracted with a local agency to provide technical assistance (TA) in developing effective and focused

quality improvement (QI) plans for each care coordination agency. These plans utilized existing data to target areas of concern that, when addressed via the QI process, would improve specific performance outcomes that had previously been identified as being of concern.

Recently, after a review of the data trends over the past two and a half years, we were in a position to develop community outcome performance standards. It is important to note that this was done in collaboration with our community providers. Because of our rich database, our community was able to identify areas of concern and as a result we have successfully implemented practices to improve performance with respect to timely submission of progress notes, as well as timeliness of case assignment.

As a result of the successes experienced in utilizing the data dashboard, data informed practices, community learning tools, and quality improvement practices, the county has also begun to implement a data dashboard for other children’s behavioral health services.

We have found the following factors critical to the success of data dashboard utilization:

- Limit the dashboard to key variables most important to your community (if you look at everything you look at nothing).
- Make reporting visually simple (at-a-glance concept).
- Involve your stakeholders, especially in choosing what outcomes are important to them.
- Make data readily available and real time.
- Operationalize data; have early reviews addressing data reliability and make amendments if necessary.
- Use strength-based approaches—avoid using data as a “club.”
- Create buy-in across various levels of the organization.
- Share across all organizational levels including CEO and direct line staff.
- Make reports transparent as early on in the process as possible.
- Have regular monitoring and communicate expectations clearly.

Table 2. Critical Data Dashboard - Family Voices of Erie County Care Coordination ABC Agency (Note: data is actual, agency name is not), August 2007

Critical Data Element	Agency Profile				Overall Family Voices Profile			
	Current Month		YTD		Current Month		YTD	
	#	%	#	%	#	%	#	%
Assignment (# and % of referrals that the Single Point of Accountability assigns within 10 calendar days)	-	-	-	-	34	94.44	260	78.08
Slot Utilization (Enrolled days versus allocated days [monthly average])	40.1	91.13	42.4	96.36	358.97	79.42	383.61	84.87
Staffing Utilization (% allocated care coordination [CC] staff days filled by permanent CC staff [does not include days temporary coverage provided] [monthly average])	-	100	-	100	-	96.67	-	99.12
Length of Stay Current Enrollees w/LOS > 14 Months (# and % [monthly average])	2	5.41	1.75	4.18	30	8.33	34.75	9.09
Engagement (# and % assigned and closed but not opened) (# and % enrolled but discharged < 90 days)	0	0	4	5.41	5	7.46	31	4.99
	1	12.5	2	4.76	2	5.88	14	4.13
Change in CAFAS® (% of those enrolled with 10 point or greater change at 6 months) (% of those enrolled with 20 point or greater change at 12 months) (% of those enrolled with 10 point or greater change from enrollment)	6	100	25	96.15	13	100	143	87.2
	-	-	10	100	2	100	96	85.71
	7	87.5	34	80.95	26	78.79	254	76.97
Successful Discharge (minimum of 65% of enrolled will be discharged with "objectives met")	6	75	30	71.43	24	70.59	233	68.73
Community Based Care (% of enrolled youth who are discharged without having been placed in a Residential Treatment Center [RTC]) (# and % being placed in an RTC > 90 days) (# and % being placed in inpatient > 30 days)	8	100	41	97.62	34	100	299	88.2
	0	0	0	0	0	0	0	2.95
	0	0	1	2.38	0	0	17	5.01

- Implement a QI component and revise as necessary.
- Drill down to individual service providers to make necessary improvements in practice.

IV. Full Operation

About three years into our implementation, Family Voices Network (FVN) was fully operational and serving nearly 350 families a year; however, we were still in need of continuous quality improvement practices. At this point our system-wide data management system, CareManager ©, was fully operational and collected process, outcome, billing and accounting information for all services provided to children and families enrolled in FVN.



We received a SAMHSA CMHS supplemental award to support and bolster the essential vendor service delivery system that provided wraparound services to children enrolled in FVN and was expanded to the Family Services Team (FST) programs that operate in targeted neighborhoods in the City of Buffalo. This award was used to fund the creation of a new quality management organization, Community Connections of New York (CCNY).

As a grassroots non-profit, CCNY was created to provide evaluation, quality improvement, training, and technical assistance to care coordination and vendor agencies within the system of care. CCNY is also charged with expanding the vendor network to include new agencies responsive to the needs of families receiving services, while also enhancing the existing network with capacity-building projects such as human resource development

and training for professionals. CCNY works to promote access to culturally competent services and ensure voice and choice to families and youth during service selection.

As part of their evaluation process, CCNY uses methods that are anchored in a blended paradigm approach of utilitarianism (Patton, 1997) and realism (Kazi, 2003), combining the tenets of iterative stakeholder involvement and utility focused evaluation tools with statistical processes that help determine underlying patterns related to change in outcomes. As use of evaluation data is paramount, heavy emphasis is placed on working supportively with agencies in application of quality improvement practices such as the DMA-IC (Define, Measure, Analyze, Improve, Control) Model (University at Buffalo Center for Industrial Effectiveness, 2008). This tag-team approach of user-focused evaluation and quality improvement strategies resulted in a mental health community organized around practice and system change to achieve better services for youth and families.

To help build community capacity, CCNY offers trainings in various modalities that are customized to the learning style of the end user. The company delivers trainings in person and online. CCNY is the only authorized training provider for the Casey Life Skills Tools in the North East region, and in this role provides learners with knowledge and tools to perform life-skills assessments, create learning plans, and evaluate life goals for clients in their programs (Downs, Nollan, Bressani, et al., 2005). CCNY provides ongoing technical assistance to community partners in FVN by offering training on the quality improvement continuum and construction of the tools to help them implement the practices. The organization hosts various trainings on cultural competency, assisting attendees in learning the behaviors, attitudes and policies that facilitate cross-cultural work between individuals, organizations and systems.

Measuring Fidelity to the Wraparound Care Coordination Process

Measuring fidelity to the wraparound care coordination model was an early strategy outlined in our logic model. Our families wanted to participate in the quality improvement process and we needed youth and care coordination input to improve practice. The Wraparound Fidelity Index (WFI) was

chosen for use in monitoring fidelity because of its growing research base and support from the National Wraparound Initiative. Data for the WFI is gathered via a phone interview with the wrap-around facilitator (or care coordinator), caregiver (usually the parent or legal guardian), and youth. The WFI assesses adherence to the wraparound principles and activities (Walker, Bruns, Adams et al., 2004). The WFI has been conducted annually for the past two years, yielding information to the system of care on areas in need of improvement. Additionally, results from the 2007 WFI study were reported to system administrators in fall of 2007, and showed undesirable scores in fidelity for the transition phase of wraparound. This sparked development of case transition training and education programs for care coordinators, and mandatory transition planning in monthly family team meetings. Results were disseminated to a group of families and youth who made suggestions for improvements to the system of care. The orientation workshop, conducted by the Families' Child Advocacy Network for newly enrolled families, now includes a discussion about the transition phase of the wraparound process.

The research team completed the WFI again during the summer of 2008 to determine the magnitude of change in fidelity scores from 2007 to 2008. The WFI results showed significant improvements in the wraparound process in 2008 as perceived by the care coordinators and caregivers. High fidelity scores, as measured by the WFI, indicating adherence to wraparound principles and activities were in the mid to high 80 percentile.. Table 3 shows that the overall mean scores improved significantly from 2007 to 2008 for all re-

spondent types except youth. Total mean score increased from 80% in 2007 to 85% in 2008. Youth scores increased from 73% to 77%. The wraparound care coordination process had improved after quality improvements were made to training and service delivery. With lower mean scores given by the youth, youth engagement in the wraparound process became a targeted area for improvement in 2009-2010. The WFI will be conducted again in the Fall 2009 to measure these quality improvement efforts (Kernan & Pagkos, 2009).

V. Innovation

Having developed and maintained a well defined data base and a method for reviewing this data on a real time basis has provided us with the opportunity to utilize this data in ways we could not have possibly planned for only a couple years ago. After a review of the data trends over the past two and a half years, we were in position to develop, in collaboration with our community providers, community outcome performance standards. Table 4 shows the performance standards that each care coordination agency should meet or exceed in 2010. For example, each agency is contracted to provide services to a set number of families. The community standard for 2010 is that each agency will utilize 95% of its allocated slots. This is a critical metric in order to maintain timely access for families and youth. Likewise, staffing at each agency should be kept at 95% to ensure timely services to families. Another metric we follow is the percent of families discharged without having been placed in a residential treatment center. We aim for a minimum of 90% of families meeting this goal in 2010. By setting these performance standards we challenge ourselves to improve service delivery and outcomes for our children and families.

Moreover, the availability of our rich data base has given us the ability to identify areas of concern within our existing processes. We have made noteworthy progress in two critical areas, specifically 1) timely progress note submission, and 2) timeliness of case assignment. Data collected from January to July 2008 showed that only 36% of all referrals to FVN were assigned within 10 days. Families were made to wait for services at the point when

Table 3. Wraparound Fidelity Index Results

WFI Total Mean Scores			
	2007	2008	P value
Total Mean Scores	80.5	85.2	.001
Care Coordinator	87.7	90.7	.006
Caregiver	75.7	80.8	.01
Youth	73.3	77.2	.38

Table 4. Care Coordination Community Standards

2010 FVN Standards Performance Metric Summary	Minimum Community Standard
Slot utilization	≥ 95%
Staffing utilization	≥ 95%
Cases with length of stay > 14 months	≤ 9%
Cases assigned and closed but not opened	≤ 4%
Cases enrolled but discharged < 90 days	≤ 4%
Cases with 10-point or > change in CAFAS® @ 6 months	≥ 80%
Cases with 20 point or > change in CAFAS® @ 12 months	≥ 80%
Cases with 20 point or > change in CAFAS® from enrollment to discharge	≥ 75%
Cases with successful discharge	≥ 65%
Cases discharged without having been placed in a Residential Treatment Center	≥ 90%
Cases placed in Residential Treatment Center > 90 days	≤ 5%
Cases placed at inpatient psychiatric setting > 30 days	≤ 5%
Cases with first Face to Face visit < 10 days	≥ 85%

they most needed them. To correct this situation, intake process was reviewed, paperwork was re-designed, strategies were put into place and improvements were made. Data collected from January to July 2009 showed that 76% of all referrals were assigned within 10 days and most recently, July 2009 saw 97.7% of all referrals were assigned within 10 days. Further, we have also begun to examine the effectiveness of wraparound services across ethnic and racial groups. As we begin 2010 we will be contracting with a local agency that will assist us in identifying any practices that are contributing to racial disparities and implement QI practices to effectively address those issues.

VI. Sustainability

How do we know our system of care is sustainable? Does it mean the goals we set for our community have been met? Have we Achieved

Cross-system Cultural Change, Enhanced the Existing Infrastructure of Care Coordination and Individualized Services and Natural Supports, and Achieved Fiscal Stability? Data is at the core of our plan, and by showing our partners that youth are more effectively served through our system of care, we can serve more youth as we reinvest savings from residential placements. Approximately 400-425 families are served at any one time, up from 200 families four years ago. Twenty-five percent of residential funding has been diverted to the system of care, resulting in more youth living at home in their communities. Table 5 shows community placement data, and illustrates that in June 2007 we had discharged 78% of youth without having placed them in a residential treatment center (RTC) while receiving services. By August 2009, this percent had increased to 88% of youth discharged without placement in an RTC. System-

Table 5. FVN Community Placement Data June 2007 - August 2009

Month	Year	% Discharged without having been placed in a RTC
June	2007	78.72
December	2007	79.24
June	2008	85.34
December	2008	86.55
June	2009	87.35
August	2009	88.3

wide sustainability is and must continue to be an on-going collaborative effort with our community partners. While our planning efforts have paid off with increasing numbers of families served from across a broad spectrum, the human services arena faces increasing stressors from the poor economic outlook in our region and state. Ongoing relationship building, development of trust with our system partners, and sharing resources will be critical to our sustainability plan for our system of care.

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