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Putting the Outcomes-Based Principle into Action

Part One: A Guide for Wraparound care coordinators

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PURPOSE AND STUCTURE OF THIS GUIDE

In this guide, our goal is to provide concrete guidance to Wraparound care coordinators about how to apply the essential Wraparound principle of being outcomes based. The introduction provides background on why routinely and systematically measuring progress and using that information to rapidly adjust a plan of care is a core component of high-quality Wraparound and clinical practice, in general. The remainder of the guide provides **details about opportunities to be outcomes based during every phase and activity of the Wraparound process**. Appendices take this guidance to greater levels of detail and include:

1. A schematic **outlining the connection between needs, outcomes, strategies, and tasks**,
2. Opportunities for **integrating standardized assessment results into Wraparound planning, with specific attention paid to the Child Adolescent Needs and Strengths (CANS)**,
3. A suggested **child and family team meeting (CFTM) agenda,** structured to highlight monitoring and rapid-cycle Plan adjustments,
4. **Examples of progress monitoring** tables and graphs, and
5. Information about **standardized outcome measures commonly used in Wraparound**.

While this document focuses on achieving outcomes-based care in practice, a subsequent guide will focus on how Wraparound supervisors, program directors, and system administrators can collect and use data more effectively for accountability and improvement. This will include descriptions of how common measures (e.g., CANS, CAFAS, CASII) can be used to monitor program outcomes and inform decision making, tips for developing a sustainable program- or initiative-level fidelity and outcomes monitoring plan, and examples from Wraparound initiatives around the country.

INTRODUCTION

One of the ten core principles of Wraparound is being "outcomes based." The National Wraparound Initiative's (NWI) foundational document, *Ten Principles of the Wraparound Process*[1] defines being outcomes based as:

> ***The team ties the goals and strategies of the Wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.***
>
> *This principle emphasizes that the Wraparound team is accountable—to the family and to all team members; to the individuals, organizations and agencies that participate in Wraparound; and, ultimately, to the public—for achieving the goals laid out in the plan. Determining outcomes and tracking progress toward outcomes should be an active part of Wraparound team functioning. Outcomes monitoring allows the team to regularly assess the effectiveness of [the] plan as a whole, as well as the strategies included within the plan, and to determine when the plan needs revision. Tracking progress also helps the team maintain hope, cohesiveness, and efficacy. Tracking progress and outcomes also helps the family know that things are changing. Finally, team-level outcome monitoring aids the program and community to demonstrate success as part of their overall evaluation plan, which may be important to gaining support and resources for Wraparound teams throughout the community.*

[1] http://nwi.pdx.edu/pdf/TenPrincWAProcess.pdf

While many Wraparound programs embody the principles such as family voice and choice, individualized, and strengths based, most still struggle with putting the outcomes-based principle into action. In a review of 72 Wraparound teams in 11 states, Walker, Koroloff, and Schutte (2003) found that fewer than a third tracked success using indicators of progress or even completion of tasks. Less than half even used a structured agenda to guide meetings. Today, even when states and sites invest in comprehensive workforce development support, the National Wraparound Implementation Center's (NWIC; www.nwic.org) training, coaching, and accountability experts report that progress is still often not formally monitored in CFTMs or used to direct adjustments to Wraparound plans. Furthermore, many programs and communities are not effectively using fidelity or outcomes data to supervise staff, or help make critical decisions about workforce development needs, system reforms, or contracting.

"Data" are facts or statistics analyzed and presented in a way that yields information and can be used for understanding and communication. Once turned into information in this way, data facilitates decision making. Judgements and decisions are made at all levels of human service provision, and common sense tells us that effective decision making requires reliable and valid data that are also *well-aligned with information needs*. Table 1 presents a summary of critical junctures at which having reliable, valid, and relevant data is essential.

Table 1: Client, program, and system level decisions for which data and information are essential[2]

	Youth and Family	Program	System
Decision Support *What am I going to do?*	• Care planning • Selecting EBPs and effective practices	• Determining eligibility • Benchmarking readiness for step-down or transition • Identifying workforce development needs	• Managing resources • Right-sizing
Outcome Monitoring *It is working?*	• Identifying and celebrating progress • Guiding plan of care revisions • Timing transition	• Evaluating outcomes • Monitoring the impact of workforce development efforts	• Evaluating outcomes • Creating provider profiles • Performance contracting
Quality Improvement *Can I do it better?*	• Managing care • Supervising and coaching	• Continuous quality improvement • Securing accreditation • Planning program redesign	• Informing system transformation • Selecting/funding EBPs and effective practices • Planning business model design

The ability for a program, system, or state to collect and/or access and then *use* high-quality data for decision making rests largely upon the data collection habits of front-line workers, such as Wraparound care coordinators. Although being a care coordinator (or care coordinator) is a complex and demanding job, collecting and using data and information (standardized assessments of functioning, progress toward needs, etc.) as a routine part of practice is critical to promoting positive outcomes for youth and families, telling teams what is working, and guiding decisions by programs and systems. Hence, striving to be as outcomes-based as possible benefits everyone involved.

[2] Adapted from John S. Lyons (2009a, 2009b), *Total Collaborative Outcomes Management (TCOM) Grid of Tactics*

THE IMPORTANCE OF BEING OUTCOMES BASED

WHAT DOES "BEING OUTCOMES BASED" MEAN IN WRAPAROUND?

Outcomes-based Wraparound practice means systematically tracking whether supports and services are "working" to meet the needs of a youth and family. At the most fundamental level, this is achieved through a simple mechanism: measuring and feeding back relevant information to child and family teams (CFTs) in a way that can inform the decision making that occurs within the Wraparound process. In concert with empathic engagement and eliciting the family story, structured assessments at the start of services can help uncover the scope and breadth of a youth's and their family's needs. The establishment of mutually accepted targets, such as the family's vision for the future, priority needs to be met, and indicators of progress, help to focus the attention of the CFT, even in the face of new crises. Progress monitoring throughout the process lets the team quickly know when the wrong needs have been prioritized or strategies in a plan of care aren't working and may need to be amended. It can also be empowering for families to see the degree of progress being made. Finally, data and information on progress can help highlight when a youth and family is ready for transition out of formal Wraparound and facilitate the transition process.

Wraparound teams will generally rely on two types of measurement: **standardized assessments** and **idiographic assessments.**

STANDARDIZED ASSESSMENT

Most care coordinators will be familiar with a number of standardized assessments. An assessment is "standardized" if it requires that 1) every respondent to answer the same (or nearly the same) questions, and 2) data from the responses are then scored the same way every time based on some pre-defined set of rules. Standardized assessments can be specific to certain types of problems, such as the Beck Depression Inventory (Beck, Steer, & Brown, 1996), or comprehensive, such as the Child and Adolescent Needs and Strengths (CANS) Assessment (Lyons, 2009a). To promote confidence, standardized tools are often "validated" by researchers, who carefully gather evidence that shows that the assessments reliably measure what they purport to measure or are associated with logical outcomes. As a function of their standardization (and often available "norms"), scores from such assessments can reliably be used to compare individuals' scores to those of the wider population, or to themselves over time.

IDIOGRAPHIC OR INDIVIDUALIZED ASSESSMENT

Less familiar—though in many ways more natural—to some providers may be what are sometimes called individualized or "idiographic" assessments. These are assessments that are unique to the individual youth and/or family being served. Unlike a standardized assessment, these are not intended to make comparisons across groups or even individuals. Instead, they are a way of measuring a single youth's or family's progress in a targeted way. For example, a provider may measure something like "The number of times Jane goes to school on time each week," or "The number of cigarettes John smokes each day," or even "How close a family feels they are to achieving their vision on a scale of 0 to 4."

WHAT VALUE DOES BEING OUTCOMES-BASED ADD TO THE WRAPAROUND PROCESS?

Behavioral health services, even at their best, do not produce uniformly positive outcomes. In fact, in carefully controlled clinical trials, somewhere around half of recipients do not improve after participating in therapy. In 2002, researchers examined a dataset of over 6,000 psychotherapy participants' assessments—real people receiving treatment in the community. In this real- life dataset, consumers of behavioral health services fared even worse; only 20% believed they got better (Hansen, Lambert, & Forman, 2002). In one relatively large study,

between around 15-25% of children receiving mental health care through either a community mental health agency or a private managed care organization got worse over the course of their services (Warren, Nelson, Mondragon, Baldwin, & Burlingame, 2010).

While limited in number, controlled studies of Wraparound's effectiveness have yielded moderately positive but mixed youth outcomes (Bruns & Suter, 2010; Suter & Bruns, 2009). Our experiences working with Wraparound initiatives across the country suggest that, as for the broader behavioral health landscape, while providers may do many things well, some youth and families will struggle, and there are some consistent areas for potential improvement. For example, Wraparound initiatives often struggle with successful transition. Too often, youth are discharged from services before they are ready—not because they have demonstrably met their needs, but because funding and time have run out, or due to an adverse event. In many places, we see plans of care that do not substantially change, even when it is clear that the youth and family are struggling. In other instances, families remain in Wraparound even when the initially identified needs have been met, meaning that another family in need may be being denied care unnecessarily.

HOW CAN MEASUREMENT HELP?

Many of the above barriers to high-quality or "high-fidelity" Wraparound practice can be addressed through measurement, feedback, and use of outcomes and other data. Being outcomes based can help a CFT stay focused and alert to concerns, such as a lack of progress, engagement, or follow through, and therefore able to intervene more rapidly and accurately to achieve better outcomes for families and youth (Scott & Lewis, 2015). There isn't, yet, good research about the effect of being outcomes based specifically within a Wraparound context, but research related fields do provide relevant examples. For example, research shows that psychotherapy participants' likelihood of dropping out of treatment can be fairly well predicted by the amount of change that they experience early in his or her treatment (Hannan et al., 2005). If this is also the case with Wraparound, then the measurement of progress early in the care process may be able to predict whether a youth and their family is likely to succeed. If progress is not occurring, Wraparound dictates that the team should quickly begin creatively brainstorming "whatever it takes" to succeed, lest a poor outcome (such as early termination of services or out-of-home placement) occur.

At a broader level, research has consistently shown that utilizing measurement-based care strategies results in better outcomes for all behavioral health service recipients, *particularly for those most likely to otherwise not succeed in treatment* (Shimokawa, Lambert, & Smart, 2010). When a therapist regularly collects and monitors structured and objective information (i.e., data) about the individuals with whom they partner, they are able to provide better treatment, especially for those individuals who do not begin their treatment on track to meet their goals. Similarly positive impacts of being outcomes based have held true for individuals with depression (Trivedi et al., 2006), for children in school settings (Lyon, Borntrager, Nakamura, & Higa-McMillan, 2013), and for adults with substance abuse disorders (Crits-Christoph et al., 2012).

There are many possible reasons why the routine and standardized monitoring of progress produces better outcomes. In a 2012 review of the Treatment Outcome Package (TOP), a standardized outcome measure and reporting system specifically designed for implementation in behavioral health care settings, researchers identified several benefits reported by users: it allows clinicians to demonstrate progress to skeptical individuals, it uncovers important information that may not otherwise be disclosed, it enhances communication with the clinician, it allows providers to better tailor services to the experience of the person, and—as the examples above outline—it alerts providers (and supervisors) to focus on those individuals who are not "on track" (Youn, Kraus, & Castonguay, 2012).

It's not difficult to imagine how these same principles might apply to a youth and family enrolled in Wraparound. Wraparound is a process characterized by complexity. Youth in Wraparound have multiple and complex needs, and often so do their families. The team-based approach invites a group of potentially competing perspectives and agendas into the process. This holistic approach is the foundation of Wraparound's strength, but it is also a source

of possible tension. Youth and families engaged in Wraparound will regularly have emergent problems ("crises") in need of being addressed or an emotional state in need of validation. **Enacting the principle of being outcomes based provides an opportunity for focus even in the face of complex needs, and an intensive, team-based process**.

Despite its importance, relatively little attention has been paid to the outcomes-based principle, compared to other key components, such family voice and choice or being strengths based. This guide aims to fill that gap. The University of Washington's Wraparound Evaluation and Research Team's work with communities across the globe and national Wraparound training and coaching experts have led us to determine the most important opportunities to promote outcomes-based care. Below we provide guidance on those areas, which include integrating progress monitoring and precision into each Wraparound phase and activity, linking needs and strategies in the Wraparound plan of care to measurable indicators of success, and facilitating efficient and effective CFTM in the implementation phased.

OPPORTUNITIES TO BE OUTCOMES BASED BY WRAPAROUND PHASE AND ACTIVITY

The following table presents additional detail to the NWI's foundational document *Phases and activities of the Wraparound process* (Walker et al., 2004; see: http://nwi.pdx.edu/pdf/PhaseActivWAProcess.pdf). Specifically, it includes **a new column that presents opportunities to be outcomes based for specific activities across the four phases. These practices and activities must be balanced with practices and activities meant to embody other Wraparound principles.** Note that to promote readability, some details from the original document have been edited for length, but all activities have been retained, even if no specific opportunity to be outcomes based has been highlighted. Furthermore, when "family" appears it is meant to be inclusive of the youth.

PHASE 1: ENGAGEMENT AND TEAM PREPARATION

MAJOR TASKS/GOALS	ACTIVITIES	OPPORTUNITIES TO BE OUTCOMES BASED
PHASE 1: Engagement and team preparation *During this phase, the groundwork for trust and shared vision-making among the family and Wraparound team members is established, so people are prepared to come to meetings and collaborate.*		
1.1. Orient the family and youth GOAL: To orient the family and youth to the Wraparound process.	**1.1 a. Orient the family and youth to Wraparound** In face-to-face conversations, the care coordinator explains the Wraparound philosophy and process to family members and describes who will be involved and the nature of family and youth/child participation. Care Coordinator answers questions and addresses concerns. Care Coordinator describes alternatives to Wraparound and asks family and youth if they choose to participate in Wraparound. Care Coordinator describes types of supports available to family and youth as they participate on teams (e.g., family/youth may want coaching so they can feel more comfortable and/or effective in partnering with other team members).	• Emphasize that the family and youth/child will be asked to collaboratively identify needs, set goals, monitor progress, and follow through with strategies. o This may mean that the family will be asked to monitor and document the occurrence of certain behaviors, rate progress toward meeting their needs, and report on success in implementing strategies and tasks. o Ensure the reason for referral and/or behaviors placing the youth at risk are discussed and understood and explain that those behaviors will be tracked and monitored for change.
	1.1 b. Address legal and ethical issues Care Coordinator reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences. Care Coordinator discusses relevant legal and ethical issues (e.g., mandatory reporting), informs family of their rights, and obtains necessary consents and release forms before the first team meeting.	• If standardized assessments are going to be collected and/or the family's record will be periodically reviewed by someone outside of the organization, make sure that the purposes of these activities are clearly explained to the family and youth/child, and that necessary consents are gathered. • Explain how standardized assessments may be used, in aggregate, to track program performance and make sure Wraparound services are of high quality and getting positive results.

MAJOR TASKS/GOALS	ACTIVITIES	OPPORTUNITIES TO BE OUTCOMES BASED
1.2. Stabilize crises GOAL: To address pressing needs and concerns so that family and team can give their attention to the Wraparound process.	**1.2 a. Ask family and youth about immediate crisis concerns** Care Coordinator elicits information from the family and youth about immediate safety issues, current crises, or crises that they anticipate might happen in the very near future. These may include crises stemming from a lack of basic needs (e.g., food, shelter, utilities such as heat or electricity).	• N/A
	1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises	• N/A
	1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization	• N/A
1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.	**1.3 a. Explore strengths, needs, culture, and vision with child/youth and family.** Care Coordinator meets with the youth/child and family to hear about their experiences; gather their perspective on their individual and collective strengths, needs, elements of culture, and long-term goals or vision; and learn about natural and formal supports. Care Coordinator helps family identify potential team members and asks family to talk about needs and preferences for meeting arrangements (location, time, supports needed such as child care, translation).	• Explore what has worked in the past (i.e., what has previously helped the youth and family achieve their desired outcomes) and include these services, people, and informal activities as they relate to the behaviors currently placing the youth or family at risk. • Help translate results from standardized assessments and explain that they are just one way of getting to know the family and that they will be used periodically to track progress and celebrate improvement.
	1.3 b. Care Coordinator prepares a summary document	• Integrate relevant standardized assessment data as supporting documentation.
1.4. Engage other team members GOAL: To gain the participation of team members who care about and can aid the youth/child and family, and to set the stage for their active and collaborative participation	**1.4 a. Solicit participation/orient team members** Care Coordinator, together with family members if they so choose, approaches potential team members identified by the youth and family. Care Coordinator describes the Wraparound process and clarifies the potential role and responsibilities of this person on the team.	• Emphasize that team members will be expected to collaboratively prioritize needs, set goals, monitor progress, and follow through with strategies. • Inquire about the team members' concerns and the behaviors placing the youth or family at risk – this is especially true for mandated team members such as child welfare or juvenile justice case workers. These concerns and behaviors may serve as the starting point for outcomes that will be tracked over time.
1.5. Make necessary meeting arrangements	**1.5 a. Arrange meeting logistics**	• N/A

PHASE 2: INITIAL PLAN DEVELOPMENT

MAJOR TASKS/GOALS	ACTIVITIES	OPPORTUNITIES TO BE OUTCOMES BASED
PHASE 2: Initial plan development *During this phase, team trust and mutual respect are built while the team creates an initial plan of care using a high-quality planning process that reflects the Wraparound principles. In particular, youth and family should feel, during this phase, that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs.*		
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the Wraparound principles	**2.1 a. Determine ground rules** Care Coordinator guides team in a discussion of basic ground rules, elicits additional ground rules important to team members, and facilitates discussion of how these will operate during team meetings.	• Some ground rules may include an understanding of how the team will come to consensus on certain assessments, such as the degree to which needs are being met or ratings on selected outcomes.
	2.1 b. Describe and document strengths Care Coordinator presents strengths from the summary document prepared during phase 1, and elicits feedback and additional strengths, including strengths of team members and community.	• The plan of care should build from things known to have helped or worked in the past, i.e., strategies that have previously resulted in good progress.
	2.1 c. Create team mission Care Coordinator reviews youth and family's vision and leads team in setting a team mission.	• N/A
	2.1 d. Describe and prioritize needs/goals Care Coordinator guides the team in reviewing needs and adding to list. The care coordinator then guides the team in prioritizing a small number of needs that the youth, family, and team want to work on first, and that they feel will help the team achieve the mission.	• Once needs are articulated and prioritized for planning, have the youth and each family member rate how close the need is to being met on a scale of 0 to 4. This can serve as a baseline for future progress monitoring and can also help with prioritizing which needs to work on first.

MAJOR TASKS/GOALS	ACTIVITIES	OPPORTUNITIES TO BE OUTCOMES BASED
2.1. (CONTINUED) Develop an initial plan of care	**2.1 e. Determine outcomes and associated measurement strategies** ***SEE APPENDICES A and B*** Care Coordinator guides team in discussing specific outcomes that will represent success in meeting each need that the team has chosen to work on. Care Coordinator guides the team in deciding how the outcome will be assessed and how frequently they will be measured.	• For each underlying need prioritized for planning, generate at least one **desired outcome that describes what it would be like if the need was met**. o Outcomes should be specific and measurable. o Ideally, outcomes should be connected to the reasons the youth and family were referred for Wraparound. o Further breaking needs down into outcomes makes measuring progress and impact more objective and consistent. • For each outcome, document baseline functioning and determine how and when functioning will be measured. *SEE APPENDIX A.* • Consider whether/how standardized assessment items could be integrated into progress monitoring. *SEE APPENDIX B for an example.* • Explicitly articulate and document under what circumstances the youth and family would be ready to transition out of formal Wraparound (e.g., a certain rating of progress toward the family vision or meeting a need for a certain number of months? A specific outcome sustained for a certain length of time?).
	2.1 f. Select strategies Care Coordinator guides the team in a process to think in a creative and open-ended manner about strategies for meeting needs and achieving outcomes. The care coordinator uses techniques for generating multiple options, which are then evaluated by considering the extent to which they are likely to be effective in helping reach the desired outcome(s) associated with the need. When evaluating more formal service and support options, care coordinator aids team in acquiring information about and /or considering the evidence base for relevant options.	• Discuss with the team and document what full implementation of a strategy would look like—what actions need to be taken? By whom? Be as explicit as possible. This will help during the Implementation Phase to accurately determine whether there was a lack of progress due to an ineffective strategy or because a possibly effective strategy has not yet been fully implemented. • If an evidence-based or promising practice relevant to the youth's or family's underlying needs is available in the community, explore the youth and family's previous experience with those approaches and whether or not they worked. o If the evidence-based or promising practice previously worked, and the family is willing, prioritize strategies related to accessing these services.
	2.1 g. Assign tasks Team assigns responsibility for undertaking tasks associated with each strategy to specific individuals and within a particular time frame.	• Break down each strategy into as many explicit "tasks" as necessary. • Give each task a "due date" and "person responsible." • Document task assignments to be able to monitor completion at future meetings.

MAJOR TASKS/GOALS	ACTIVITIES	OPPORTUNITIES TO BE OUTCOMES BASED
2.2. Develop crisis/safety plan GOAL: To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan that is consistent with the Wraparound principles.	**2.2 a. Determine potential serious risks** Care Coordinator guides the team in a discussion of how to maintain the safety of all family members and things that could potentially go wrong, followed by a process of prioritization based on seriousness and likelihood of occurrence.	• N/A
	2.2 b. Create crisis/safety plan In order of priority, the care coordinator guides team in discussion of each serious risk identified. The discussion includes safety needs or concerns and potential crisis situations, including antecedents and associated strategies for preventing each potential type of crisis, as well as potential responses for each type of crisis.	• Similar to 2.1
2.3. Complete necessary documentation and logistics	**2.3 a. Complete documentation and logistics** Care Coordinator guides team in setting meeting schedule and determining means of contacting team members and distributing documentation to team members	• Ensure that the documentation includes underlying needs and outcomes statement and their baseline ratings. In addition, strategies and tasks, with due dates and team member responsible, should be noted.

PHASE 3: PLAN IMPLEMENTATION

MAJOR TASKS/GOALS	ACTIVITIES	OPPORTUNITIES TO BE OUTCOMES BASED
PHASE 3: Implementation *During this phase, the initial plan of care is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal Wraparound is no longer needed.*		
3.1. Implement the plan of care GOAL: To implement the initial plan of care, monitoring completion of tasks and strategies and their success in meeting need and achieving outcomes in a manner consistent with the Wraparound principles.	**3.1 a. Implement tasks for each strategy** Care Coordinator aids completion of tasks by checking in and following up with team members.	• N/A
	3.1 b. Track progress on tasks Team monitors progress on the tasks for each strategy in the plan, tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the plan, and the completion of the requirements of any particular intervention.	• All team members should be contacted weekly, or as appropriate, to ensure successful implementation of the plan of care. • Tasks' due dates and persons responsible should be documented during every CFTM so the status of their completion can be reviewed and discussed at subsequent CFTMs.

MAJOR TASKS/GOALS	ACTIVITIES	OPPORTUNITIES TO BE OUTCOMES BASED
3.1. (CONTINUED) Implement the plan of care GOAL: To implement the initial plan of care, monitoring completion of tasks and strategies and their success in meeting need and achieving outcomes in a manner consistent with the Wraparound principles.	**3.1 c. Evaluate success of strategies** Using the outcomes associated with each need, the care coordinator guides the team in evaluating whether selected strategies are helping team meet the youth and family's needs.	• ***See the Annotated Agenda in Appendix C for more detail.*** • ***For examples of progress monitoring, see Appendices B and D.*** • In advance of or at the very beginning of each CFTM, have each family member rate (on scale of 0 to 4 or some other consistent method) their progress toward achieving their vision. o Compare this to previous months' ratings. o Briefly discuss any discrepancies in ratings, and celebrate progress, and/or probe for reasons for progress/lack of progress. • For each need: o Each family member should rate (on scale of 0 to 4 or some other consistent method) perceived progress toward meeting the need. ▪ Ideally, this rating is done rapidly and simultaneously ▪ Compare to previous ratings ▪ Prioritize discussing needs with the least amount of progress to develop a more effective approach o Track progress toward achieving the desired outcomes (e.g., youth will display desired behavior at least X times a week, etc.). ▪ Compare to baseline and previous performance o Probe for reasons for progress and ongoing need to determine the effectiveness of overall plan and each strategy. o Revise plan of care as necessary. • Based on progress monitoring, determine whether or not sufficient progress has been made to warrant transition out of Wraparound services. • As standardized assessments are re-administered periodically, use the results to take stock of progress and reconfirm need prioritization (or administer the tool collaboratively with the team, if appropriate, as a way to facilitate a discussion about progress). o Bring reports that chart change or discuss and chart change on a flip chart within the CFTM. o Repeat this process every time a major assessment is completed.
	3.1. d. Celebrate successes	• N/A

MAJOR TASKS/GOALS	ACTIVITIES	OPPORTUNITIES TO BE OUTCOMES BASED
3.2. Revisit and update the plan GOAL: To use a high quality team process to ensure that the plan of care is continually revisited and updated to respond to the successes of initial strategies and the need for new strategies.	**3.2. a. Consider new strategies as necessary** When the team determines that strategies for meeting needs are not working, or when new needs are prioritized, the care coordinator guides the team in a process of considering new strategies and tasks using the process described in activities 2.1.f and 2.1.g.	• Discussion of new strategies should be directly tied to ratings of progress toward meeting needs and achieving desired outcomes. • Before deciding to revise a strategy that does not appear to be effective, be sure to determine whether or not it was fully implemented (i.e., measure task completion). If the strategy hasn't been sufficiently realized, work to address barriers to implementation.
3.3. Maintain/build team cohesiveness and trust GOAL: To maintain awareness of team members' satisfaction with and "buy-in" to the process, and take steps to maintain or build team cohesiveness and trust.	**3.3 a. Maintain awareness of team members' satisfaction and "buy-in"** Care Coordinator makes use of available information (e.g., informal chats, team feedback, surveys—if available) to assess team members' satisfaction with and commitment to the team process and plan, and shares this information with the team as appropriate. Care Coordinator welcomes and orients new team members who may be added to the team as the process unfolds.	• As a check on process, the care coordinator could routinely (e.g., after every CFTM) administer a brief satisfaction survey to all team members. o One such ultra-brief measure that could be adapted for Wraparound is the Session Rating Scale (SRS), developed by Johnson, Miller, and Duncan (2003). In four questions, it assesses a participant's view on the team's relationships, goals and topics, approach or method, and overall satisfaction.
	3.3 b. Address issues of team cohesiveness and trust	• N/A
3.4. Complete necessary documentation and logistics	**3.4 a. Complete documentation and logistics** Care Coordinator maintains/updates the plan and maintains and distributes meeting minutes. Team documentation should record completion of tasks, team attendance, use of formal and informal services and supports, and expenditures. Care Coordinator documents results of reviews of progress, successes, and changes to the team and plan.	• See Section 2.3.

PHASE 4: TRANSITION

MAJOR TASKS/GOALS	ACTIVITIES	OPPORTUNITIES TO BE OUTCOMES BASED
PHASE 4: Transition *During this phase, plans are made for a purposeful transition out of formal Wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the Wraparound process, and the preparation for transition is apparent even during the initial engagement activities.*		
4.1. Plan for cessation of formal Wraparound GOAL: To plan a purposeful transition out of formal Wraparound in a way that is consistent with the Wraparound principles, and that supports the youth and family in maintaining the positive outcomes achieved in the Wraparound process.	**4.1 a. Create a transition plan** Care Coordinator guides the team in focusing on the transition from Wraparound, reviewing strengths and needs and identifying services and supports to meet needs that will persist past formal Wraparound.	• Just as in section 2.1, each need on the transition plan should have associated and measurable outcomes. o Consider creating outcomes that could feasibly be tracked by family members after formal exit from Wraparound as a way to monitor maintenance of progress.
	4.1 b. Create a post-transition crisis management plan Care Coordinator guides the team in creating post-Wraparound crisis management plan that includes tasks, specific responsibilities, and communication protocols.	• Consider retaining tasks and strategies that have been especially successful in generating progress and are easy to implement and sustain.
	4.1 c. Modify Wraparound process to reflect transition	• Meetings could be less frequent, but check-ins with team members should still occur regularly, based on tasks outlined in the plan of care.
4.2. Create a "commencement" GOAL: To ensure that the cessation of formal Wraparound is conducted in a way that celebrates successes and frames transition proactively and positively.	**4.2 a. Document the team's work** Care Coordinator guides team in creating a document that describes the strengths of the youth/child, family, and team members, and lessons learned about strategies that worked well and those that did not work so well.	• Include graphs of ratings over time of progress toward the family's vision, meeting needs, and achieving outcomes. Provide objective data, when available.
	4.2 b. Celebrate success	• Create space for families to voice the accomplishments they are most proud of and celebrate success they feel they have made.
4.3. Follow-up with the family GOAL: To ensure that the family is continuing to experience success after Wraparound and to provide support if necessary.	**4.3 a. Check in with family** Care Coordinator leads team in creating a procedure for checking in with the youth and family periodically after commencement. If new needs have emerged that require a formal response, care coordinator and/or other team members may aid the family in accessing appropriate services, possibly including a reconvening of the Wraparound team.	• Consider including outcomes and thresholds to monitor stability and possible need for a formal response (e.g., "If Thalia begins missing more than three days of school per month, her grandmother should call the care coordinator to discuss service needs."). • Consider including a brief set of standard questions every transitioned family is asked at a particular point after transition.

APPENDIX A: GETTING FROM UNDERLYING NEEDS AND STRATEGIES TO OUTCOMES AND TASKS

Below is a Wraparound vignette that demonstrates how outcomes and tasks can flow from and should be logically tied to a youth and family's underlying needs and chosen strategies.

MATTHEW'S STORY AND PLAN

After meeting several times with Matthew and his family, a Wraparound care coordinator, Tasha, wrote the following family story. She also completed an initial CANS assessment, which is required by the state within 30 days of the family's enrollment. Tasha has become fluent in using initial and ongoing CANS data in Wraparound engagement, planning, and implementation, ensuring collection of these data are not merely for program use (e.g., eligibility determination) nor are they viewed as simply "busy work" for the care coordinator and family.

Abbreviated Family Story

Matthew is a mixed-race 15-year-old male of African-American and Caucasian heritage. He currently lives with his adoptive parents, Mona and John, and little brother, Steven, who is 3 years old. Matthew also has a younger biological sister, but was separated from her when he entered into foster care at the age of 4. Mona and John adopted Matthew when he was 14. Mona originally met Matthew through her job at a local outpatient mental health clinic where she was his caseworker. Mona has worked with Matthew since he was 11.

Matthew and his family were referred to Wraparound by his mother's co-worker when she learned from Mona that Matthew had assaulted her. Matthew began showing signs of aggression about 1 year ago, and within the past 6 months he has started skipping school, his grades are dropping, and he seems angry all the time. At first, Mona suspected it was drugs but Matthew denies using any substances and drug screens have all been negative. His behaviors have escalated and he is now staying out late, disobeying the rules, and starting fights with peers at school.

Matthew's parents report when Matthew gets angry, he will hit things, slam doors, follow them around the house yelling, flip over furniture, threaten to call Child Protective Services, and threaten to run away. The last time Matthew hit Mona, she called the police. He is currently on probation for 6 months. Matthew has been hospitalized a total of three times in the last year. Despite the aggressive behavior, Mona and John report that Matthew is sweet, kind, shy, loves sports, and is very friendly. Matthew currently is diagnosed with Mood Disorder NOS, and ADHD and is prescribed Vyvanse 70mg, Fluoxatine 20mg, and Abilify l0mg. Matthew takes his medication as prescribed and sees his psychiatrist on a monthly basis. His probation officer describes Matthew as a 'good kid' that has had some tough times. She is convinced he can turn things around and wants to give him every chance she can.

Matthew was born in another state and only resided with his biological parents for a short time before he was placed in foster care. Matthew witnessed domestic violence on a daily basis and watched his mother stab his father. His biological parents' rights were terminated and he was placed in foster care at the age of 4. He reports he doesn't really have any memories of his younger sister while still residing with his biological parents.

While in his first foster home, Matthew was sexually abused for two years from the age of 4-6. He disclosed this information to his school teacher when he started kindergarten and was immediately removed. He quickly bounced through two more foster homes before being placed with an adoptive family with whom he bonded. He thought he had found his permanent home and describes that time as good. He participated in little league sports and continued playing for recreational leagues until middle school when he joined the school team. Matthew describes this time as doing things normal families do. They started the adoption process but before it could become final, the foster father lost his job and the state would not allow the adoption to go through. Due to the economic hardship, his foster family had to move back to their home town where the foster father found a job.

Matthew was not allowed to move with them and placed in yet another foster home. It was at this time he entered the public mental health system and met Mona.

Matthew struggled in his next foster home and often confided in Mona when things got tough. Mona reports that even with all that Matthew went through, she saw something in him that she couldn't ignore. He was and still is a star football player. She would often attend his games with her husband. Mona and John describe Matthew as a leader on the field. He pumps up his team to get ready for the game and rallies them when they are behind. He never takes credit for good plays and attributes successes to the whole team. Mona also stated Matthew would push his foster family away. He refused to participate in family activities and asked if he could spend time with her and her family more and more. Mona was afraid he would be removed from yet another foster home and talked to her husband about taking in Matthew. They both had grown to love Matthew and wanted to give him the same opportunities they had to move beyond their past. Matthew was almost 13 when he was placed with them.

It was after the adoption when Matthew was 14 that the issues began. Mona and John don't understand because things were good prior to the adoption. They have tried everything from removal of privileges to pulling him out of sports. Nothing has worked. They do report having good days and that Matthew is so helpful when they are participating in their community service activities. Mona reports that she has heard Matthew crying in his bedroom and it breaks her heart. John feels like Matthew needs to 'pull himself up by his bootstraps and move on'.

Matthew is very protective of his little brother and often babysits for them. He is gentle and patient with Steven. Steven adores Matthew. If Steven walks in the room when Matthew is angry and acting out, Matthew will immediately stop his behavior. Matthew apologizes after the incidents, but Mona is still fearful sometimes when Matthew gets really angry. If she tries to walk away from him, he will yell at her and say she doesn't love him and will abandon him like everyone else does. John and Mona are tired and while they knew it wouldn't be easy taking Matthew in, they just want him to know he is part of their family now.

Strengths

Matthew (youth):

1. He hasn't given up hope of being a permanent member of a family
2. He steps up to help out with his little brother, is patient with him, and will protect him
3. He is close to Mona and talks to her about everything
4. He stands up for himself and tries to protect himself from getting hurt again
5. He is able to build relationships with adults he trusts
6. He is a leader on the football field
7. He likes being part of a team and the sense of family a team gives him – 'someone always has your back'

Tasha (care coordinator):

1. Is awesome at dance revolution and dances to de-stress
2. Volunteers at the local human society and likes helping animals.

Mona (Mom):

1. She learns from past mistakes and experiences and builds off those lessons learned and experiences to help others
2. She is committed to keeping her family together
3. She asks for help when needed
4. She confides in Michelle (her co-worker) and they work out together every other day
5. She gives of herself freely in support of her family's needs
6. She sees the good in people when most people would give up
7. She is the rock of her family

Adam (therapist):

1. He comes from a long line of football fanatics and uses his knowledge of football to connect with Matthew
2. He is very handy with tools and does wood working in his spare time

Michelle (Mom's Co-worker):

1. She has known Mona & John for over 15 years and feels comfortable being very honest and open with them – she is a "tell it like it is" kind of person
2. She uses her sense of humor to calm people down in times of crisis and using humor helps her to stay calm in stressful situations

Coach Smith (Coach):
1. He believes the team is like family and we stand up for one another
2. Goes above and beyond for kids and will step up when asked to take on a task

John (Dad):
1. He works hard to support his family and wants to pass on the value of hard work to his kids
2. He learns from watching others
3. He believes in picking yourself up and moving forward despite obstacles
4. He believes doing things as a family keeps the family strong and together – he attends all Matthew's sports events and looks for activities to keep him busy

As a family they:
1. Enjoy giving back to the community by participating in community service activities (Habitat for Humanity)
2. Believe in the power of education to achieve your goals and commit time every day to helping with homework and reading

Steven (younger brother):
1. He loves reading adventure books
2. He likes riding on the back of Matthew's bike and going fast
3. He wants to play football like Matthew when he grows up

Ratings on Initial Child Adolescent Needs and Strengths (CANS) Assessment

A rating of a 2 or a 3 on a Needs item indicates that the youth or caregiver are having serious difficulties in this domain that warrants action. A lower rating on a Strengths item indicates the presence of a strength that can be used for planning.

Actionable Needs (ratings of 2 or 3)
- Child's Risk Behaviors
  - Danger to Others - 2
  - Social Behavior - 2
- Behavioral/Emotional Needs
  - Depression - 2
  - Adjustment to Trauma – 3
  - Anger Control - 2
- Life Domain Functioning
  - Family - 2
  - School - 2
  - Legal - 2
- Caregiver
  - Family Stress – 2

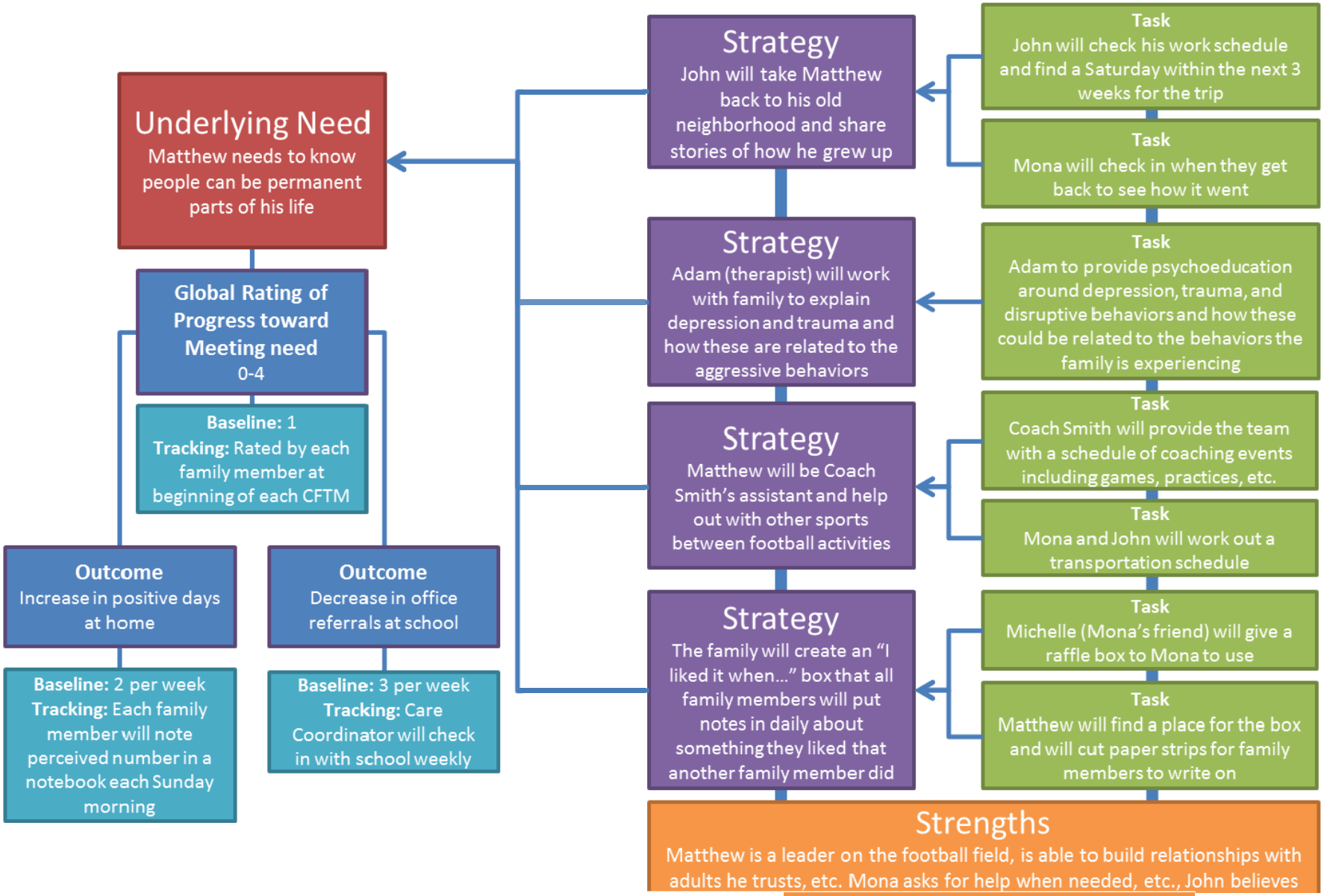
Strengths to Build (ratings of 2 or 3)
- Relationship Permanence - 2

Useable Strengths (ratings of 0 or 1)
- Talents/Interests – 0
- Family – 1
- Interpersonal - 1
- Community Life – 1
- Natural Supports - 1

Please note: CANS differ by jurisdiction, and therefore may be slightly different than what you are familiar with.

Plan of Care Flow Chart

In collaboration with Matthew, his family, and his team, Jennifer created a plan of care that included an underlying need statement, several measurable outcomes, and strategies and related tasks. Below is a schematic, based on Matthew's story and plan of care, of how outcomes, strategies, and tasks flow from an underlying need, as well as key questions to consider when assessing the success of the strategies. There may be more strategies included in the plan of care. This schematic is just for demonstration purposes. However, mapping a plan of care in this way may be a helpful visual for some team members.



Questions for monitoring:

Is meeting the need getting us closer to the family's vision for the future?

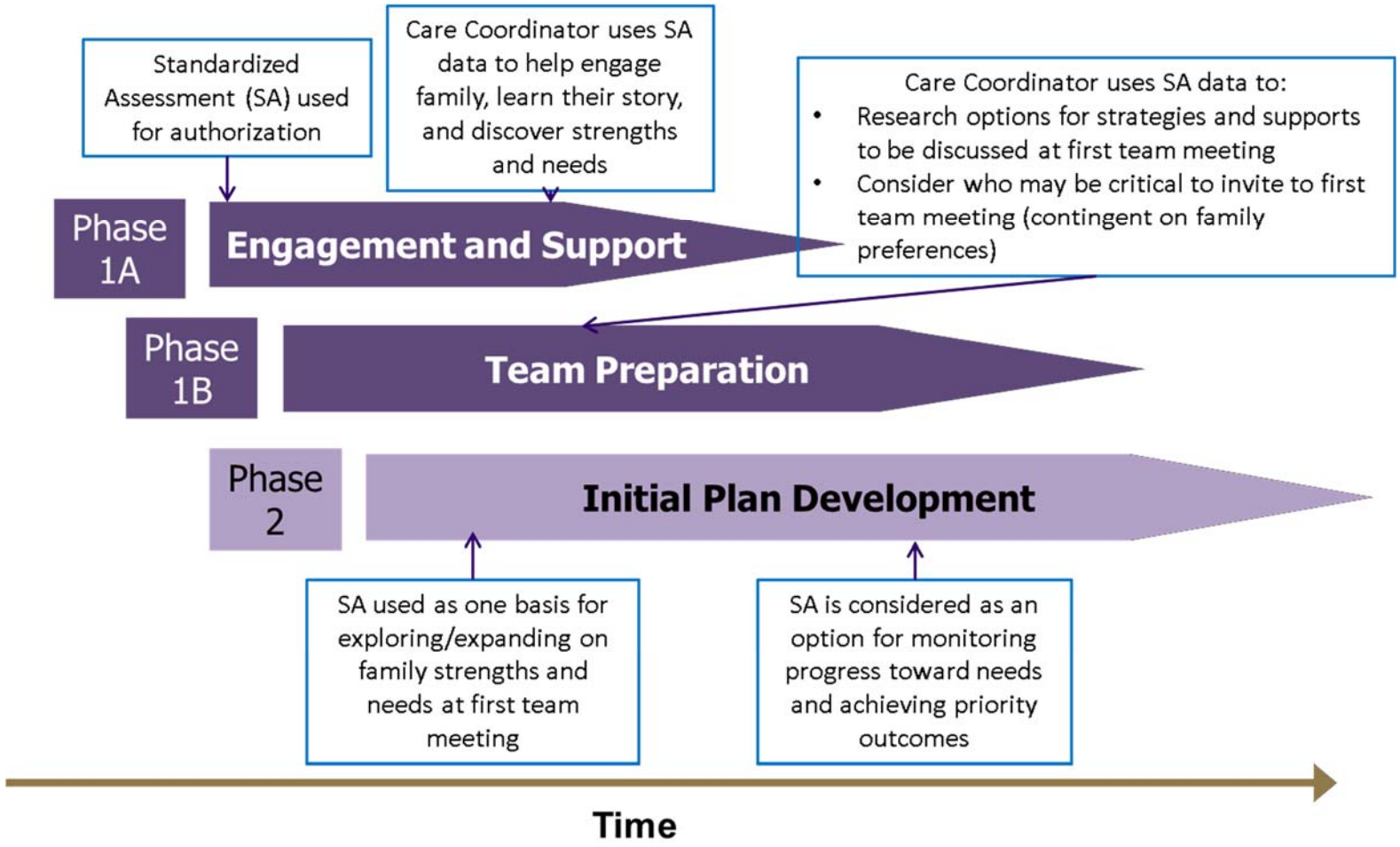
Is strategy implementation getting us closer to meeting the underlying need?

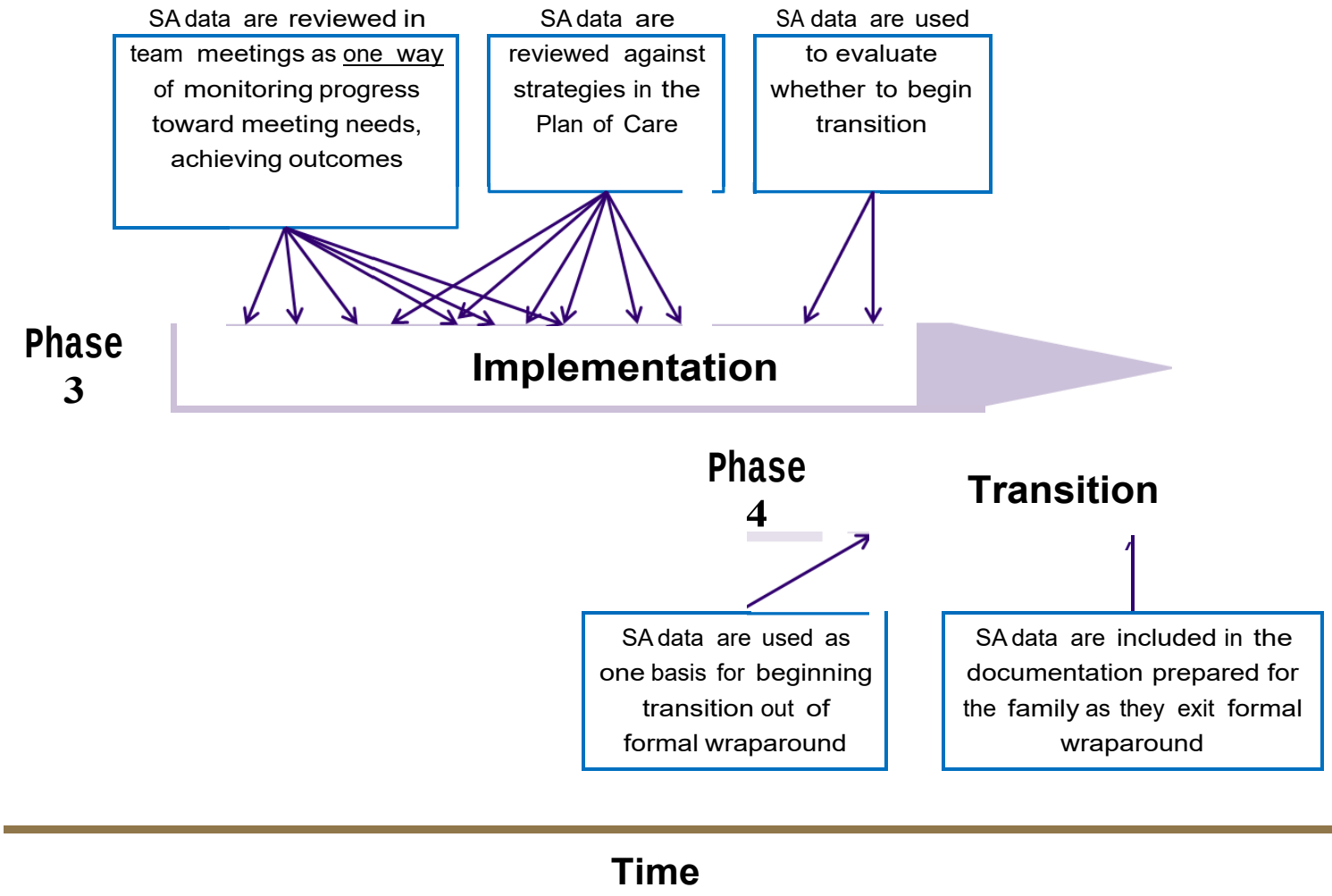
Were the tasks completed fully and in a timely manner (i.e., are the strategies being implemented as planned)?

APPENDIX B: INTEGRATING STANDARDIZED ASSESSMENTS INTO WRAPAROUND PLANNING

OPPORTUNITIES FOR INTEGRATION BY WRAPAROUND PHASE

There are several common junctures at which it may be appropriate to use the results of standardized assessments to inform the Wraparound planning process.




SA data are reviewed in team meetings as one way of monitoring progress toward meeting needs, achieving outcomes
SA data are reviewed against strategies in the Plan of Care
SA data are used to evaluate whether to begin transition
Phase 3
Implementation
Phase 4
Transition
SA data are used as one basis for beginning transition out of formal wraparound
SA data are included in the documentation prepared for the family as they exit formal wraparound
Time

INTEGRATING THE CANS INTO WRAPAROUND PLANNING

The simultaneous implementation of Wraparound and CANS is increasingly common across the United States. We receive frequent requests for guidance about how best to use the CANS tool within the Wraparound process. There are differing opinions on this matter, but below is the NWIC's and the NWI's suggested best practices. It should be noted that most of the suggestions below pertain to other commonly used standardized assessments, as well, as highlighted in the figures above.

Whether you're facilitating the development of a Wraparound plan of care or a crisis/safety plan, it will be driven by relevant information about the youth and family you are working with. Wraparound care coordinators should be skilled in gathering and synthesizing this information in a way that is both empowering and efficient. While a large part of the engagement and initial planning phases is about organically eliciting and making sense of the family's story, it should also aim to integrate information from many different sources and potential team members. This often includes collecting quantitative and/or standardized data, such as school attendance and academic progress records, the number of mental health-related hospital visits, and/or scores on assessment measures, such as the CANS tool.

Quantitative and standardized data can add tremendous value to the Wraparound process. However, its introduction **should not compete with adherence to the core Wraparound principles**. Rather, it **should leverage the tools' unique strengths. In the case of the CANS, this means comprehensiveness and standardization for the purposes of improved communication and progress monitoring**.

The outline below expands upon the guidance provided in the "Opportunities to be Outcomes based by Wraparound Phase" table above by proposing specific activities to meaningfully integrate the CANS into high-quality Wraparound practice.

DURING ENGAGEMENT—ENGAGE FIRST, COMPLETE THE CANS SECOND; MITIGATE IMMEDIATE RISKS

1. Engage the family and potential team members as usual. Develop a trusting rapport with them while learning about the family's story, values, hopes for the future, and previous attempts to address their current concerns.
2. If the initial CANS was completed ***prior* to initiation of Wraparound**:
    a. Review previously recorded CANS scores, with the youth, family, and other team members to confirm that the ratings are seen as accurate. This can be especially useful for items that the care coordinator disagrees with the rating based on their own assessment of the family.
        i. Disagreement about an item's rating is a good opportunity for targeted and yet comprehensive discovery with an in-depth discussion about the topic to arrive at a consensus about a more realistic score. The team should not feel that CANS scores represent a "truth" separate from the youth's and family's understanding of events. It's OK to make a new assessment to get a more current rating of baseline need.
    b. Prompt the family and other team members to discuss higher-rated Risk Behaviors/Factors that do not come up organically in conversation to assist in immediate crisis stabilization.
3. If the initial CANS ***was not completed*** prior to initiation of Wraparound engagement:
    a. Complete the CANS based on information gathered during the engagement phase. Circle back with family and team members, as necessary, to confidently rate each item.
        i. Ideally, the CANS should be administered collaboratively, with input from the youth, family and other potential team members gathered via structured interviews. Relevant

information should then be integrated by a certified CANS user and reviewed and confirmed by all parties involved.[3]

b. Once completed, explore what needs to be done to stabilize any immediate or potentially emerging crises, as identified by a rating of a 2 -- or especially a 3 – on CANS Risk Behaviors/Factors items.

Scores on the CANS should reflect the youth's and family's reality. It does not provide new information, per se, but helps facilitate focused communication and action about complex issues. Each item's anchored definitions can help team members from diverse backgrounds and settings "speak the same language"—one that focuses on the level of urgency of need—so they are more likely to stay on the same page about what needs to get done to help a youth and family live a better life.

Once there is agreement about the list of needs and strengths generated from the CANS, there are **two main ways the information can be used to facilitate planning and progress monitoring: 1) to check the plan of care's comprehensiveness, and 2) to track patterns of very complex needs in a structured and consistent fashion over time**. This consistency is especially helpful when monitoring outcomes at a program or system level.

First of all, **we strongly recommend that the CANS be used as a check of the outputs of the plan of care development process, rather than a key input**. With the list of actionable CANS items in hand, it can be tempting for the team to jump forward to matching strategies to each actionable need before fully acknowledging and understanding the family's situation and or constructing deep underlying needs statements. Part of the power of the Wraparound process is in its narrative approach—developing deep underlying needs statements stimulates the generation of new and individualized strategies beyond typical formal services. Starting the planning process with a list of CANS items flagged for action can constrict the brainstorming and creative team process critical to the Wraparound process. Thus, put the CANS aside and engage the family and team to develop a draft of an initial plan of care as driven by the principles of Wraparound, *then* check the plan against the CANS.

DURING INITIAL PLAN DEVELOPMENT—CHECK THE PLAN AGAINST THE CANS

1. Review the CANS Risk Behaviors/Factors domain items and confirm that all items rated as requiring immediate action (i.e., rated a 3, and possibly a 2) are addressed by the crisis/safety plan.
2. Develop the Wraparound plan of care as usual—collaboratively create underlying needs statements that generate meaningful desired outcomes and creative and individualized formal and informal strategies.
3. Review the list of "useful" CANS strengths items (i.e., rated a 0 or 1) and ensure that they are being considered when developing strategies and tasks.
4. Review the list of "actionable" CANS needs *and* strengths items (i.e., rated a 2 or 3) and ensure that the chosen strategies can be logically expected to result in improvement on the CANS items.
5. If the team feels that the strategies do not logically address an "actionable" CANS need or strength item, discuss whether additional strategies aimed at the item should be developed, whether a new underlying need should to be planned for, *and/or* whether the family is comfortable setting the actionable need or strength aside to address other, higher-priority, needs.

The CANS should not drive the plan—the family's perspective and effective teamwork should. But, using the CANS as a check on planning provides thoroughness and transparency to help assess whether the plan is addressing and balancing all of the youth's and family's many pressing issues, all in the service of developing the most effective plan of care possible. This double checking process should also allow confidence in the assumption that implementing the plan of care will result in improvements on the CANS over time.

[3] For more information about collaboratively administering the CANS, please see Praedfoundation.org.

DURING IMPLEMENTATION—USE THE CANS FOR PROGRESS MONITORING AND TO INFORM TRANSITION TIMING

1. At regular intervals (preferably quarterly), collaboratively complete a CANS reassessment as required by program standards or mandates.
    a. Review change in CANS scores during a CFTM.
        i. Compare baseline ratings to subsequent ratings on the reassessment CANS. This can be done via a simple list of actionable items and strengths, or in a table or graph form (see Appendix D for examples). Have the Child and Family Team explore:
            1. Have initially actionable items improved, resolved, or gotten worse?
            2. Have strengths been maintained or developed?
            3. Have new actionable items been identified?
    b. Check the most recent reassessment CANS against the current plan of care as outlined in the "During Initial Plan Development" section above.
2. Use results of the CANS, factored in with other information, to determine if transition is warranted.

APPENDIX C: SAMPLE IMPLEMENTATION TEAM MEETING AGENDA

FOR FAMILIES AND TEAM MEMBERS

[Youth Name]'s Team Meeting Agenda: Wraparound Implementation Phase

Date of CFTM: _____

1. Family's rating of progress toward achieving their vision (on scale of 0 to 4)
2. Celebrate new accomplishments and successes
    a. Any new functional strengths developed?
3. Monitor progress toward meeting needs and achieving outcomes
4. Adjust plan of care, as needed
5. Review game plan between now and the next meeting
    a. Assigned tasks
    b. Outcomes to be tracked
6. If a crisis has occurred since last CFTM, review and modify the crisis/safety Plan
7. Note any important upcoming dates or events
8. Schedule next meeting

Your assigned tasks:

-
-
-
-
-

Date of next team meeting: _____

ANNOTATED AGENDA FOR CARE COORDINATOR TRAINING

Wraparound Child and Family Team meetings should be seen as the key vehicle by which to engage in an iterative Plan-Do-Study-Act process to develop the most effective plan of care possible and make sure it is adjusted as circumstances and evidence of progress change. Care Coordinators (or care coordinators) and other team members should come into the meeting with a general idea about what has been going on with the youth and family via contact outside of the team meeting; thus, the meeting should very quickly move through a status update, into substantial planning. It should be expected that the plan of care, especially the strategies, will be revised and/or reprioritized at every meeting based on progress toward meeting needs.

1. Have each family member rate (on scale of 0 to 4 or some other consistent method) their progress toward achieving their vision (suggested: 5 minutes)
    a. Compare this to previous months' ratings
    b. Briefly discuss any discrepancies in ratings, and celebrate progress, and/or probe for reasons for progress/lack of progress
2. Briefly solicit and celebrate new accomplishments and successes (suggested: 5 minutes)
    a. Keep this process focused and positive, as a way to break the ice. Avoid this becoming a lengthy check in. Perhaps have each member note the thing since the last meeting they are most proud or happy about
    b. Review and add or refine functional strengths, as they become apparent
    c. If there are any new team members present, note their functional strengths
3. Monitor progress toward meeting needs and achieving outcomes (suggested: 5 minutes)
    a. Have each family member rate (on scale of 0 to 4 or some other consistent method) the youth and family's progress toward meeting the 1-3 underlying needs being planned for in the plan of care
        i. Ideally, this rating is done rapidly and simultaneously (post-it notes on a flipchart, holding up scores on pieces of paper at the same time, etc.)
    b. Determine performance on outcomes
        i. Ideally, a team member will be responsible for tracking outcomes in between CFTMs so the data can be quickly relayed to the group for consideration.
        ii. If new information/ratings needs to be collected, ideally this is done rapidly and simultaneously.
    c. Briefly discuss any discrepancies in ratings between family members. It is not necessary to resolve the discrepancy. Simply seek understand what is driving each rating.
    d. Compare this to previous months' ratings.
        i. If possible, track progress visually on a graph or numbers chart.
        ii. If ratings of needs being met are not moving in the same direction as achievement of outcomes, explore the assumed connections between the two and alter either, as needed.

e. Collectively determine which needs have seen significant progress or still need to be planned for in order to set agenda for the rest of the meeting (see below)

4. Adjust plan of care, as needed—should be the bulk of the meeting

    a. <u>For need(s) with significant progress:</u> discuss whether or not it is time to work on a new underlying need in place of the one that has been sufficiently met (suggested: 5 minutes/need)

        i. Probe for reasons for progress and encourage continued implementation of successful strategies

        ii. Celebrate progress

        iii. Note any new strengths that could be used in future planning

        iv. Decide whether or not to table met need to plan for a new need

        v. If a new need is identified, note it and then plan for it after the other needs are addressed (see below)

    b. <u>For need(s) with some to little progress:</u> Spend a few minutes reviewing what's working and which strategies should be maintained in the plan of care (suggested: 15 minutes/need)

        i. Probe for reasons for progress and ongoing need

        ii. Celebrate incremental progress

        iii. Review whether current outcomes are still relevant and desired (i.e., should different youth or caregiver behaviors be tracked?)

        iv. Review status of previously assigned tasks, and discuss and resolve any barriers to follow through for strategies the team would like to retain

        v. If deemed necessary, brainstorm and prioritize new strategies that may result in more progress

        vi. Explore ways that identified strengths could be used in developing strategies and assigning tasks

        vii. Make sure ongoing tasks, or new tasks are explicitly assigned to various team members

    c. <u>Plan for any newly articulated needs:</u> (suggested: 15 minutes/need)

        i. Create underlying need statement

        ii. Articulate at least one measurable outcome (i.e., what it would look like if the need was met)

        iii. Brainstorm strategies to meet the need and assess for feasibility

        iv. Explore ways that identified strengths could be used in developing strategies and assigning tasks

        v. Prioritize strategies and assign tasks

5. If a crisis has occurred since last CFTM, review and modify the crisis/safety Plan (suggested: 15 minutes, if needed)

    a. Did the existing Plan sufficiently anticipate the crisis?

        i. Have new triggers or behaviors emerged?

    b. Was the plan adequately implemented?

        i. If not, what were the barriers to implementation and how can they be resolved?

ii. If so, why didn't the plan successfully deescalate the crisis? What should be done differently next time?

6. Review game plan between now and the next meeting to make sure each team member is clear on their responsibilities
    a. Assigned tasks
    b. Outcomes to be tracked
7. Note any important upcoming dates or events
8. Schedule next meeting

CARE COORDINATOR IMPLEMENTATION PHASE CFTM CHECKLIST

- ☐ Elicit strengths and successes that have emerged since last CFTM
- ☐ Obtain youth/family's rating of progress toward family vision (scale of 0-4)
- ☐ Obtain youth/family's rating of progress toward meeting underlying need (scale of 0-4)
- ☐ Obtain or present updated outcomes performance data
- ☐ Compare current progress to data from previous CFTMs and discuss trends
- ☐ Explicitly check in with team members around completion of assigned tasks and strategy implementation; brainstorm ways to overcome barriers to completion, if necessary
- ☐ Use progress and outcome performance data and status of strategy implementation to focus plan adjustments. What would promote further progress?
    - o New, revised, or reassigned tasks?
    - o New or revised strategies?
    - o New or revised outcomes?
    - o New or revised underlying needs statement?
- ☐ Determine if crisis/safety plan needs to be adjusted based
- ☐ Use progress and outcome performance data to determine if transition should be discussed
- ☐ Review assigned tasks with each team member
- ☐ Review and plan for monitoring of outcomes
- ☐ Schedule next meeting

APPENDIX D: PROGRESS MONITORING EXAMPLES

EXAMPLE OF A PROGRESS DATA TABLE

At minimum, there should be an easily accessible place on the plan of care for progress to be documented over time. A simple data table, such as the one below, under each underlying need would suffice.

Sample Progress Monitoring Tables from Matthew's plan of care (See Appendix A)

Underlying Need: "Matthew needs to know that people can be permanent parts of his life."

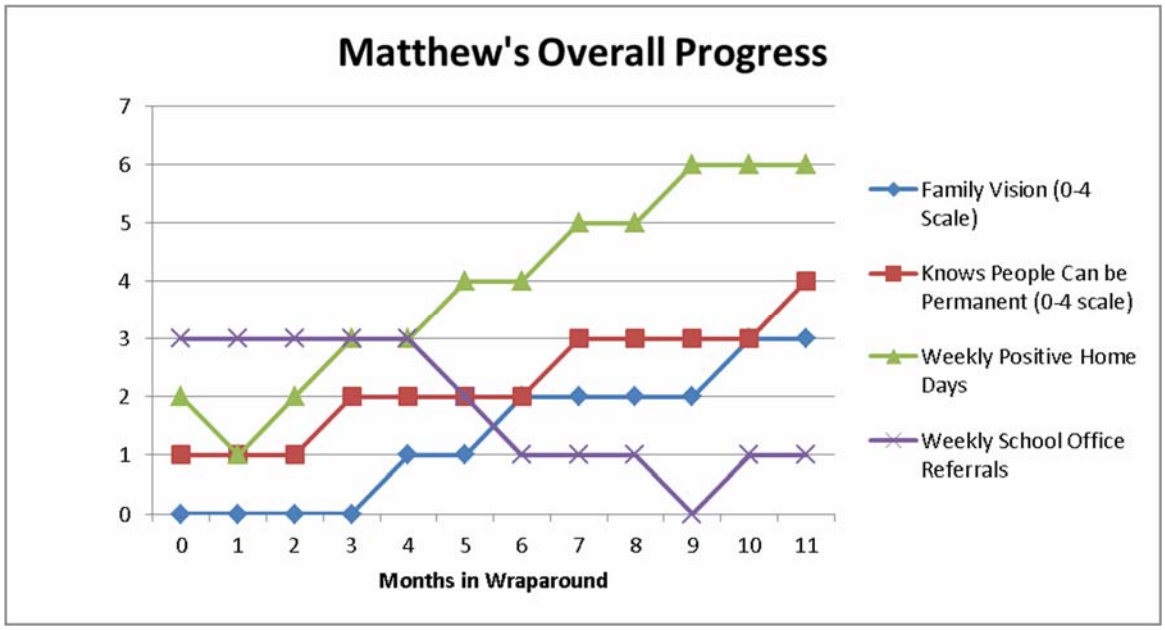
Matthew's Progress Monitoring Table

	Month											
Outcome	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Progress toward achieving the family vision (rated on a scale of 0-4)	0	0	0	0	1	1	2	2	2	2	3	3
Progress toward meeting underlying need (rated on a scale of 0-4)	1	1	1	2	2	2	2	3	3	3	3	4
Typical number of positive days at home each week	2	1	2	3	3	4	4	5	5	6	6	6
Typical number of office referrals at school each week	3	3	3	3	3	2	1	1	1	0	1	1

EXAMPLES OF PROGRESS CHARTING

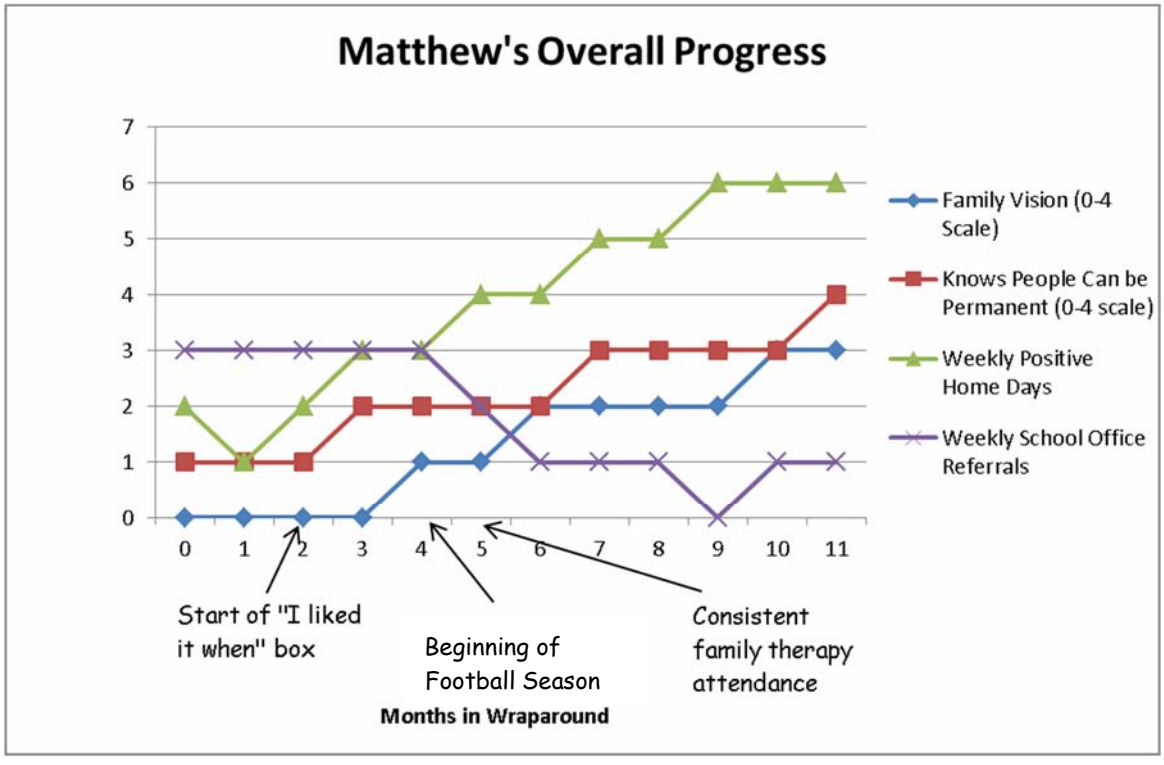
While the data tables above contain the critical information to evaluate progress over time, many people prefer a visual representation, as well. A simple line graph of progress and outcomes ratings can make progress trends (or lack thereof) more tangible and easier to identify.

Below is a chart that displays Matthew's progress toward meeting his family vision, prioritized underlying need, and outcomes (see Family Story and plan of care in Appendix A). Displaying these diverse ratings on one chart can help the team discuss the interaction between progress in one area and progress in another. In this example, it is clear that real positive change began taking hold in the fifth month of Wraparound. It is possible that reviewing this information and visually seeing progress could serve to reinforce Matthew's and his family's perceptions of progress and feelings of hopefulness.

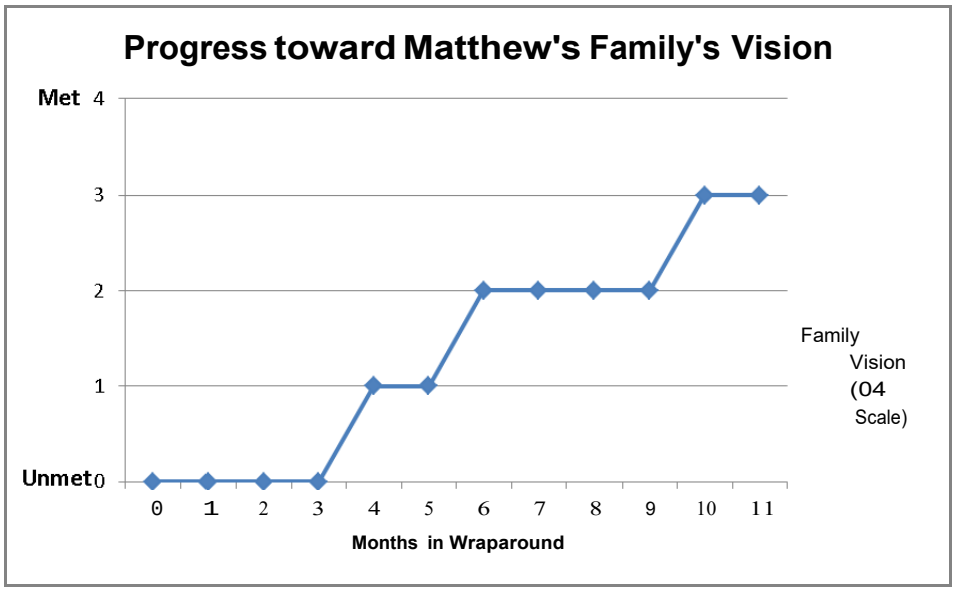


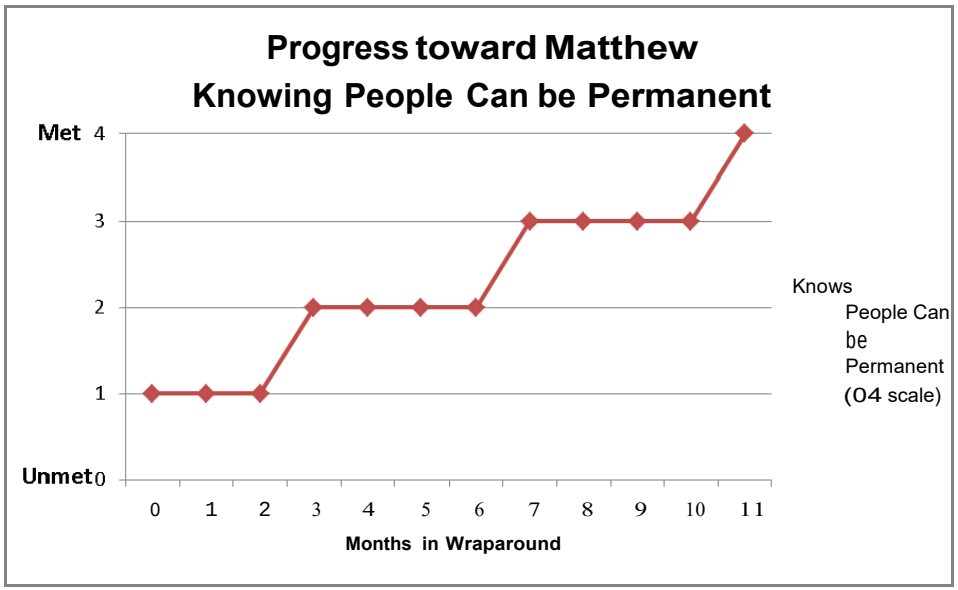
A chart like this could be done by hand on flip chart pages that are brought to each meeting. Ideally, the care coordinator would then take the ratings and create an electronic tracking display via an Excel template for review at the next CFTM.

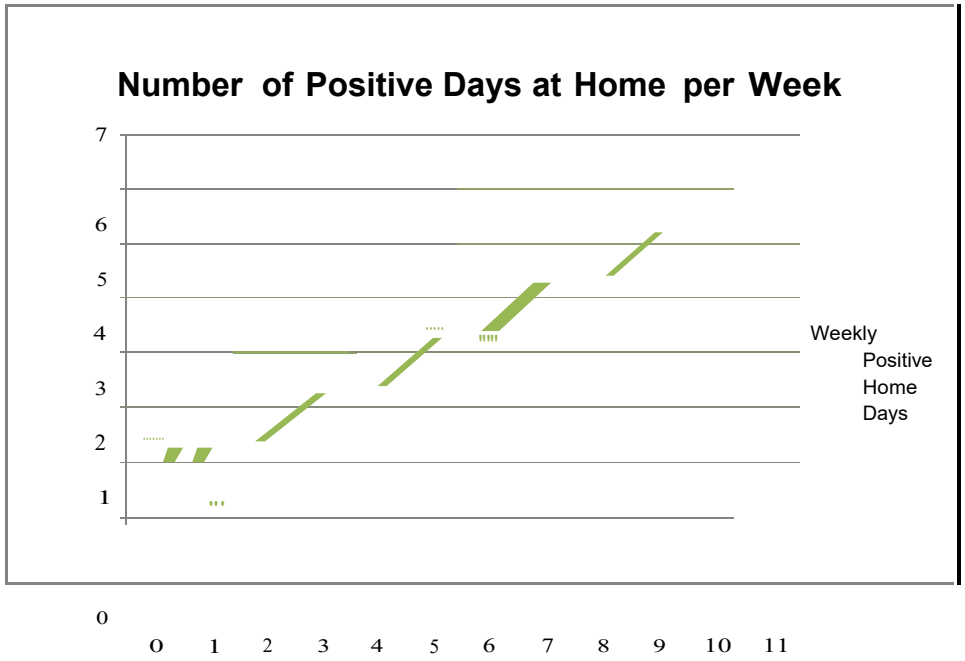
Other important events, like implementation of various strategies could also be mapped on the graph to provide more context and link progress to strategies.

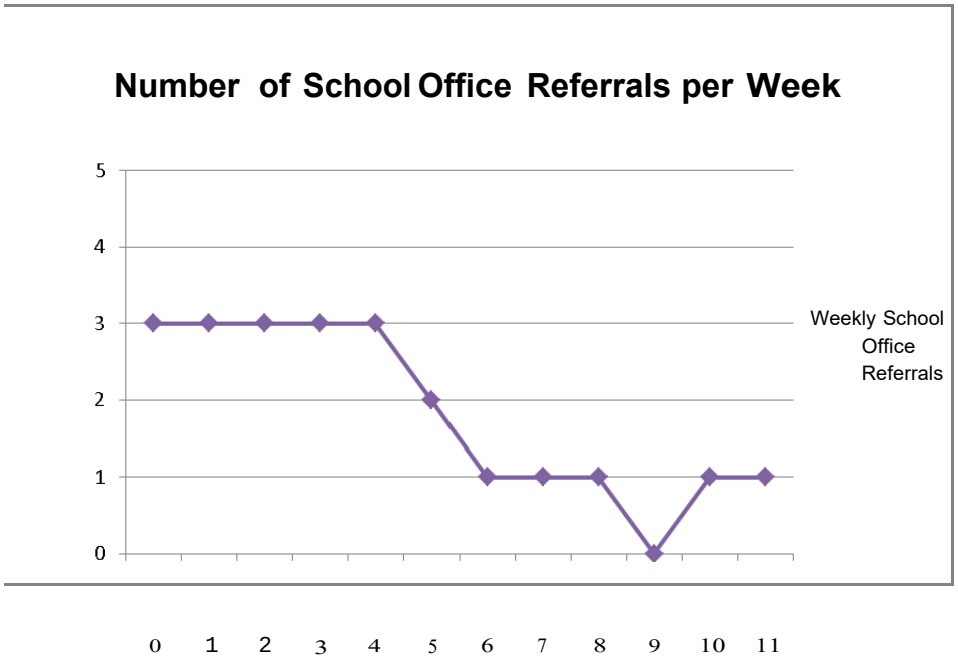


Pulling progress graphs apart to be viewed separately but on the same page may be helpful or more readable for some team members and preserves the individual items' response scales.







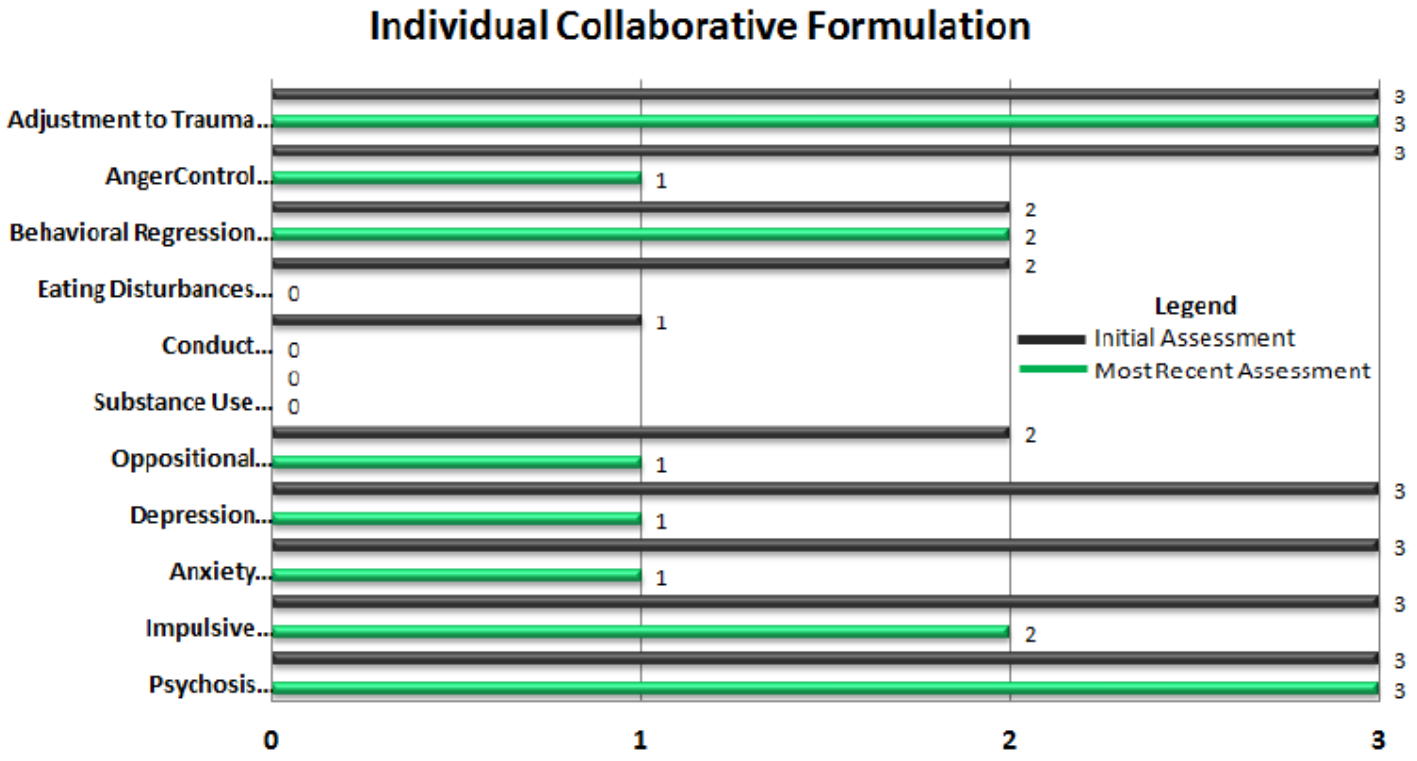


Months in Wraparound

Months in Wraparound

CLIENT-LEVEL CANS PROGRESS MONITORING

Below is an example of a "Individual Collaborative Formulation" graph that compares a youth's initial and subsequent scores on the CANS. This is one of several reports receommended by CANS developer John Lyons to facilitate data use for treatment planning.

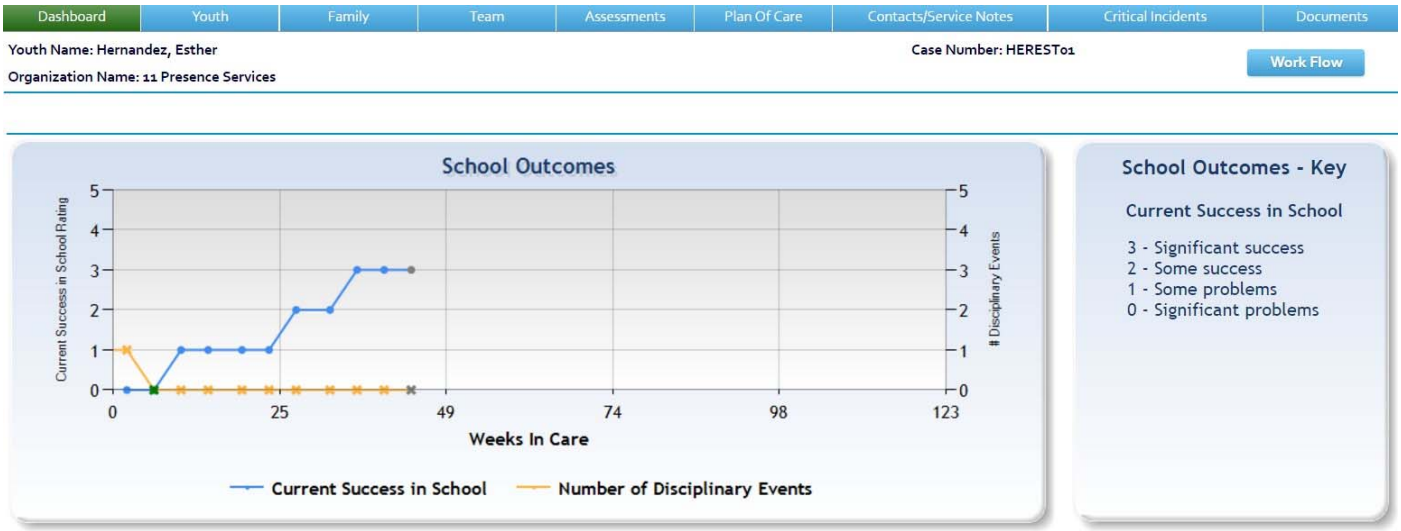


EMBEDDED ELECTRONIC HEALTH RECORD (EHR) CHARTING EXAMPLES

Some electronic heath records have embedded reporting capabilities that can be utilized by care coordinators to chart progress. For example, FidelityEHR (http://www.fidelityehr.com/), a platform designed specifically to support behavioral health coordinated services, provides the following client-level progress monitoring tools:

For youth with multiple underlying needs being planned for at the same time, it can be helpful to visually monitor global progress on each need on the same graph to foster understanding of how the needs are interconnected and to be able to balance progress in multiple domains at once.

Another approach to charting progress over time is to display multiple outcomes related to the same life domain on one graph. The example below charts a subjective rating of "Success in School" alongside a more objective measure of the "Number of Disciplinary Events."



As highlighted in Activity 3.3.a., team and/or family member satisfaction should also be tracked. Below is an example of charting the family's satisfaction with both Wraparound Services and their amount of progress toward getting their needs met.

APPENDIX E: COMMONLY USED STANDARDIZED TOOLS/ADMINISTRATIVE DATA

Name	Assessment Purpose	Number of Items and Subscales	Administration	Cost
Brief Problem Checklist	Youth Mental Health/Functioning	12-15 questions for school-age youth, with two subscales: internalizing and externalizing problems	Administered to youth and/or caregiver	Free
Child and Adolescent Functional Assessment Scale (CAFAS), 2nd Version	Youth Mental Health/Functioning	315 items measuring eight domains: School; Home; Community; Behavior Toward Others; Moods; Self-Harm; Substance Use; Thinking; Material Needs (Caregiver Scale only); Social Support (Caregiver Scale only)	Administered to youth and/or caregiver	Fixed yearly maintenance fee and a nominal fee for each assessment you use. Since the software is entirely web-based, there are no installation costs or setup fees
Child and Adolescent Needs and Strength (CANS) Assessment	Youth Mental Health/Functioning; sometimes used for determining Level of Service Need	Varies by state, often 10 domains with 10-15 items each, plus optional modules for in-depth exploration of key needs (e.g., trauma, delinquency, etc.)	Wraparound care coordinator or other certified personnel complete with or with information from caregiver, youth, and possibly other team members	Free—many version available online, but most jurisdictions partner with the Praed Foundation to develop a customized tool and purchase training and implementation support; certification strongly recommended
(Early) Child and Adolescent Service Intensity Instrument (CASII/ECSII)	Youth Level of Service Need	6 Risk dimensions about youth and youth's environment and a score on 7 levels of service intensity	Mental health provider/care manager	Free to use, but training required with a per-person charge; $35 per manual plus shipping fees
Ohio Scales	Youth Mental Health/Functioning	48 items and four subscales: 1) Problem Severity subscale (20 items), 2) Functioning subscale (20 items), 3) Satisfaction with treatment subscale (4 items), and 4) Hopefulness subscale (4 items)	Self-administered youth, parent, and agency worker forms	Free—available online, no certification required
Strengths and Difficulties Questionnaire (SDQ)	Youth Mental Health/Functioning	25	Self-administered by caregiver, youth, or teacher	Free—available online, no certification required
Treatment Outcome Package (TOP)	Youth Global Functioning	Youth (48 items), adolescent and adult versions (58 items), each with a series of key symptom and functioning domains targeted to the respondent's developmental category	Self-administered by child, adolescent, or adult	Registration conducted on the agency-level, with costs determined on a per user basis
Youth Top Problems (YTP)	Youth Global Functioning	Respondent asked to list problems, and rater then obtains severity ratings for each problem until 3 top problems are identified	Administered to youth and caregiver (separately) by a clinician/care coordinator	Free—not a scale, per se, but rather a structured approach to measuring idiographic outcomes
Caregiver Strain Questionnaire, Short Form (CGSQ-SF)	Caregiver Functioning	10	Self-administered by caregiver	Free—available online, no certification required
Parenting Stress Index, Fourth Edition (PSI™-4)	Caregiver Functioning	120 items focused on three major domains of stress: child characteristics, parent characteristics, and situational/demographic life stress	Self-administered by caregiver	$227 for intro kit (includes manual, 10 reusable booklets, 25 answer sheets, 25 profile forms)

Administrative System Data	Various	N/A	Secondary data collection	Free, but requires personnel time for data queries and sharing

BRIEF PROBLEM CHECKLIST (BPC)

DESCRIPTION

The BPC consists of two 12-item interviews administered to child and caregiver designed to assess clinical outcomes over time. Measured on a scale of 0 to 2 for each item, the BPC yields an Internalizing and Externalizing Subscale, with higher scores indicating higher problem levels. The measure is free to use. The BPC can also be administered in conjunction with the Youth Top Problems Assessment. It should be noted that this measure has been validated to assess similar constructs of the Child Behavior Checklist (CBCL) as part of the Achenbach System of Empirically Based Assessment (ASEBA) battery of assessing youth functioning.

Chorpita, B. F., Reise, S., Weisz, J. R., Grubbs, K., Becker, K. D., & Krull, J. L. (2010). Evaluation of the Brief Problem Checklist: child and caregiver interviews to measure clinical progress. *Journal of Consulting and Clinical Psychology*, *78*(4), 526.

MEASURING CHANGE

The measure developers recommend the BPC be administered on a weekly basis over a 3-month interval or more in order to track the course of clinical progress. However, they recommend that it be included as part of a larger strategy that involves a more comprehensive baseline assessment battery of measures with less frequent administrations (e.g., every 3 or 6 months), such as the CANS. Change can be measured on an item-level basis, as well as the subscale and total scores.

ADDITIONAL RESOURCES

Child Form (*Also includes items from the Youth Top Problems Assessment)*:
http://www.childfirst.ucla.edu/Brief%20Problem%20Checklist%20-%20Child.pdf

Caregiver Form (*Also includes items from the Youth Top Problems Assessment)*:
http://www.childfirst.ucla.edu/Brief%20Problem%20Checklist%20-%20Parent.pdf

CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE (CAFAS)

DESCRIPTION

The CAFAS is a measure administered to both youth and caregiver in order to assess eight domains of youth day-to-day functioning [School; Home; Community; Behavior Toward Others; Moods; Self-Harm; Substance Use; Thinking; Material Needs (Caregiver Scale only); Social Support (Caregiver Scale only)]. For each domain, the rater assesses a list of descriptors for each level of the domain, and assigns a rating once a description has been found that corresponds to the youth. Although the tool is free to use, training is required, as well as a fee of $35 per manual.

Hodges, K. (2003). *CAFAS: manual for training coordinators, clinical administrators, and data managers*.

MEASURING CHANGE

As an outcome measure, the CAFAS is used to track youth functioning over time across the critical life subscales. Change from the first and last administration of the CAFAS can be measured in three ways: (1) the total score mean; (2) the Overall Level of Dysfunction, based on the total score; and (3) the frequency of life subscales for which the youth was rated "severely impaired."

ADDITIONAL RESOURCES

Overview of the CAFAS: http://www2.fasoutcomes.com/Content.aspx?ContentID=12

CAFAS Description and Subscales: http://www.mhs.com/product.aspx?gr=cli&prod=cafas&id=overview

Ordering Assessments: http://www2.fasoutcomes.com/Content.aspx?ContentID=19

(Article) Use of the Child and Adolescent Functional Assessment Scale (CAFAS) as an outcome measure in clinical settings: https://www.researchgate.net/profile/Maria_Wong6/publication/13598959_Use_of_the_Child_and_Adolescent_Functional_Assessment_Scale_CAFAS_as_an_outcome_measure_in_clinical_settings/links/54411d9e0cf2e6f0c0f5fec4.pdf

CHILD AND ADOLESCENT NEEDS AND STRENGTHS ASSESSMENT (CANS)

DESCRIPTION

The CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS is administered to the caregiver(s) by the Wraparound care coordinator or other individual in a care coordination role. Each state that implements the CANS has its own slightly altered version of items based on the context in which it is primarily implemented (i.e., foster care, child welfare). Items in the CANS are divided into different domains (e.g., school, developmental concerns, caregiver needs, etc.). Additionally, most states have additional modules that are contingent on certain items in the domains being actionable, so as to avoid unnecessary items for irrelevant needs.

MEASURING CHANGE

Each item of the CANS is measured on a scale of 0 to 3, with each value associated with an "action level" of what degree the specific item needs to be addressed by the Wraparound team (No evidence action needed; Needs watchful watching; Needs action; Needs immediate/intensive action). As an outcomes measure, individual items and entire domains can be tracked over time, so that the Wraparound team can measure progress on items that required action in the past.

Common metrics for change on an individual youth and family level include: change in number of "actionable" items (rated 2 or 3), change in total domain score, number of items to see clinical (1-point) change over time, etc.

ADDITIONAL RESOURCES

Overview of the CANS and FAQ: http://praedfoundation.org/tools/the-child-and-adolescent-needs-and-strengths-cans/

CANS Manuals by State: http://praedfoundation.org/general-manuals-cans/

(EARLY) CHILD AND ADOLESCENT SERVICE INTENSITY INSTRUMENT (CASII/ECSII)

DESCRIPTION

The CASII is a standardized assessment tool that provides a determination of the appropriate level of services needed by a child or adolescent and his or her family. It is unique in its capacity to determine service intensity need, guide treatment planning, and monitor treatment outcome in all clinical settings. The CASII is developmentally informed and compatible with the System of Care approach – embracing individualized service planning, offering CFTs, and providing a broad service array.

MEASURING CHANGE

A decrease in the level of care determination at re-administration is considered progress. The larger the decrease, the more improvement.

ADDITIONAL RESOURCES

CASII Description:
http://www.aacap.org/App_Themes/AACAP/docs/member_resources/practice_information/casii/CASII_one_page_summary.pdf

CASII Introductory Video: http://www.aacap.org/aacap/Member_Resources/Practice_Information/CASII.aspx

(Article) CASII Background Information and Initial Data Analysis
http://www.aacap.org/App_Themes/AACAP/docs/member_resources/practice_information/casii/CASII_infor_and_data.pdf

OHIO SCALES

DESCRIPTION

The Ohio Scales for Youth is a compilation of several brief outcome measures for youth receiving mental health services. The scales include a 20 item Problem Severity scale and a 20 item functioning scale rated from the youth, parent, and agency worker perspective. In addition, the youth and parent rate short scales of Satisfaction with treatment and Hopefulness, each of which contains 4 items.

Ogles, B. M., Melendez, G., Davis, D. C., & Lunnen, K. M. (2000). The Ohio youth problem, functioning, and satisfaction scales: Technical manual. *Columbus, OH: Ohio Department of Mental Health*.

MEASURING CHANGE

The Reliable Change Index (RCI) is used to determine clinically significant change. A change score of 10 represents meaningful change on the Problem Severity scale, with a clinical cutoff score of 25. For the Parent, Youth, and Agency Worker Functioning Scales, a change score of 8 represents a meaningful change, with clinical cutoff scores of 50, 60, and 50, respectively.

ADDITIONAL RESOURCES

Overview and Measures: https://sites.google.com/site/ohioscales/the-scales

Ohio Scales User's Manual:
http://mha.ohio.gov/Portals/0/assets/Planning/OutcomesResearch/ohio-scales-user-manual.pdf

Ohio Scales Technical Manual:
https://docs.google.com/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxvaGlvc2NhbGVzfGd4OjM3YzNhOWU4MjVjYzBjYTU

STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (SDQ)

DESCRIPTION

The SDQ is a brief behavioral screening questionnaire about 3-16 year olds. The measure is self-reported by either the youth or caregiver, each with 25-items. The items are divided into four negative scales (emotional symptoms; conduct problems; hyperactivity/inattention; and peer relationship problems) as well as one positive scale (pro-social behavior). The SDQ is free to use.

MEASURING CHANGE

In addition to the five subscales, there is also a global score, each with cutoffs for "normal", "borderline", and "abnormal" behavior ranges.

ADDITIONAL RESOURCES

Homepage and Overview: http://www.sdqinfo.org/

English-Version Measures: http://www.sdqinfo.org/py/sdqinfo/b3.py?language=Englishqz(USA)

Scoring Guidelines: http://www.sdqinfo.org/py/sdqinfo/c0.py

TREATMENT OUTCOME PACKAGE (TOP)

DESCRIPTION

The TOP is a questionnaire self-administered either on paper or online, designed for children (48 items), adolescents, and adults (58 items). The TOP assesses symptom and functional domains in the last two weeks on a Likert scale ranging from "None of the time" to "All of the time". Different domains are present for each of the three versions of the measure: child (suicide; violence; psychosis; depression; ADHD; separation anxiety; eating; sleep; conduct; assertiveness; incontinence; strengths; sexual acting out), adolescent (suicide; violence; psychosis; depression; ADHD; social conflict; sleep; conduct; work/school functioning; mania; substance abuse) and adult (suicide; violence; psychosis; depression; substance abuse; panic (psychological symptoms of anxiety; mania; sleep; work functioning; social functioning/social conflict; sexual functioning; quality of life).

Registration is conducted on an agency-level basis, with costs determined on a per case basis.

MEASURING CHANGE

The TOP is generally administered at the beginning, middle and end of treatment. The frequency of TOP administration varies based on the needs of individual agencies, with a recommended frequency of once every 1 to 3 months. All scores are entered into the TOP's online system, where agency workers can generate several different reports tracking client changes over time. Clients' scores are compared to US population norms.

ADDITIONAL RESOURCES

Overview and Registration Information:
http://www.outcomereferrals.com/index.php/main/sub-page/category/top-assessment/top-assessment

Measure Overview:
http://www.outcomereferrals.com/main-downloads/child-welfare-1.pdf

YOUTH TOP PROBLEMS ASSESSMENT (TPA)

DESCRIPTION

The TPA is simply a structured way of assessing client and/or parent report of primary concerns to be addressed in treatment. Administered separately for youth and caregivers, the respondent is asked to list the problems they are currently experiencing. The problems are then recorded by the administrator, and the respondent rates the problem on a scale of 0 (*not at* all) to 10 (*very much*). This process continues until the youth/caregiver has exhausted the list of problems. The problems with the top three scores from each respondent are then used to inform treatment. The TPA can also be administered in conjunction with the BPC.

Weisz, J. R., Chorpita, B. F., Frye, A., Ng, M. Y., Lau, N., Bearman, S. K., ... & Hoagwood, K. E. (2011). Youth Top Problems: using idiographic, consumer-guided assessment to identify treatment needs and to track change during psychotherapy. *Journal of consulting and clinical psychology*, *79*(3), 369.

MEASURING CHANGE

While this measure was designed to address immediate needs of the youth/family, it can also be used as an outcomes measure by tracking both the presence of and subjective severity ratings of specific problems over time.

ADDITIONAL RESOURCES

(Article) Youth Top Problems: Using Idiographic, Consumer-Guided Assessment to Identify Treatment Needs and to Track Change During Psychotherapy: http://www.childfirst.ucla.edu/Weisz%20et%20al%20(2011)-Youth%20Top%20Problems.pdf

Child Form (*Also includes items from the Brief Problems Checklist)*:
http://www.childfirst.ucla.edu/Brief%20Problem%20Checklist%20-%20Child.pdf

Caregiver Form (*Also includes items from the Brief Problems Checklist)*:
http://www.childfirst.ucla.edu/Brief%20Problem%20Checklist%20-%20Parent.pdf

CAREGIVER STRAIN QUESTIONNAIRE (CGSQ-SF)

DESCRIPTION

The Caregiver Strain Questionnaire-Short Form (CGSQ-SF) assesses the extent to which caregivers and families experience additional demands, responsibilities, and difficulties resulting from caring for a child with emotional or behavioral disorders. The CGSQ-SF is a free, self-reported measure completed by the caregiver, consisting of 10 items on a 5-point Likert scale.

MEASURING CHANGE

Although no RCI scores are available for individual improvement, a paired samples t-test would be appropriate for determining significant changes of a sample of caregivers from baseline to follow-up administrations of the measure.

ADDITIONAL RESOURCES

Measure and Scoring Guidelines: http://peabody.vanderbilt.edu/docs/pdf/ptpb/PTPB_AppB_CGSQ_SF.pdf

(Article) Caregiver Strain Questionnaire – Short Form:
http://peabody.vanderbilt.edu/docs/pdf/ptpb/PTPB_Chapter12.pdf

PARENTING STRESS INDEX (PSI™-4)

DESCRIPTION

The PSI™-4 is a 120-item self-reported measure administered to both the caregiver and youth. It is designed to evaluate the stress of the parent-child system, focusing on three major domains of stress: child characteristics, parent characteristics, and situational/demographic life stress. The PSI™-4 costs $227 for an introductory kit, which includes the training manual, 10 reusable booklets, 25 answer sheets, and 25 profile forms.

Abidin, R. R. (2012). PSI-4 Professional Manual. *Psychological Assessment Resources, Lutz, FL*.

MEASURING CHANGE

Normed data is available in the manual, and so it may be possible to determine the Reliable Change Index for individual scores (Jacobson & Truax, 1991). A paired samples t-test would be appropriate for determining significant changes of a sample of caregivers from baseline to follow-up administrations of the measure.

ADDITIONAL RESOURCES

PSI-4 Overview, Features, Technical Information, and Product Orders:
http://www4.parinc.com/products/Product.aspx?ProductID=PSI-4

Jacobson, N. S., & Truax, P. (1991). Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of consulting and clinical psychology*, *59*(1), 12. Retrieved from: http://www.personal.kent.edu/~dfresco/CRM_Readings/JCCP_Jacobson_ClinSIG.pdf

ADMINISTRATIVE SYSTEM DATA

Data collected primarily for administrative purposes, usually during the delivery of services, can be a treasure trove of information about youth and family needs and outcomes. Data points such as the number of previous psychiatric hospitalizations, foster care placements, school attendance, arrests, etc. can provide concrete context to a youth's and family's story and ongoing progress.

Many Wraparound programs seek data sharing agreements with local school, child welfare, health care, and justice agencies to routinely access and/or receive administrative data about Wraparound-enrolled youth. If this data is identifiable at a youth level it can be used for planning and progress monitoring. Even if the data is de-identified (i.e., not able to be tied directly back to a youth or family) it can still be used for program or system accountability. Collecting data directly from an agency's database, often via routine "data dumps" can save care coordinators time and ensure completeness, but does require Wraparound providers to have data management capabilities.

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