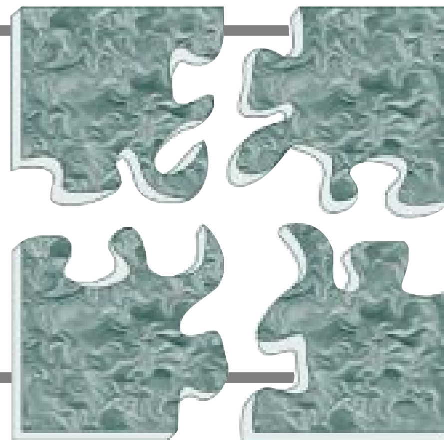
No. 14, 1999-2000

BEST PRACTICE BRIEFS



PUTTING THE PIECES TOGETHER

SERVICE COORDINATION

- takes many different forms
- involves careful agency planning
- can be connected to systems reform

WRAPAROUND PROMOTES GOOD OUTCOMES because it

- is respectful
- empowers
- creates a single service plan
- meets needs
- uses informal services
- overcomes agency limitations

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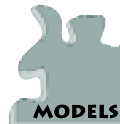
EXAMPLES OF SERVICE COORDINATION

__BEST PRACTICE BRIEF__ No.13 explored the parameters of Service Coordination. This __BRIEF__ presents four examples of Service Coordination—two experiences of persons receiving services (the Wraparound Model illustrating empowerment and a brief description of a support approach to Service Coordination) and two outlines of systems design (Service Coordination within Head Start and a brief description of a compliance model for serving juvenile delinquents). Reference is made to the various characteristics of Service Coordination discussed in __BRIEF NO. 13.__

EXAMPLE 1: USING THE WRAPAROUND MODEL FOR FAMILIES WITH DEVELOPMENTAL DISABILITIES[1]



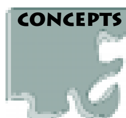
Background.

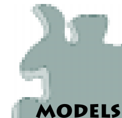
"Wraparound" is a well articulated model for intervention and service coordination. Developed initially for severely emotionally disturbed children to reduce use of out-of-home services, Wraparound has also been applied in Michigan for other populations.

The basic premises of Wraparound are

- ***Unconditional commitment.** Individuals and families are never discharged for lack of progress; agency team members are obligated to find another solution.*
- ***Focus on family and individual strengths,** not deficits.*
- ***Individualized service planning across all relevant life domains.***
- ***Collaborative participation** across agencies in service planning and delivery and in funding.*
- *Use of **community and informal resources.***
- ***Individuals or families** partner with agency staff to **make decisions.***
- ***Flexible funding** for nontraditional services and to minimize eligibility or use limitations.*

[1] This example reflects experience in Livingston County, Michigan.





The Issue

Middleton County, between two metropolitan areas, has a well functioning multi-purpose collaborative body (MPCB) that has been successful in implementing the Wraparound Model for severely emotionally disturbed children referred from the mental health agency, the courts, and social services. Using capitated funding under Medicaid, the county agencies have saved substantial sums of money. The MPCB was open to using this approach for other difficult-to-serve populations. An interagency group of providers that works with families with young children, meeting for training and consultation, identified ***parents with developmental delays*** as a population poorly served by current arrangements. The issue was taken to the MPCB who agreed to test the relevance of a Wraparound approach.

The Target Population. Service providers perceived the following issues in the delivery of traditional services for families with young children where the parents had a developmental disability, difficulties with learning, or a cognitive impairment:

- These families characteristically did not seek out services until someone in the community recognized they were in crisis.
- Families were overwhelmed by receiving uncoordinated services from multiple agencies.
- Families did not view agency services as helpful for their primary problems; what families needed was not necessarily within staff assignments.
- Service providers found working with these families stressful, anxiety-producing, and time-intensive.
- Families kept resurfacing; difficulties seemed to be on-going and minimally affected by services provided.
- No agency was taking action to overcome the children's high risk for poor cognitive development.

A Sample Target Family. The family consists of mother, father—both graduates of special education —and Marie aged 2. Mother is subject to epileptic seizures. Family is receiving Temporary Assistance to Needy Families (TANF); the father is employed part-time at a local grocery. Family lives in a trailer that agency workers consider unsafe for a young child. Paternal grandmother lives close by but has quarreled with mother over letting the child outside without supervision. Family had attended a Public Health well baby clinic but did not follow through on recommendations for an assessment for developmental delay. Public Health nurse was concerned about the child's sad affect. Family is considered recalcitrant and unmotivated, and a potential candidate for Protective Services.

The Process

Organization. The MPCB and its participating agencies took the following steps in preparation for the pilot:

- **Flexible funds** were identified and assigned.
- The agencies (Community Mental Health, Social Services, Public Health, Intermediate School District) **made staff available** for teams to work with each child and family.
- Persons trained in the wraparound process were assigned as service coordinators.
- An **oversight committee** was selected to trouble shoot and evaluate.
- **Families** were **nominated.**

Getting Underway. The Wraparound Coordinator approached the family who, in view of their previous aversive contact with agencies, reluctantly agreed to participate. The parents selected representatives of the following agencies who were then invited to be members of the family's Team: Mental Health, Intermediate School District, Public Health, Social Services, employment/training agency. Several of the Team members had attended wraparound training. Because the family's trailer was so small, the parents decided to hold the meeting at the neighborhood church. It was decided to hold the first planning meeting in the afternoon so that the father could attend.

The Wraparound Coordinator met with members of the Team before the family meeting so that all members of the Team had a common understanding of the wraparound process, including the ground rules for the meetings.

The First Meeting. The Team brought snacks to the meeting and a toy for the child. The Wraparound Coordinator facilitated a discussion in which the parents agreed that they would like life to be better for themselves and their child.

Step 1. The Strength Assessment identified the strengths of the family—the willingness of the father to support his family, the mother's concern for the child, the skills and interests of the parents, the attractiveness of the child and her ability to reach out to strangers, the interest of the grandmother.

Step 2. Review of Life Domains. The family and the Team identified the family's priority needs. The family agreed on some things that they would like to accomplish:

- Health—the mother would like to be free of seizures.
- Finances—the family needed more income; therefore the father wanted a fulltime job.
- Housing—the trailer was too small and not safe; the family agreed it should be sold and more appropriate housing obtained.
- Social support—the mother and grand-mother needed to get along better.

At this meeting, it was not possible to focus on the needs of the child.

Step 3. Wraparound Plan

- The Public Health nurse agreed to assist the mother to make an appointment for a check up and review of medications.
- The employment/training representative invited the father to a work search group.
- The mother and father agreed to get the trailer ready to sell. The Team and the family discussed what would have to be done, and what the father would do first.
- The mother agreed that the grandmother should be invited to the next meeting.

The Second Meeting. The Team again brought snacks. The Team and the family talked about how things might be better for Marie.

- The mother said she yelled at the child a lot and she would like to feel less stressed. The Team explored whether the seizures were related to these periods of stress. The Mental Health representative said that there were various parents groups in town; the mother said she would rather have someone come to her home.
- The grandmother noted that Marie wasn't talking yet. The Intermediate School District representative noted that children learn at different rates but suggested that it would be helpful to have Marie's development checked out at the Intermediate Center.
- The father said there weren't any children nearby for Marie to play with. The Team talked about Head Start.

The Coordinator agreed to facilitate linkages by finding a parent mentor and by assisting the mother to set up an appointment for Marie at the Intermediate Center. *(By not making the appoinment for the mother, she used an empowerment strategy.)* The grandmother said she could drive Marie and her mother to the Intermediate Center.

The rest of the meeting was spent reviewing what had been accomplished after the first meeting. The father announced that the family would provide snacks next time.

Subsequent Meetings. The family and the Team reviewed progress, discussed how the family might accomplish what they set out to do, and revised the service plan.

The Team provided funds for paint and other repairs to the trailer. The Coordinator facilitated the arrangements for service and empowered the family by supporting them in making appointments. Team members advocated for service provision to the family within their agencies and educated the family by interpreting the reasons for agency recommendations.

Results

Over a period of four months, the family was able to accomplish the following:

- The father received coaching in job search and found a fulltime job.
- The trailer was made ready for sale.
- The mother had a health evaluation and her medication was changed, but she is still subject to seizures.
- The grandmother is actively involved with the family.
- A neighbor was found to support the mother during stressful periods and to help her find ways to work with Marie without yelling.
- Marie's developmental status was evaluated, and some remediative measures were taken.
- Marie was enrolled in Early Head Start.
- She changed from a sad little girl to one who smiles more and talks more.

In addition, the family learned a problem-solving process, expanded their supports, took more respon-sibility for resolving issues, and gained confidence in their ability to cope. The family said working with a Wraparound Team was less confusing and more pro-ductive than working with individual service providers.

The service providers indicated that the Wrap-around approach required more investment of their time and energy. However, unlike previous service episodes, the family was making significant progress toward accomplishing a wide range of meaningful goals that would avoid future problems and result

in cost-savings to the agencies.

The Team, augmented by the Head Start family service worker, continued to meet periodically at the family's request to assess progress and revise plans.

Example 2. Providing Continuity with a Support Model[2]

Jenny, age 13, with a history of involvement with the Juvenile Court and mental health system, was assigned to a Child and Family Team consisting of representatives from Social Services, Mental Health, the Juvenile Court, and the school. Over the next three years, the Team stayed with Jenny through run away episodes, termination of parental rights, and placement in four foster homes. The Team, carrying out their unconditional commitment, fought to have her remain in the community, maintained contact with her, and advocated for what Jenny saw as her needs.

The team approach had many benefits according to one member:

- **continuity** in service planning—when the Social Services staff changed, the new worker didn't start all over again but used the Team's service plan
- **consistency** in approach among agencies
- more **creative use of community resources** such as Big Sisters
- **greater responsiveness** by the Juvenile Court to Jenny's needs
- **staff** with interagency support could be **more flexible** in making arrangements for Jenny

The Team facilitated Jenny's connection to services, monitored her progress, managed emergencies, advocated for her, provided support, coordinated services, and buffered her from the bureaucracy. While empowerment was not stressed, there was greater attention to Jenny's concerns than would have occurred under usual agency practice.

At 16, Jenny has stabilized. The Team expects to be involved with her until she turns 18.

[2]This example reflects experience in Marquette County, Michigan.

Example 3. Developing Service Coordination in Head Start

Background

Performance standards for Head Start and Early Head Start[3] specify that Head Start staff must assess, on an ongoing basis, "the resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their child."[4] Individualized Family Partnership Agreements are ordinarily developed for each family covering health and other family goals; however, participation is voluntary, and a family may refuse. Performance standards specify the development of ongoing collaborative relationships with community organizations to promote access to community services for Head Start children and families.[5]

[3] Relevant excerpts from *Part 1304—Program Performance Standards for the Operation of Head Start Programs by Grantee and Delegate Agencies* are cited in footnotes.

[4] §1304.3(a)(1)(ii). [5] §1304.31(a)(2).

Sites must organize staff to perform the functions and timelines specified in the Performance Standards within the limited dollars allocated by the federal government. Budgetary constraints and historical development have predisposed Head Start programs to use paraprofessional staff, often parents whose children have received Head Start services. A Policy Council of parents guides the program.

The Issue

XYZ Head Start provides both center-based and home visiting services for children ages 0 to 5. Deciding to reassess their procedures, the Director of the agency receiving the Head Start grant and the Director of the Head Start and Early Head Start programs met to map out a strategy. They identified their task as improving Service Coordination for Head Start families, with a goal of enhancing connections with community agencies. They undertook the steps outlined below as one way of going about this process. *(These and similar suggestions are already in the procedures used by many Head Start programs.)*

The Process

Step 1. Information Gathering

- **They identified the outcomes for a better system of Service Coordination:**
  - obtaining needed information
  - meeting deadlines for obtaining health services for children
  - avoiding duplication in service plans and uncoordinated services
  - linking families to needed services
  - empowering families to be their own Service Coordinators
- **They assessed their relationships with community agencies,** noting that
  - they were already working well with the Local Education Authority (LEA) and its Service Coordinator for families with a child with disabilities, but they did not have adequate working relationships with other agencies;
  - there were no formal agreements in writing;
  - arrangements in place for health screening and health care had been disrupted by the advent of managed care;
  - families receiving TANF had a case manager who assisted them to overcome barriers to obtaining jobs;
  - families receiving TANF were enrolled in one of two HMOs serving the area.
- **They looked at their current situation** and talked to staff. They found that
  - the enrollment was 500 families;
  - the people currently involved in linking families to services included four family service workers and the health worker;
  - teachers and the parent educator had the most contact with families and were the ones most likely initially to identify needs for service;
  - staff members met independently with most parents, discussing specific needs and appropriate services;
  - the disability services worker and the mental health consultant primarily worked with teachers, although they might identify and follow through with a need for linkage to services;
  - teachers, home visitors, and family service workers made home visits;
  - the staff were not familiar with all community services that might benefit their families;
  - there was no one on staff with professional training in Service Coordination.

Step 2. Preliminary Decision Making. They talked over their insights with staff and the Head Start Policy Council and made some tentative decisions.

- They needed **some basic information about each family.** Answers to relevant questions would be obtained at intake by staff after eligibility for Head Start services had been established and noted in health and health history forms.
  - Was the family enrolled in an HMO? What was the name of their physician? Had the child had a basic health screening? Immunizations?
  - Were the staff of any other agency working with the family as a Service Coordinator? Authorization would be obtained to invite the family's Service Coordinator(s) to work with Head Start in developing the family's plan of service.
  - Did the family identify any immediate needs?

- The staff capacity as currently organized would be stretched to provide all families with in-depth service planning within the time limits. They proposed to try a **modified generalist model.** For example,
  - Home visitors would do service coordination for their families.
  - The family services workers and the health worker would become a cadre, identified as family services/health workers, working on health and all other issues.
  - The teachers, the parent educator, and the disability services worker would provide information to parents not initially assigned to the other workers.
- They would **prioritize families** for service coordination based on the information obtained at intake and make assignments as follows[6]
  - **Priority 1.** Families of children whose health requirements were unmet. These families would be the primary responsibility of the family services/health workers.
  - **Priority 2.** Families of children whose health requirements were being met but had needs for service coordination. These families would be the primary responsibility of the family services/health workers.
  - **Priority 3.** Families of children whose health requirements were being met and did not appear to have unmet needs for service coordination. These families would be the initial responsibility of the teachers, the parent educator, and the disability services worker.
- All **parent training would include practice in accessing services and advocacy.**[7]
- There would be a **single plan of service** for each family within Head Start that, if possible, would incorporate the service plans of other community agencies.[8]
  - Each family would be assigned to a lead person in Head Start (a family services/health worker) who would involve the teacher and coordinators from other agencies in service planning.
  - A Family Partnership Agreement would document the working agreement with the family and all of the services provided.
- Staff would meet as **multi-disciplinary staffing teams** to plan and coordinate activities. Outside service providers would be invited to participate in the discussion.
- Staff needed more accessible **information about community resources.**
  - The Head Start Director would update a master file covering eligibility, arrangements for access, contact person, etc., and develop an easy-to-use list for each staff member.
  - Developing or accessing an existing computerized file would be explored.
- The agency would **facilitate the work** of staff by providing cell phones, hand held computers, and access to a company car.
- Staff needed **training** in the process for service coordination and service planning. They would identify a social worker knowledgeable about Service Coordination who would train staff in the wraparound process and in
  - engaging parents,
  - working with service coordinators from other agencies,

[6] §1304.40. Family Partnerships. (a) Family goal setting. (1)… (Head Start) agencies must engage in a process of collaborative partnership building with parents to establish mutual trust and to identify family goals, strengths, and necessary services and other supports. This process must be initiated as early after enrollment as possible and it must take into consideration each family's readiness and willingness to participate in the process… (b) Accessing community services and resources. (1) …(Head Start) agencies must work collaboratively with all participating parents to identify and continually access, either directly or through referrals, services and resources that are responsive to each family's interests and goals, including (i) emergency or crisis assistance in such areas as food, housing, clothing, and transportation; (ii) Education and other appropriate interventions including opportunities for parents to participate in counseling programs or to receive information on mental health issues that place families at risk, such as substance abuse, child abuse and neglect, and domestic violence; and (iii) Opportunities for continuing education and employment training and other employment services through formal and informal networks in the community.

[7] Ibid…(g) Parent involvement in community advocacy. (1) …(Head Start) agencies must (i) Support and encourage parents to influence the character and goals of community services in order to make them more responsive to their interests and needs; and (ii) Establish procedures to provide families with comprehensive information about community resources.

[8] Ibid…(3) To avoid duplication of effort, or conflict with, any preexisting family plans developed between other programs and the Early Head Start or Head Start family, the Family Partnership Agreement must take into account, and build upon as appropriate, information obtained from the family and other community agencies concerning preexisting family plans. …(Head Start) agencies must coordinate, to the extent possible, with families and other agencies to support the accomplishment of goals in the preexisting plans.

- identifying family strengths and needs according to life domains,
- developing a single plan of service,
- using the directory of services and facilitating access,
- supporting, empowering, and enabling parents to be their own Service Coordinator,
- advocating and using informal resources, and
- monitoring the provision of services.

- The social worker would also be engaged as a **consultant/supervisor** to attend the meetings of the multi-disciplinary staffing teams.
- A **simple protocol** and a **feedback report** would be developed for Service Coordination.
- **Job descriptions** and **recruitment interview procedures** would be reviewed and modified to emphasize Service Coordination skills.
- The agency Director/Head Start Director would raise the issue of **coordination and collaborative service planning**[9] with the **multi-purpose collaborative body** to obtain sanction and assistance and an agreement to report during the year about successes and obstacles.
- The agency Director/Head Start Director would **visit the HMO** to clarify how health screening and joint service planning might be accomplished. Understanding of how to proceed would be verified in a memorandum of agreement.
- The agency Director/Head Start Director would make **visits to the social services Director** and to the **coordinator of services for handicapped and developmentally delayed infants** to clarify how joint service planning might be accomplished. Understanding of how to proceed would be verified in a memorandum of agreement (see **BEST PRACTICE BRIEF NO. 7**).

Step 3. Implementation. The last step in the planning process would be to write out, try out, evaluate, and revise the new procedures. The procedures would provide a framework and facilitation for Service Coordination.

EXAMPLE 4. COORDINATING SERVICES FOR JUVENILE DELINQUENTS: A COMPLIANCE MODEL

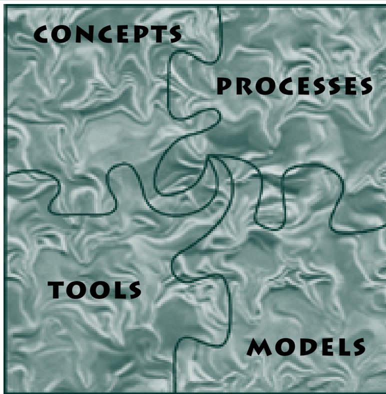
Each month between 150 and 200 adolescents adjudicated as juvenile delinquents are committed to or placed with the court system in Wayne County, Michigan. This year, they will enter a service coordination system of care developed to reduce residential placements and recidivism and to improve educational outcomes.

- Assessment centers will identify the adolescents' needs and required levels of service and assign each adolescent to a care management organization.
- The care management organization will develop a service plan for each adolescent and monitor the provision of services.

In this focus on systems reform, the approach to services will be community-based, family-focused, strength-based, integrated and collaborative; service plans will be individualized, covering all life domains.

Carrying out compliance functions, the care management organization is responsible for seeing that a network of needed services is available; for managing the allocation of capitated dollars; for monitoring service delivery and assessing quality, process, and outcomes; and for assuring that federal, state, and county reporting requirements are met.

[9] §1304.41. Community Partnerships. (a) Partnerships. (1) …(Head Start) agencies must take an active role in community planning to encourage strong communication, cooperation, and the sharing of information among agencies and their community partners and to improve the delivery of community services to children and families in accordance with the agency's confidentiality policy…. (2) … (Head Start) agencies must take affirmative steps to establish ongoing collaborative relationships with community organizations to promote the access of children and families to community services that are responsive to their needs and to ensure that Early Head Start and Head Start programs respond to community needs including (i) Health care providers…; (ii) Mental health providers; (iii) Nutritional service providers; (iv) Individuals and agencies that provide services to children with disabilities and their families…; (v) Family preservation and support services; (vi) Child protective services…; (vii) Local elementary schools and other educational and cultural institutions…; (viii) Providers of child care services; and (ix) Any other organizations or businesses that may provide support and resources to families… .(4) To enable the effective participation of children with disabilities and their families, …(Head Start) agencies must make specific efforts to develop interagency agreements with LESAs and other agencies.



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SUMMARY

This **BRIEF** has explored four examples of Service Coordination to clarify the concepts and processes outlined in **BRIEF NO. 13.** The fully articulated Wraparound model shows the effect of bringing a previously unempowered family into decision making and coordinated service planning. The story of Jenny illustrates the positive consequences when agencies join together to support an individual, incorporating unconditional commitment and coordinated service planning. The Head Start example illustrates the complex decision making required to implement Service Coordination. The compliance model of Service Coordination proposed to serve juvenile delinquents is a highly articulated community system of care. These examples, while representative of various populations and modes of operating, do not exhaust the range of current permutations and future possibilities for Service Coordination.

This **BEST PRACTICE BRIEF** was developed with the assistance of **Michigan State University** faculty and staff DAVID KNAGGS and PAUL FREDDOLINO, School of Social Work; CELESTE STURDEVANT REED, Institute for Children, Youth and Families; BROOKE FOULDS and JAN KOWALSKI, Q-Net, Outreach Partnerships; and JOAN ABBEY, Consultant to Wayne County; RUTH ALMEN, Pathways, Marquette; LYNN CROTTY, Oakland-Livingston Human Service Agency; MARY LUDTKE, Michigan Department of Community Health; BETH SHERMAN and KATHY MANTA, Livingston County Intermediate School District; and the School and Community staff at Mott Children's Health Center, Flint.
SANDY KALLEN, Nursing Consultant, provided material for **BEST PRACTICE BRIEF NO. 13.**

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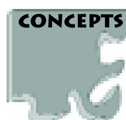

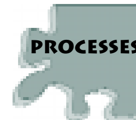

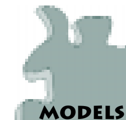

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