Wraparound Milwaukee, Milwaukee County (WI)

(**Group Three:** Formalized Wraparound Process)

Overview

The "Wraparound Milwaukee" program, which began in 1995, is a multi-stakeholder, public system of care for high risk youth and families organized around risk-based, blended funding that pays for a broad range of services and supports provided through an individualized, wraparound approach to service planning and provision. Wraparound Milwaukee is managed by the Milwaukee County Division of Child Mental Health Services, which functions as a management services organization (or managed care entity). Initially based upon a six year, $15 million federal grant from the Center for Mental Health Services (CMHS) to Milwaukee County, it was one of the first ten such sites funded throughout the country. The intent of the federal grants was to "foster the development of more comprehensive, community-based care for children with serious emotional needs and their families,"[90] Milwaukee Wraparound is designed to be accountable and at risk for service use, dollars spent, and clinical results achieved, and its administrators are fluent in managing care and reporting outcomes. It has both far more information about individual children served than most public mental health systems and far more flexibility as to what can be provided, largely as a result of blended funding and case rate and captitation financing arrangements. It is built on a foundation of CASSP principles.[91] In the ten years since it started, Wraparound Milwaukee has repeatedly demonstrated improvements in areas such as community safety and school attendance. There have also been significant improvements in the program's ability to maintain youth at home who were otherwise likely to be placed in hospital or residential care.

Goals

As previously documented in the Health Care Reform Tracking Project's Promising Approaches series.[92] Wraparound Milwaukee was designed to reduce the use of institutional-based care, such as residential treatment centers and inpatient psychiatric hospitals, while providing more home and community-based services. CMHS grant support was targeted to ensure greater family inclusion in treatment programs, along with collaboration among child welfare, education, juvenile justice, and mental health in the delivery of services.[93] Therefore, many of Wraparound Milwaukee's measurement points and data collection activities relate to items of importance to the program's stakeholders/purchasers, such as: the number of youth in placement, service dollars broken out by offender type, recidivism, school attendance, and level of functional impairment.

90 alt.samhsa.gov/samhsa_news/VolumeXII_5/article2

91 Stroul, B. A. & Friedman, R. M. (1994, rev. ed.). A system of care for children and youth with severe emotional disturbances. Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

92 Pires, S.A (2002). Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems, 1: Managed care design & financing (FMHI Publication #211-1). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

93 More information on the origin and design of Wraparound Milwaukee can be found on their website: www.milwaukeecounty.org/service

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Background

Wraparound Milwaukee uses formal instruments to monitor clinical progress, such as the Child Behavior Checklist (CBCL),[94] Youth Self Report (YSR),[95] and the Child and Adolescent Functional Assessment Scale (CAFAS)[96] (five scales), as determined by the original CMHS grant evaluation protocols. They do not use any pre-admission "assessment tools" because they are required to accept any court-ordered child who matches eligibility. However, the eligibility definition itself is based on level-of-care criteria described within their contract with the State Medicaid agency. These include:

(a) the federal definition of "serious emotional disturbance" (SED)

(b) must have clinical symptoms consistent with SED within the last six months and having persisted over the past year

(c) presence of a DSM-IV diagnosis

(d) functional impairment in any of the following areas: psychosis, dangerous to self or others, lack of self-care, personal grooming, lack of age-appropriate decision making, social relationships, peers and adults, family, disruptive behavior, violence, school/work

(e) involved with two or more service systems

(f) at risk of immediate placement in psychiatric hospital, residential care or correctional system.

The eligible population is therefore a special population, determined by the referring agencies within the county, as well as (initially) the federal government, to require highly intensive services. Wraparound Milwaukee does not represent either a floor or a ceiling for services within the county, but is instead an alternative to usual care. The program increases access to clinically appropriate services for those youth who are able to remain at home as a result of the individualized, community-based services, but administration of the eligibility guideline is done before the referral is generated.

Initial treatment decisions, ongoing care and treatment monitoring are done within the context of the "Child and Family Team" concept. The team determines "medical necessity;" all care is signed off on by either a psychologist, or if medication is involved, a psychiatrist. This person may be either a treating clinician on the team or a consultant to the team.

94 Achenbach, T. M. & Rescorla, L. A. (2001). Manual for the ASEBA school-age forms & profiles: an integrated system of multi-informant assessment. Burlington, VT: ASEBA

95 Ibid.

96 Hodges, K., Wong, M. M., & Latessa, M. (1998). Use of the Child and Adolescent Functional Assessment Scale (CAFAS) as an outcome measure in clinical settings. Journal of Behavioral Health Services and Research, 25 (3), 325-336.

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Selection of treatment goals and appropriate interventions is guided by the use of structured "Life Domain" documents. These are updated and reviewed to measure clinical improvement and for quality management purposes. Clinical tools are also used to measure improvement, but not to drive immediate service decisions. Analysis of trends in functional measures does ultimately provide input for changes in program treatment strategies.

Description

The instruments and guidelines used by Wraparound Milwaukee are not mandated by the state nor are they widely in use within the state. They are a combination of formal measures defined by SAMHSA as part of the federal grant participation, along with additional measures chosen by the program for the purposes of following and reporting results. An example of the latter is the collection of data regarding juvenile offenses for the periods six months prior to the program, during the program, and up to three years post program involvement.

Care Coordinators collect: a) CAFAS scores and b) school attendance and related records. Family members and youth periodically provide: (a) CBCL and YSR data, (b) Updated Life Domain information. Juvenile justice staff provides information on offense records, past and present. There are audits regarding missing or completed data, but the need for monitoring of the way that guidelines are being used is up to individual supervisors to determine.

Individualized, Culturally Competent Family Focus

Wraparound Milwaukee is a model of family-driven, individualized care, and Care Coordinators are instructed to share all instruments and results with the families. The Child and Family team process supports flexible care planning, consistent with the wraparound philosophy, and also supports caregiver/youth decision-making roles.

The Care Coordinator makes edits to the care plan on a regular basis in response to informal and formal feedback regarding the youth's progress toward his goals. Individual factors, such as strengths, needs, culture, language and ethnicity are integral to the definition of appropriate interventions and services within the care planning done by the Child and Family Team.

Impact of Service Availability

If selected services are not immediately available, the team works to create alternatives, either temporary or sustainable, that can address the needs driving the initial service selection.

Training, Fidelity and Oversight

Training and certification on the use of the formal instruments is performed by the Program Evaluator, who also submits reports to stakeholders, following the standard set by CMHS, and monitors contractual compliance.

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Experience to Date

Wraparound Milwaukee stakeholders shared the following from their experience with use of standardized instruments within a wraparound process:

(a) Optimal use of clinical care guidelines requires a process that includes systematic training

(b) It is important to select indicators that are meaningful to stakeholders

(c) "Be careful what you collect"—all items require resources to collect and report

(d) Clinical tools are not a substitute for an effective Child and Family Team process but a guide for monitoring progress.

Major Benefits, Concerns and Lessons Learned

Wraparound Milwaukee identifies its most valuable indicators as: school attendance reports and rates of recidivism. Stakeholders indicated that the major benefit of an organized protocol to capture and compare this information is that it supports program sustainability. The non-traditional strategies, such as the wraparound approach, gain credibility when the evidence of a reduced level of need is presented to external stakeholders. Internal to the program, guidelines that require clinical instruments to be used offer support to ongoing quality improvement processes.

Wraparound Milwaukee stakeholders identified several challenges associated with use of standardized instruments. Specifically, they noted that clinical information at the individual level is difficult to collect. It costs money both to collect and to analyze individual level data. Furthermore, staff must be trained to use the formal instruments and how to interpret results, and much of the work still relies on manual processes, which also requires supervisory resources and quality control.