The Home for Little Wanderers

Executive Summary:

Organizational history and Background

The Home for Little Wanderers (HFLW) has served the greater Boston community since 1799 starting out with the operation of a single orphanage. Over the years we have expanded our programming to fully address the complex needs of our clients and adopted a more holistic approach. Our mission today is to ensure the healthy behavioral, emotional, social and educational development and physical well-being of children and families living in at-risk circumstances. We operate over 20 different residential and community-based programs that are client centered with a focus on team and service coordination and collaboration. Our broad range of services include adoption, foster care, residential and group home treatment, special education, intensive care coordination and case management, independent living skills/life coaching, after school programming, outpatient mental health services, early childhood mental health services, therapeutic and peer mentoring and in-home therapy. Each year we serve over 3,500 children from birth through young adulthood and their families. These include young children who need prevention services, school age children struggling with educational or behavioral issues, children and youth with serious emotional disturbance in need of service coordination and treatment, children/youth/young adults struggling with LGBTQ-related issues, and young adults seeking housing and other services to successfully transition out of state care. Many of these clients have co-occurring medical conditions. We partner with state and private service organizations, medical providers, court systems, and other community agencies as well as immediate and extended families to ensure that all aspects of clients' needs are addressed. Programing and services are delivered at our facilities, as well as in clients' homes, schools and other convenient and accessible locations in the community with the goal of strengthening and empowering clients, and their support systems, so they can prosper in their home communities.

Challenges, current performance, and goals

Our CSA Development Plans are composed of multiple goals and objectives to guide our programs in achieving excellence in the delivery of intensive care coordination (ICC) services. These goals and objectives fall under two major categories: 1) continuous quality improvement and 2) work flows and communication both internally within our programs and externally with our stakeholders and Managed Care Entities (MCEs).

Continuous Quality Improvement: To maintain an effective workforce it is critical that we continuously identify areas for which our staff may need additional training and support. Significant resources are dedicated to our Workforce Learning and Development Department which provides support and training to our staff. CSA staff are currently receiving training on documentation techniques. The completion of standardized assessments and quality improvement tools are also included on our development plans. Multiple tracking strategies have been developed to assist our staff in monitoring the successful completion of these tools. Efficient and supportive supervision is at the center of these efforts.

Work Flows and Communication: HFLW leadership, program directors, and program management staff are strongly supervised on this concept and it will continue to be a goal on our own CSA development plans for the future. In addition to ensuring successful communication and work flows with our external stakeholders, HFLW also has goals and objectives for improving internal communication to help us problem solve critical components of program management. These goals include timely access to our services, development of a robust system of care (SOC), and the management of our efforts to not have

a wait list for services. Our CSAs have instituted successful workflows and protocols in our development plans to achieve these objectives including 1) contact with families referred within 24 hours and then weekly contact until assignment 2) dedicating a staff person in each program to manage referrals and ensure timely access to our services, 3) regular outreach and solicitation for attendance at our SOC meetings, and last but not least 4) ensuring that intakes, discharges, and all development plan objectives and deliverables are standing agenda items in our weekly program leadership meetings.

Use of DSRIP funds to address challenges

We believe the addition of two new key staff members, a Talent Acquisition Specialist and a Wraparound Trainer/Coach; added nursing consultation, coupled with improvements in our electronic health record, will address the aforementioned goals. With the help of a dedicated Talent Acquisition Specialist we believe that we will be able to reduce the time to fill staff vacancies which will allow for our CSAs to work with more ICC involved families in a timely manner. The technology enhancements and nursing expertise that will be available in Year 1 will result in time saving efficiencies and better access to services as well as better care coordination with ACOs and pediatric primary care providers. The ultimate outcome from these efficiencies won't be limited to time savings, but that it will significantly reduce the amount of time cases stay open due to stronger client engagement. In the spirit of the Wraparound philosophy, up to date technology utilization will make it exponentially easier for a family to manage their own provider team, thus limiting the need for an ICC. The Trainer/Coach will help our programs address goals around communication, workflows and documentation.