UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK

Comparing Traditional Case Management Models to Wraparound Care Coordination	
Traditional Case Management	**Wraparound Care Coordination**
Focus on youth behaviors and strategies to fix them	Ecological focus inclusive of the whole family with focus on why behaviors occur
High staff ratios (1:25-50; sometimes higher)	Low staff ratios (1:8-10)
Based on some consistent practices	Requires full fidelity to a practice model that follows explicit steps and processes. In the process of being deemed evidenced-based (currently a research-informed approach).
Minimal requirement for contact	Child and Family team meetings required every 30/45 days; at least 1-2 additional face-to-face meetings with the youth and their caregivers/parents, minimum weekly telephonic contact
Used to serve all levels of care/intensity	Intensive process used primarily with individuals with intensive behavioral health needs
Often requires some broad based training	Requires intensive training, coaching and certification approach
May not have an evaluation component to ensure standardized best practice	Requires an evaluation to ensure hi fidelity practice and skilled staff who meet standards
Makes decisions alone or in consultation with colleagues	Child and family team decision making inclusive of family voice and choice
Creates a plan for the family that has family tasks	Facilitates a process that builds a team of formal and natural supports and assigns team tasks
Works alone, consulting colleagues as needed	Part of a team
Creates plans with minimal family input	Learns and understands the family story and incorporates the family into all decision making
Focus on negative behaviors	Focus of strengths, positives, resiliency and understanding the reason behind the behavior
Assessment-driven engagement process	Multi-meeting engagement process to understand the full family story spanning to before the identified youth's birth through to the present reason for referral. Understanding of the entire family story not just the child and the coping mechanisms of the family unit.
Meetings with providers about the family without family	Not holding a meeting about the family without the family
Creates a plan that includes referrals to available services to address behavior	Creates a plan of care that is driven by underlying needs (behind the behavior) and incorporates outcomes, strengths, strategies which include formal services, community activities and natural supports that are determined by the team and tasks for which the entire team is responsible. The goal is still to decrease challenging behaviors, but through a very intensive, individualized evidence informed process.
Utilization of available services	Responsibility to identify and build new services to enhance the service array
Standardized crisis plan if there is one at all)	Individualized crisis and safety plan that moves from least intensive to most restrictive strategies to prevent and stop a crisis. Inclusion of the team and all areas of a child's life in the crisis plan (home, school, etc).
Traditional "cookie cutter" services – over reliance on system responses	Use of both traditional/professional and informal supports (community and natural); normalizing approach
Focus on following the service plan and participating in services	Focus on transition and assistant the family in achieving self-efficacy
Not responsible for outcomes	Team tracks & is accountable for outcomes; families don't fail, plans fail & need to be changed
Minimal availability for after-hours crisis response	24/7 crisis response available where the family has someone to call to walk through the crisis plan if necessary in the hope of maintaining the child in the community (this may not include formal mobile crisis response)