UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK
THE INSTITUTE FOR INNOVATION & IMPLEMENTATION
https://theinstitute.umaryland.edu/

Care Management Entities

MARYLAND WRAPAROUND IMPLEMENTATION REPORT
FY13 QTR 1 & 2 • JULY-DECEMBER 2012

DATA FEATURED IN THIS REPORT:

Characteristics of youth in CME

Youth and caregiver needs and strengths

Fidelity to the Wraparound Model

Outcomes of Youth Served by CME

TABLE OF CONTENTS:

Up-to-date: Status of CME's in Maryland	1
Who has been served?	1
How well were services delivered ?	4
What were the outcomes of youth served?	5
Summary	7

Up-to-date: Status of CME's in Maryland

The Children's Cabinet awarded a single Statewide contract for a Care Management Entity (CME) in Maryland effective July 1, 2012 to Maryland Choices, LLC to serve as an entry point for specific populations of children, youth and families with intensive needs so that they can achieve the goals of safety, permanency, and well-being through intensive care coordination using a Wraparound service delivery model and the development of home- and community-based services. Since July 2012, the CME has participated in the collection of administrative data on the youth and families they serve. These data include how many youth and families were served; length of service; reason for discharge from the CME; youth demographic characteristics; youth history of mental health and special education services; psychosocial functioning at entry into the CME, during enrollment and at discharge from the CME; and societal impact outcomes. Administrative data have been collected for youth at baseline (i.e., upon intake into the CME) and every six months afterwards until discharge from the CME. In addition to administrative data, The Institute conducts interviews with caregivers and youth to measure how well the CME is adhering to the Wraparound model and to better understand the impact services are having on families and youth.

From November 9, 2009 until June 30, 2012, the State contracted with two venders - Maryland Choices, LLC (Choices) and Wraparound Maryland, Inc. - for a Statewide system of three regional CMEs. When the contracts ended, CME youth enrolled with Wraparound Maryland, Inc. were transferred to Choices for continuing services. These transfers are reported below as new episodes of care; and significant differences ($p<.05$) with the new Choices enrollees are noted. In this report, youth enrolled refers only to new CME enrollees between July 1 and December 31, 2012.

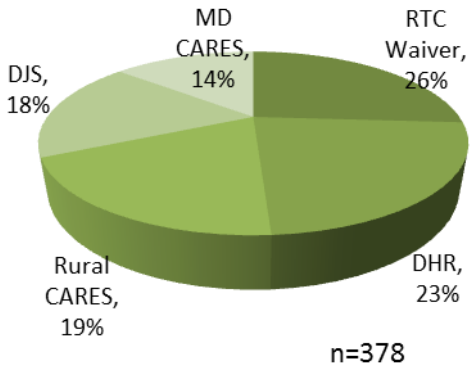
Wraparound is a team-based planning process intended to provide individualized, coordinated, family-driven care to meet the complex needs of youth. For further information on the Wraparound process and national efforts, see The National Wraparound Initiative: http://nwi.pdx.edu

Who has been served?

Populations of Youth

Three-hundred seventy-eight (378) youth were newly enrolled in the CME between July 1, 2012 and December 31, 2012. Populations* of youth served included the Psychiatric Residential Treatment Facility (PRTF) Waiver (26%), Department of Human Resources (DHR) Out-of-Home Placement Diversion (23%), Rural CARES (19%), Department of Juvenile Services (DJS) Out-of-Home Placement Diversion (18%), and MD CARES (14%).

Figure 1: Categories of Youth Enrolled in CME, July 1 - December 31, 2012



*See Appendix 1 for definitions of the categories of population.

A total of 223 (53%) of the youth enrolled transferred from a different CME (Wraparound Maryland, Inc.) effective July 1, 2012. A greater proportion of these youth were in the categories of PRTF Waiver (33%), DHR Out-of-Home Placement Diversion (27%), and Rural CARES (24%). Fewer were in the DJS Out-of-Home Placement Diversion category (4%).

Demographic Characteristics

The majority of youth enrolled were African American/Black (62%), male (64%), and approximately 14 years old. Youth in the DJS Out-of-Home Placement Diversion category were older than youth in other categories, with an average age of about 16 years. DJS Out-of-Home Placement Diversion also included a larger proportion of male youth (73%). The percentages of male and female youth in the DHR Out-of-Home Placement Diversion and MD CARES categories were more evenly distributed than the Statewide distribution. African American/Black youth comprised the majority of youth served by MD CARES (87%), and Caucasian/White youth were the largest racial/ethnic group served by Rural CARES (50%). See Appendix 2 for the full distribution of demographics by population.

Youth who transferred from a different CME vendor in July 2012 were about a year younger (13.2, *sd*=3.21) than those who did not (14.4, *sd*=2.98).

Figure 2: Sex of Youth Enrolled in CME, July 1 - December 31, 2012

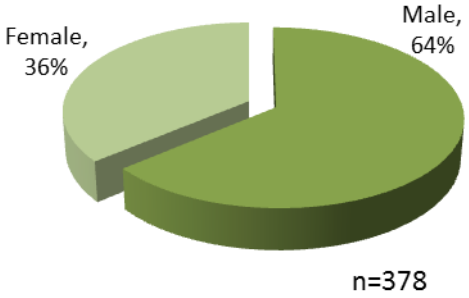
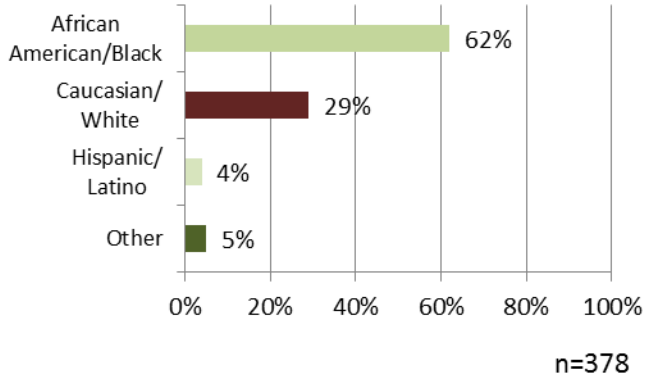
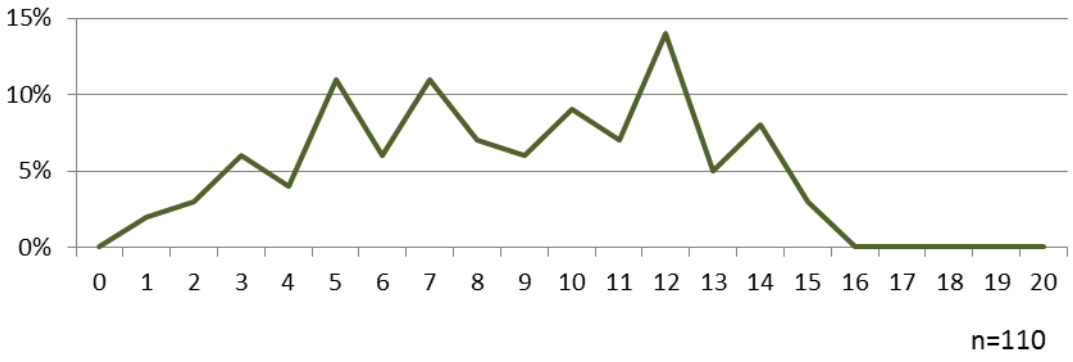


Figure 3: Race/ethnicity of Youth Enrolled in CME, July 1 - December 31, 2012



Of the youth who had received mental health services prior to CME enrollment (n=110)[1], a majority first received treatment between the ages of five and 12 (71%). Youth enrolled in the MD CARES category were the youngest when they first received mental health services (7.6 years), and youth in the PRTF Waiver were the oldest (9.8 years). See Figure 4 below for the Statewide distribution of ages that CME youth first received mental health service.

Figure 4: Age of First Mental Health Service



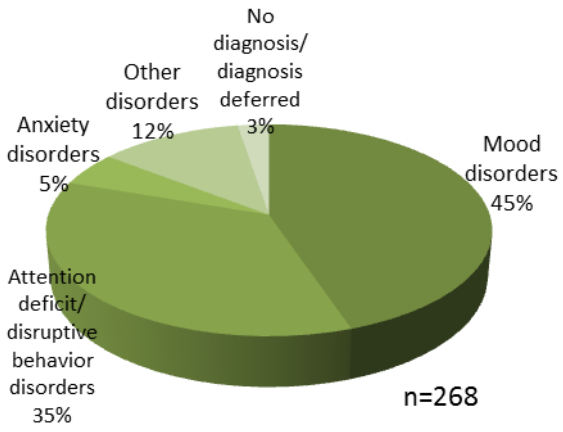
[1]Prior mental health treatment data were only available for youth who had been in enrolled in the CME for a minimum of three months, thus not all youth who enrolled during this reporting period are represented; data are based on self-report.

Diagnoses

Among youth enrolled in the CME with a psychiatric diagnosis within three months of enrollment (n=268)[2], primary diagnoses were predominantly mood disorders (45%) and attention deficit or disruptive behavior disorders (35%). This pattern was consistent across all populations of youth. See Appendix 2 for the breakdown of all diagnoses by population.

The Statewide average Global Assessment Functioning (GAF; American Psychiatric Association [DSM-IV-TR], 2000) score was 48.0 (*sd*=8.77, n=128). Scores ranged by population from 46.6 (PRTF Waiver, *sd*=7.50) to 51.0 (DJS Out-of-Home Placement Diversion, *sd*=9.01), with no significant differences among the categories of youth. These scores indicate that youth enrolled in the CME generally displayed symptoms of moderate to serious impairment in social, occupational, and/or school functioning.

Figure 5: Primary Diagnoses of Youth Enrolled in CME, July 1 - December 31, 2012



Youth and Caregiver Needs and Strengths

Three-hundred eleven (311) of the youth who enrolled in the CME had a Child and Adolescent Needs and Strengths (CANS)* assessment completed within six weeks of enrollment (82%). A majority demonstrated need (scored 2 or 3) in areas of interpersonal, vocational, spiritual/religious, and community life functioning. All of these items fall into the Child Strengths domain, indicating that the most prevalent issues among the youth enrolled pertain to a lack of protective factors.

Youth in the categories of DJS Out-of-Home Placement Diversion and MD CARES demonstrated higher need in recreational activity (64% and 60%, respectively), compared to the Statewide rate. Youth in the MD CARES categories also showed higher need in the community life protective factors (73%). Further, youth in the DJS Out-of-Home Placement Diversion Category had higher need in areas of crime/delinquency (20%) and judgment (52%), and their caregivers had greater need with social resources (54%). Youth in the Rural CARES categories showed lower need pertaining to depression (8%). See Appendix 2 for the distribution of all CANS items by population.

Youth who transferred from a different CME vendor in July 2012 demonstrated significantly lower needs in areas of living situation (33% vs. 45%), social behavior (17% vs. 27%), recreational activity (38% vs. 53%), sexuality (3% vs. 14%), conduct (19% vs. 31%), anxiety (16% vs. 32%), oppositional behavior (32% vs. 46%), and judgment (25% v 40%). These reduced levels of need may reflect the positive impact of prior CME involvement.

*See Appendix 1 for a description of the CANS instrument.

Figure 6a: % Need in Life Domains/Functioning

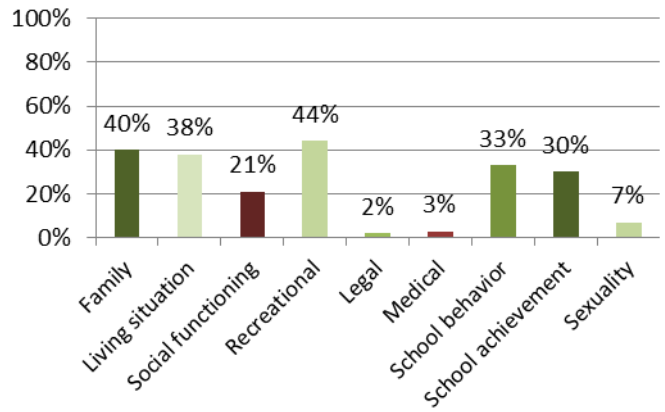
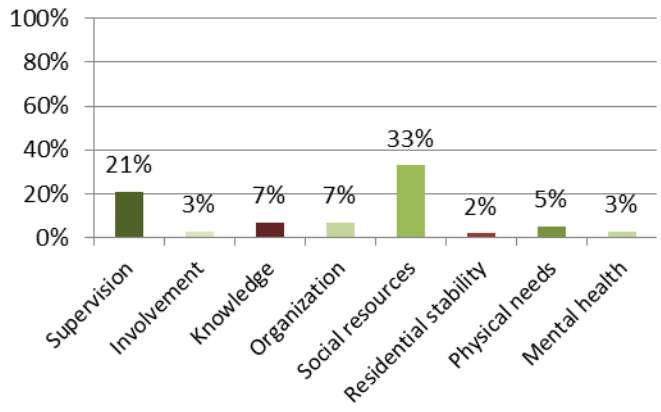


Figure 6b: % Need in Caregiver Needs & Strengths



[2]For youth who transferred from a different CME vendor in July 2012, diagnoses acquired within three months of their initial enrollment were included if there was not a new diagnosis at the time of their transfer to Choices.

Figure 6c: % Need in Child Behavioral/Emotional

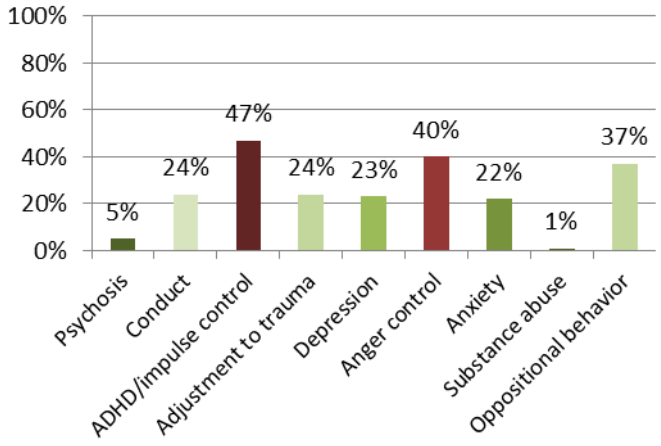


Figure 6d: % Need in Child Strengths

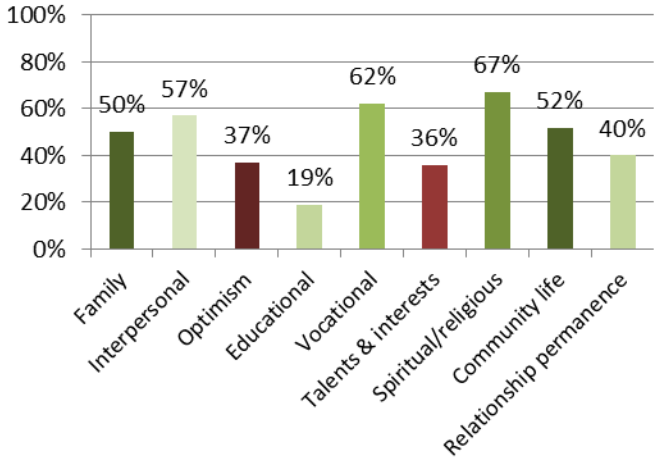
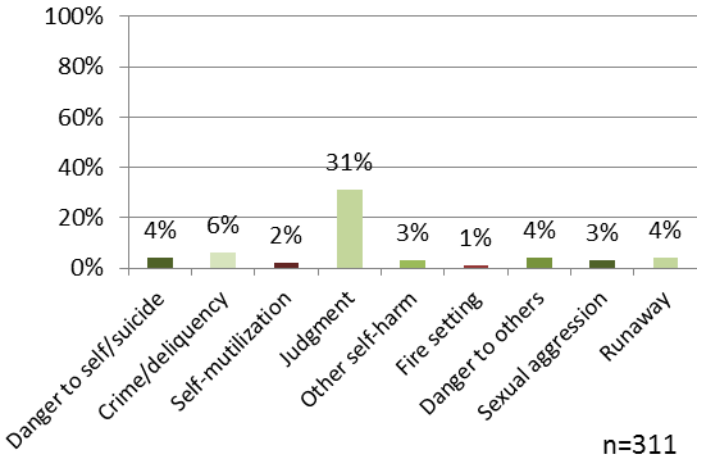


Figure 6e: % Need in Child Risk Behavior



How well were services delivered?

Wraparound Fidelity Index

The quality of services was measured using the Wraparound Fidelity Index, v. 4 (WFI-4).* Because The Institute recently assumed responsibility for monitoring fidelity, WFI-4 data were only available for a small number of youth and caregivers enrolled in the CME in the MD CARES or Rural CARES categories, and should thus be interpreted with caution.

The average total WFI-4 score for youth who completed an interview during the first and second quarters of FY13 (n=7) was 67 (*sd*=16.26). For caregivers who completed an interview (n=14), the average score was 74 (*sd*=16.56). These scores indicate that Wraparound was delivered with borderline fidelity (see Table 1). It should be noted that these benchmark scores were developed for a previous version of the instrument (WFI-3), and were meant to include responses from Wraparound facilitators and team members.

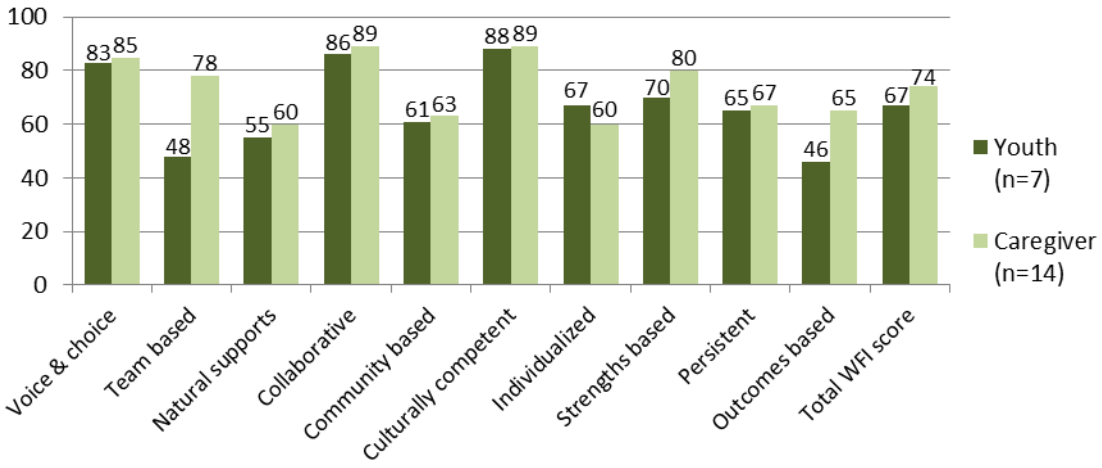
For both youth and caregivers, the highest-rated Wraparound principles were Culturally Competent, Collaborative, and Voice and Choice (see Figure 9).

*See Appendix I for a description of the WFI-4 instrument.

Table 1: WFI Scoring Benchmarks

Below 65	**65-75**	**75-85**	**Above 85**
Not Wraparound	Borderline Fidelity	Adequate Fidelity	High Fidelity

Figure 9: Youth and Caregiver WFI-4 scores, by Principle



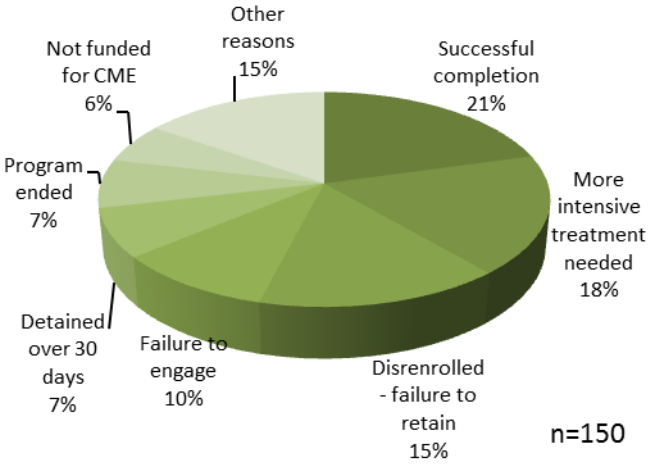
In future reports, fidelity will be monitored using the Wraparound Fidelity Index, Brief version (WFI-EZ) - an updated version of the WFI instrument that provides a valid and reliable measurement of fidelity, and is less burdensome to administer than the WFI-4 (Sather, Bruns, & Hensley, 2012). Two additional measures - the Family Empowerment Scale and the California Healthy Kids Survey, Supplemental Resilience and Youth Development Model - will also be reported. Including these instruments will help to provide a more comprehensive assessment of the youth and families served and the quality of services delivered.

What were the outcomes of youth served?

Reasons for Discharge

A total of 150 youth discharged from the CME during the first and second quarters of FY13 (July 1 - December 31, 2012). The most common reasons for discharge included successful completion (21%), more intensive level of treatment needed (18%), disenrolled at participant's request/failure to maintain participation (15%), and failure to engage within 30-60 days (10%). Youth in the PRTF Waiver were most likely to complete (37%), and those in the MD CARES category were the most likely to need more intensive treatment (30%). See Appendix 3 for the breakdown of all discharge reasons by population.

Figure 8: Reasons for Discharge, July 1 - December 31, 2012



Duration of Services

The Statewide average length of stay for all discharged youth was 161.2 days (*sd*=181.01, range=10-866), and ranged by population from a low of 86.3 days (MD CARES; *sd*=57.05) to 236.1 days (PRTF Waiver; *sd*=255.61). This trend reflects that of the discharge reasons reported above, with youth in the PRTF Waiver - who were most likely to successfully complete - having the longest duration of CME involvement, and youth in the MD CARES category - who were most likely to need more intensive treatment - having the shortest.

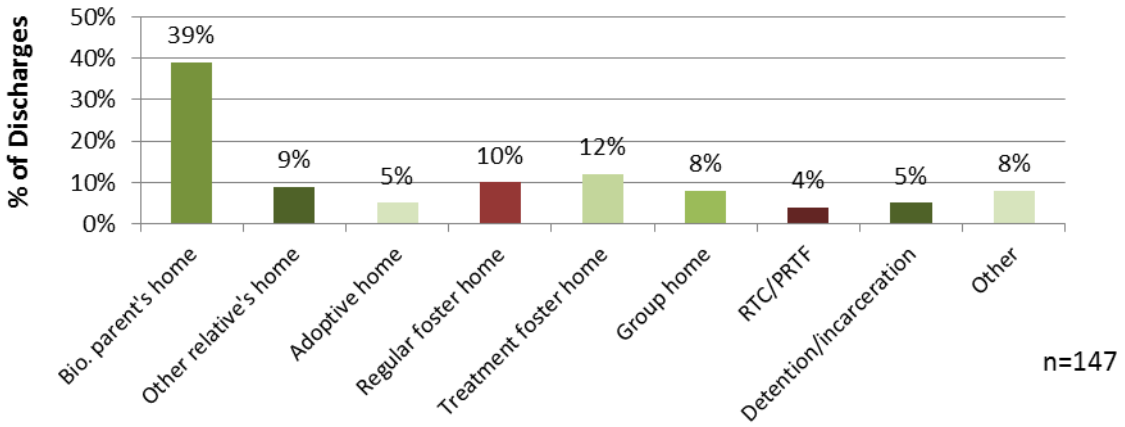
Among youth who successfully completed services (n=31), the average length of stay was 316.0 days (*sd*=266.53), ranging by population from 151.0 days (Rural CARES; n=1, no *sd*) to 403.8 days (DHR Out-of-Home Placement Diversion; *sd*=299.65).

Youth who transferred from the previous CME vendor had, on average, a shorter length of stay than those who did not. This applies to all discharges (92.4 vs. 273.5 days) and successful completions (110.8 vs. 485.0 days).

Living Situation

Data on living situation at discharge were available for 147 (98%) of the youth who exited the CME during this reporting period. The most prevalent living situation at discharge was biological parent's home (39%), followed by treatment/therapeutic foster home (12%), regular foster home (10%), and non-biological parent relative's home (9%). Youth in the DJS Out-of-Home Placement Diversion category had the highest proportion of youth discharge to a biological parent's home (61%), and youth in the DHR Out-of-Home Placement Diversion category had the most in a treatment/therapeutic foster home (21%). See Appendix 3 for the full distribution of living situations by population.

Figure 9: Living Situations at Discharge

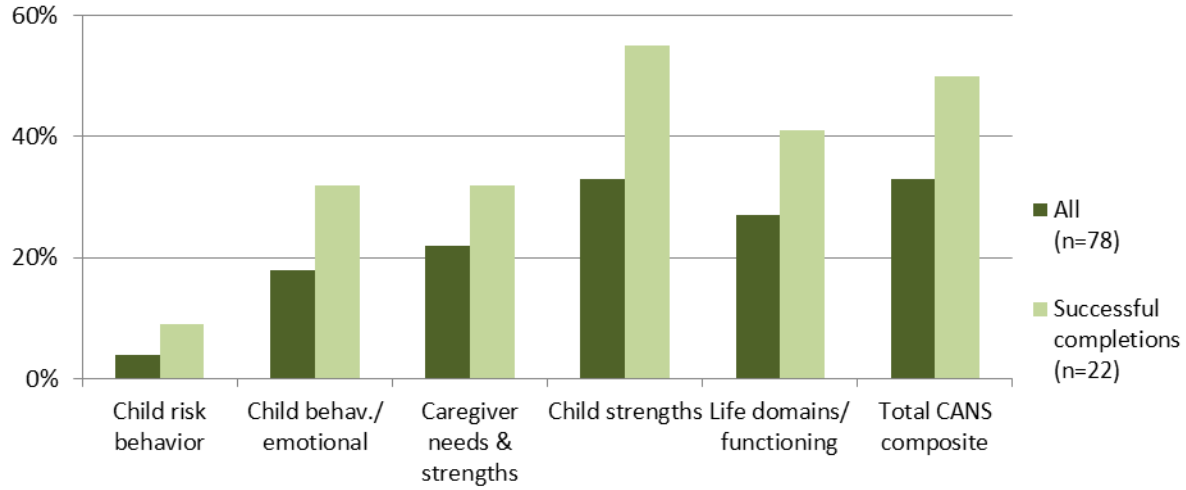


Youth and Caregiver Needs and Strengths

Improvement in risk and protective factors was measured using the Reliable Change Index (RCI; Jacobson & Truax, 1991), with 90% confidence, for each CANS subscale from enrollment to discharge. Of the youth discharged during this reporting period who had CANS assessments at both enrollment and discharge (n=78, 52%), one-third (33%) showed [reliable] improvement on the total CANS composite score. Youth in the DHR Out-of-Home Placement Diversion category had the highest rate of improvement (50%), followed by youth in the MD CARES category (36%). The Child Strengths and Life Domains/Functioning subscales were the domains on which youth showed the most improvement (33% and 27%, respectively). See Appendix 3 for the breakdown of improvement on all CANS subscales by population.

The rates of improvement for youth who successfully completed services were higher than those of all youth discharged, for each subscale and for the total composite score.

Figure 10: Reliable Improvement (90% C.I.) on CANS Domains from Enrollment to Discharge



Summary

We know from implementation science literature that organizational and policy changes can have great impact on the ability to effectively implement an intervention (Fixen, et. al., 2005). For example, large changes in staffing have been shown to have impact on fidelity ratings (Woltmann et. al., 2008). Fixen and colleagues also have outlined several stages of implementation that align with expectations for programmatic outcomes (2005). Policy and organizational changes such as the ones that occurred in Maryland in July 2012, with the change to a single Statewide CME vendor, can move a program/intervention from full implementation back to the installation or initial implementation stages. Given this change in the stage of Maryland's CME implementation, it is expected that fidelity and outcomes may not be at their previous level. Within a short period of time, Maryland Choices, LLC made a shift in its organizational structure, hired additional staff, and began serving youth in Baltimore City and 14 additional Counties during its transition from operating in one of three Maryland regions (encompassing Allegany, Baltimore, Carroll, Frederick, Garrett, Harford, Howard, Montgomery, and Washington Counties) to serving as the single Statewide CME vendor.

Maryland Choices, LLC is acknowledged for its transition efforts. Staff are enthusiastic and demonstrate the desire to continue to develop skills necessary for the implementation of quality Wraparound practice.

Providing the level of intensity required for the CME populations in the community is another challenge. Outcomes are impacted by the availability of services required to support the needs identified by the child and family teams during the Wraparound process. Lack of service capacity within the youth's home community impairs the development of a plan of care that meets the required level of intensity to keep youth in the community in the least restrictive environment possible. Ongoing focus on resource development and provider network management is needed and should be enhanced through further partnerships with Local Management Boards, Core Service Agencies, Local Departments of Social Services, local school systems, and local/regional offices of the Department of Juvenile Services, as well natural and community supports, including faith-based organizations.

The Institute continues to provide coaching, mini-trainings, and core trainings to assist the CME with providing high fidelity Wraparound and quality practices. Utilization of coaching tools, training, targeted supervision and consistent shadowing of Wraparound practitioners will assist in improving both practice and outcomes.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th edition, text revision). Washington, DC: Author.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). Implementation Research: A Synthesis of the Literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

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), 12-19. doi:10.1037/0022-006X.59.1.12

Sather, A., Bruns, E. J., & Hensley, S. (2012). Pilot test of the Wraparound Fidelity Index, Brief version (WFI-EZ). Wraparound Evaluation and Research Team, University of Washington: Seattle, WA.

Woltmann, et. al., (2008). The role of staff turn over in the implementation of evidence based practices in mental health care. Psychiatric Services, 59 (7), 732-737.

Appendix 1: Definitions

Population Categories

· Psychiatric Residential Treatment Facility (PRTF) Waiver - Youth who meet the need for a residential treatment-level of care, can be adequately served in the community with waiver supports, and meet Medicaid eligibility requirements.

· Department of Human Resources (DHR) Out-of-Home Placement Diversion - Youth meeting specific DHR/DSS-established criteria.

· Department of Juvenile Services (DJS) Out-of-Home Placement Diversion - Youth who are in, pending, or at risk of out-of-home community residential placement; i.e., group homes.

· Maryland Crisis and At Risk for Escalation diversion Services (MD CARES) - Youth with severe emotional disturbance who are served by, or at risk of entering the Maryland foster care system in Baltimore City.

· Rural CARES - Youth with severe emotional disturbance who are served by, or at risk of entering the Maryland foster care system in The State's Eastern Shore Region.

Child and Adolescent Needs and Strengths

The Child and Adolescent Needs and Strengths (CANS)[1] instrument helps to inform decision-making in areas of youth behavioral and emotional functioning, as well as caregiver needs and strengths. The care coordinators complete CANS assessments of CME-enrolled youth at intake, and every three months throughout the course of enrollment. The score for each CANS item ranges from zero - indicating no evidence of need - to three - indicating the need for immediate, intensive action; a score of two or three is considered indicative of the need to intervene on that item.

The items load onto different subscales that comprise the following CANS domains:

· Life Domains/Functioning - Youths' struggles in major areas of life, such as school, family, [physical] health etc.

· Child Behavioral and Emotional Needs - The impact of mental health challenges on youth functioning.

· Child Risk Behaviors - The extent to which youth pose a danger to themselves and/or others.

· Caregiver Needs and Strengths - The degree to which caregivers' needs inhibit their parenting.

· Child Strengths - Youth protective factors.

Wraparound Fidelity Index, v. 4

The Wraparound Fidelity Index 4.0 (WFI-4) is a set of four interviews that measures the nature of the wraparound process that an individual family receives. The WFI-4 is completed through brief, confidential telephone or face-to-face interviews with four types of respondents: caregivers, youth (11 years of age or older), wraparound facilitators, and team members. In Maryland, the WFI is administered to caregivers and youth when they reach six months into services. In addition to providing an overall assessment of Wraparound services, the items of the WFI-4 also measure adherence to the 10 principles of the Wraparound process:[2]

· Family voice and choice - The Wraparound process is grounded in the youth and family's perspectives, values, and preferences.

· Team-based - The members of the Wraparound team are agreed upon by, and are committed to serving, the youth and family.

· Natural supports - The team seeks participation from the family's interpersonal and community relationships.

· Collaboration - The team members work together and share responsibility for delivering all aspects of the Wraparound plan.

· Community-based - The services occur in settings that are inclusive, responsive, and accessible, and promote safe integration into home and community life.

· Culturally competent - The Wraparound process respects and builds upon the youth and family's values, preferences, beliefs, culture, identity, and community.

· Individualized - Services are customized for each youth/family to fit their needs, strengths, preferences, etc.

· Strengths-based - The Wraparound process recognizes and builds upon existing assets of the youth/family and their community.

· Persistence - The team continues to pursue the family's goals until an agreement is reached that Wraparound is no longer required.

· Outcome-based – The team defines and monitors measurable indicators of progress toward the youth and family's goals, and uses them to inform and revise the Wraparound plan throughout the duration of service.

---

[1] Lyons, J. (2009). *CANS Executive Summary.* Retrieved from: http://praedfoundation.org/About%20the%20CANS.html

[2] Bruns, E. J., Walker, J. S., Adams, J., Miles, P., Osher, T. W., Rast, J., VanDenBerg, J. D. & National Wraparound Initiative Advisory Group (2004). *Ten principles of the wraparound process.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.