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Care Management Entities

MARYLAND IMPLEMENTATION REPORT
FY14 QTR 1 & 2 • JULY-DECEMBER 2013

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Introduction

Maryland Choices, LLC collects administrative data on the youth and families they serve. including how many youth and families were served; length of service; reason for discharge; youth demographic characteristics; youth history of mental health and special education services; psychosocial functioning at entry into the CME, during enrollment and at discharge; 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. During this period, data were collected using the Wraparound Fidelity Index – Short Form (WFI-EZ) at six and 12 months involvement with the CME. A pilot version of the WFI-EZ was used in the past and with significant changes made. Implementation of the new instrument started in August 2013. Youth Resiliency and Caregiver Empowerment data are also collected at baseline, six months and 12 months. The Evaluation team invites enrolled families to participate; families can opt to complete these surveys online, over the phone or by paper copies via mail. Most of the surveys were completed over the phone. The Institute received information on 141 (73%) of the families involved with the CME, and data from youth enrolled between July 1 and December 31, 2013 are included in this report.

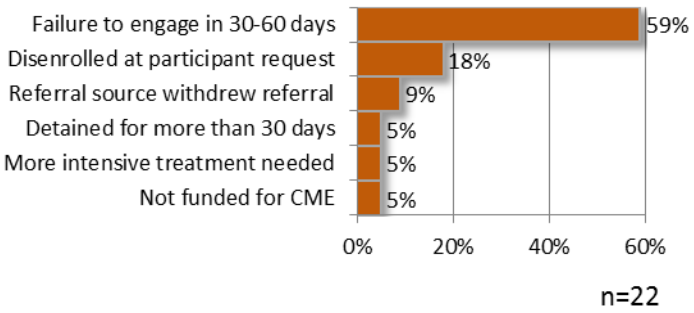
Wraparound is a team-based planning process intended to provide individualized, coordinated, family-driven care to meet the complex needs of youth. For further information on the Wraparound process and national efforts, see The National Wraparound Initiative: http://nwi.pdx.edu

Who has been served?

Admission Rate

A total of 194 new CME referrals were accepted between July 1, 2013 and December 31, 2013. Of these, 163 (84%) started services (i.e., had at least one face-to-face meeting with a care coordinator), 9 (5%) were pending their first face-to-face meeting, and 22 (11%) did not start services and were disenrolled. Of those who were disenrolled, the most common reasons for non-admission were failure to engage within 30-60 days (59%) and the referral being withdrawn by the referral source (18%). Among the youth who started services with the CME, it took an average of 11.7 days (*sd*=8.91) from the date of acceptance to have the first face-to-face meeting with the care coordinator. It is important to note that the contract specifies that initial contact shall be made within 72 hours, with the initial face-to-face meeting occurring in the next seven days. Of admitted youth with at least one Child and Family Team (CFT) meeting (n=126), the number of days from acceptance to the first CFT meeting was approximately 38.5 (*sd*=21.45).

Figure 1: CME Non-Admission Reasons, July - December, 2013



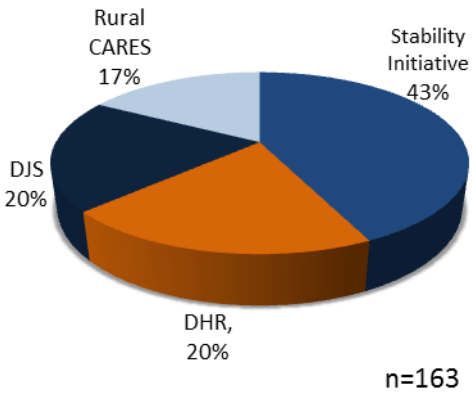
Populations Served

Youth who started CME services were from different populations including Stability Initiative (43%), Department of Juvenile Services Out-of-Home Placement Diversion (DJS, 20%), Department of Human Resources Out-of-Home Placement Diversion (DHR, 20%), and Rural CARES (17%).

Compared to the previous two quarters (January - June, 2013), there were significantly ($p<.05$) more youth starting services who were part of the Stability Initiative population (43% vs. 18%), and fewer who were part of the DJS population (20% vs. 29%), during the third and fourth quarters of FY13. Because the Stability Initiative population opened to new referrals effective April 22, 2013, the current semi-annual reporting period was the first during which it was fully implemented. MD CARES was closed to new referrals as of June 30th, 2013.

*See Appendix 1 for definitions of the different populations.

Figure 2: Populations of Youth Entering CME, July - December, 2013



Demographic Characteristics

The majority of youth starting CME services was African American/Black (55%), male (59%), and approximately 14 years old. Youth in the DJS population were older than youth in the other populations, with an average age of about 16 years. The DJS population also included the largest proportion of African American (73%) and male (82%) youth. DHR was the only population for which a majority was female (67%), and Rural CARES was the only population that was predominantly Caucasian/White (67%). Compared to the previous two quarters, there were significantly ($p<.05$) fewer African American/Black youth starting services during this reporting period (55% vs. 65%). Gender and age did not significantly differ.

See Appendix 2 for the full distribution of demographics by population.

Figure 3: Sex of Youth Entering CME, July - December, 2013

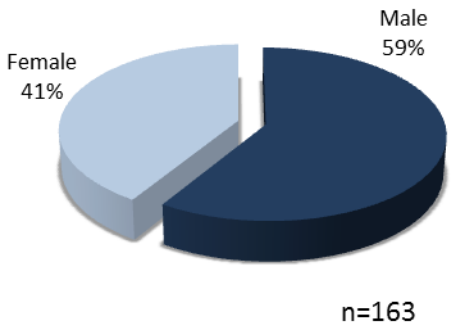
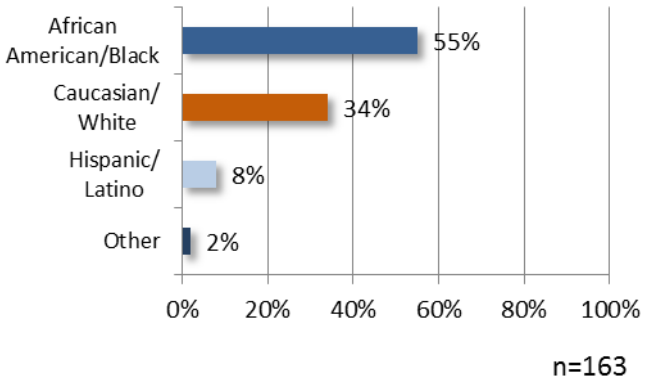
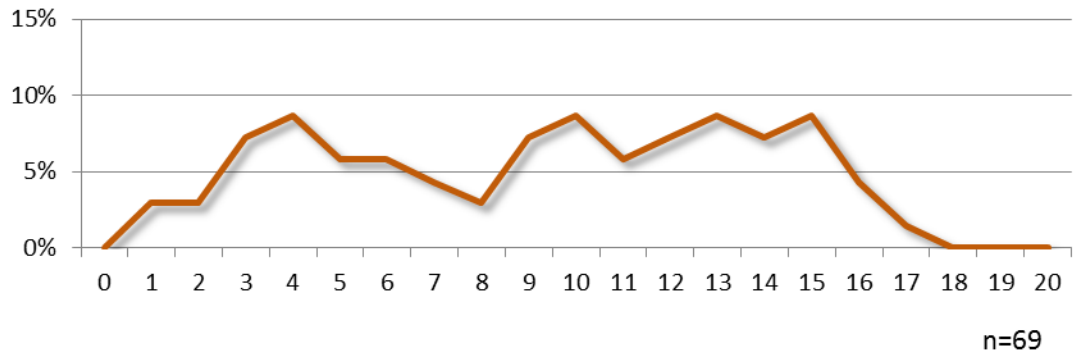


Figure 4: Race/Ethnicity of Youth Entering CME, July - December, 2013



Of the youth starting CME services who had received mental health services prior to CME enrollment (n=69)[1], the age that services were first received ranged from one through 17, and was fairly evenly distributed. Youth in the Rural CARES population were the youngest first receiving mental health services (8.7 years), and youth in the DJS population were the oldest (11.3 years). The average age youth first received mental health services (9.8 years) was not significantly different from what was seen during the previous reporting period (9.6 years). See Figure 5 below for the Statewide distribution of ages that CME youth first received mental health service.

Figure 5: Age of First Mental Health Service of Youth Entering CME, January - June, 2013

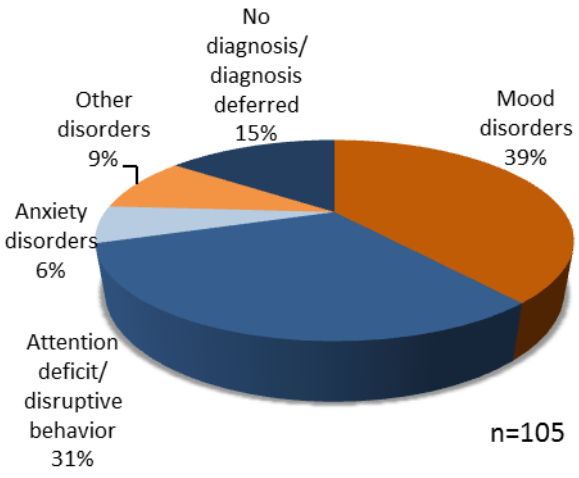


Diagnoses

Among youth who started CME services and had a psychiatric diagnosis within three months of enrollment (n=105, 64%), the primary diagnoses were predominantly mood disorders (39%) and attention deficit or disruptive behavior disorders (31%). This pattern is similar to that of youth who entered the CME during the previous two quarters. Mood disorders were more prominent in Rural CARES and Stability Initiative youth (61% and 48%, respectively), and attention deficit/disruptive behavior disorders were common in DJS youth (50%). 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 46.2 (*sd*=8.63, n=67). Scores ranged by population from 45.9 (DHR, *sd*=8.20) to 50.9 (DJS, *sd*=7.25), with no significant differences among the populations. These scores indicate that youth starting CME services generally displayed symptoms of moderate to serious impairment in social, occupational, and/or school functioning.

Figure 6: Primary Diagnoses of Youth Entering CME, January - June, 2013



[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.

Youth Resilience

During the first and second quarters of FY13, 26 youth completed the California Healthy Kids Survey, Resilience & Youth Development Module (RYDM)* upon entry to the CME (within four weeks). Further, the RYDM was completed by 13 youth at six months into CME service, and by six youth at 12 months into service. On a scale of 1 through 4 (with a higher score indicating greater resilience), the Statewide average scores at intake on domains measuring environmental protective factors ranged from 2.8 (*sd*=.79) on the Meaningful Participation at Home domain, to 3.6 (*sd*=.56) on the High Expectations at Home domain. Of the domains measuring personal resilience strengths, average intake scores ranged from 2.8 (*sd*=.78) on the Problem Solving domain, to 3.4 (*sd*=.55) on Goals and Aspirations. These scores indicate that youth enrolled in the CME during this reporting period generally demonstrated moderate-to-high personal and environmental resilience. As Figure 8 illustrates, a majority of youth fell into either the moderate (score 2-3) or high (score >3) categories on all domains of the RYDM.

The scores of youth who completed the RYDM at six months did not meaningfully differ from those completed at intake. Because of the low response rate, the 12-month scores (n=6) were not compared.

Figure 7a: RYDM Environmental Protective Factors, Intake and 6 Months

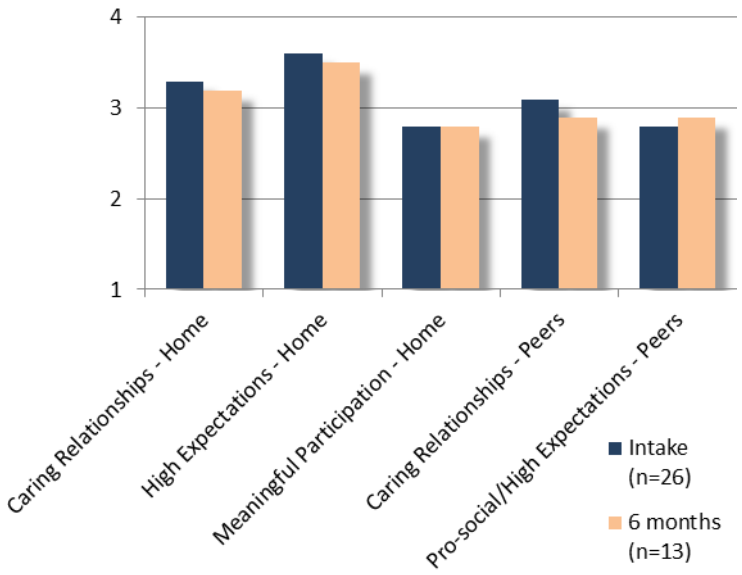


Figure 7b: RYDM Personal Resilience Strengths, Intake and 6 Months

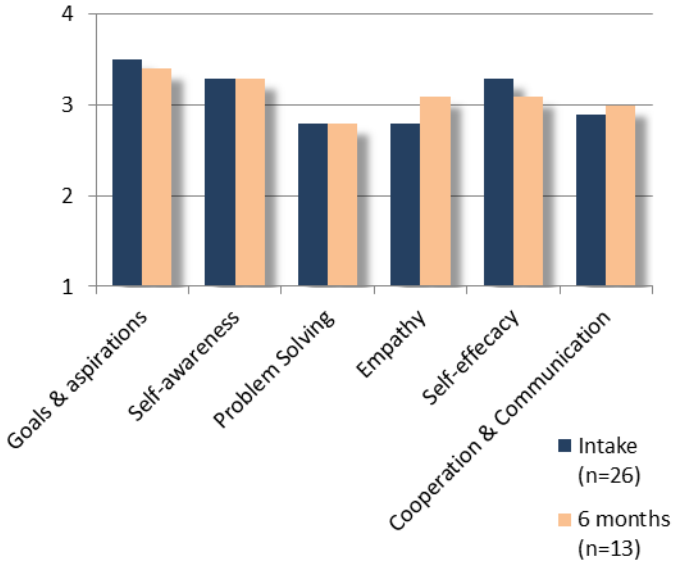
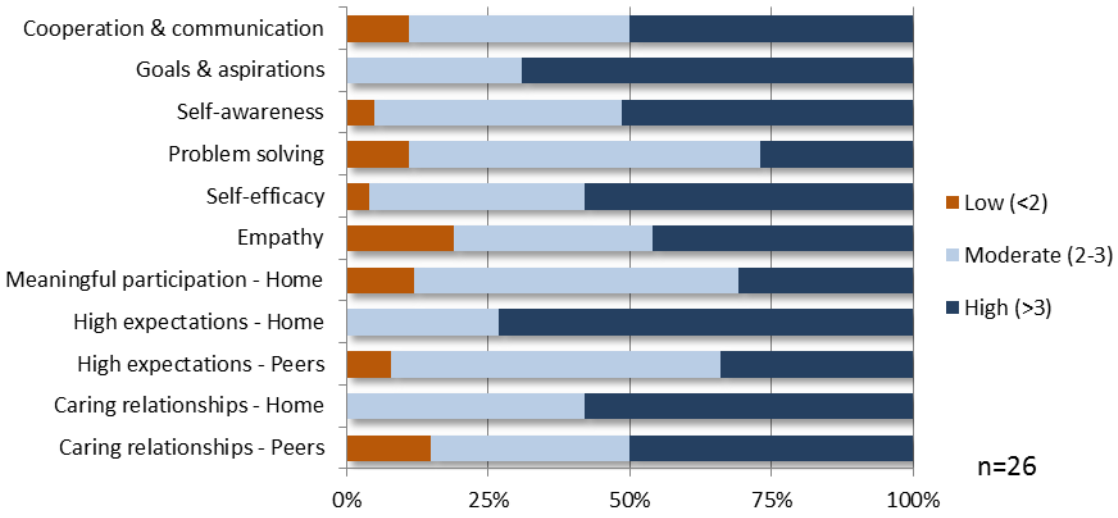


Figure 8: RYDM Environmental and Personal Resilience: Categorical Domain Scores at Intake

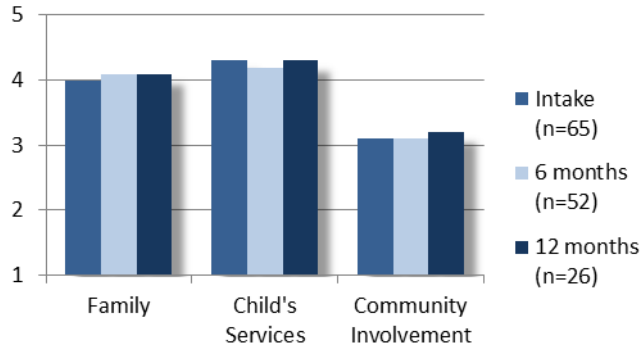


Caregiver Empowerment

The caregivers of 65 youth starting CME services completed the Family Empowerment Scale (FES)* within four weeks of intake during this reporting period. The FES was also completed by 52 caregivers at six months into service, and by 26 caregivers at 12 months into service. Possible scores on the FES range from 1 through 5, with a higher score indicating greater empowerment. At intake, caregivers generally reported feeling most empowered in navigating the system(s) of child services to access the services their children need (mean score=4.3, sd=.56). Caregivers felt least empowered in their community/political involvement in influencing the policies around child services (mean score=2.93, sd=.95). These scores were similar to those of the caregivers that completed the FES at six and 12 months into CME services during this reporting period.

*See Appendix 1 for descriptions of the RYDM and FES instruments.

Figure 8: FES Domain Scores



Youth and Caregiver Needs and Strengths

One-hundred and twenty of the youth who started CME services (74%) had a Child and Adolescent Needs and Strengths (CANS)* assessment completed within six weeks of admission. The highest areas of demonstrated need (score of 2 or 3) included school behavior (45%), recreation (44%), family functioning (43%), and areas of problem behavior such as ADHD/impulse control (43%), anger control (43%), and oppositional behavior (43%). This suggests that youths' greatest areas of need are in the Life Domain Functioning and Behavioral/Emotional Needs domains.

All youth had at least one identified strength (score of 0, 1, or 2) from the Child Strengths domain, and most (97%) had at least two strengths identified. Each of the nine strengths was identified in a majority of the youth, with the most common strengths being optimism (97%), educational (96%), and talents and interests (95%).

See Appendix 2 for the distribution of all CANS items by population.

Figure 9a: Common Areas of Need

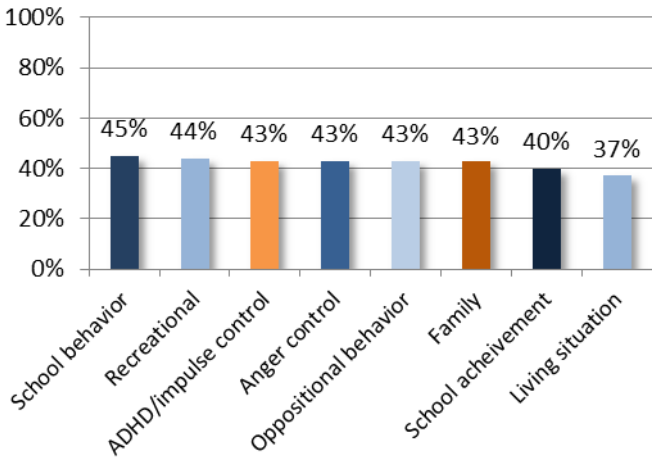
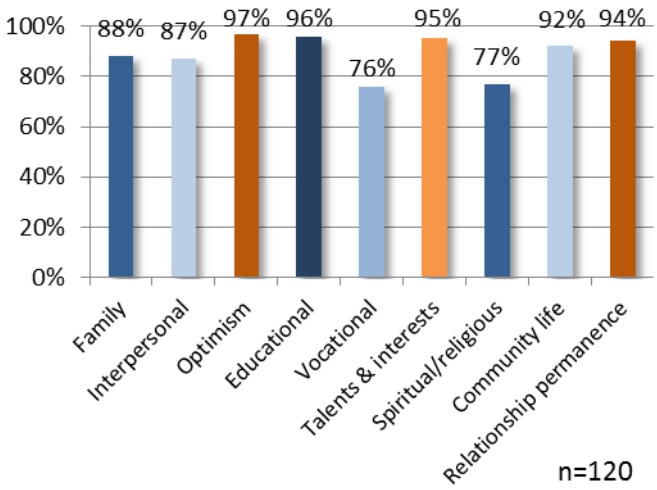


Figure 9b: Identified Strengths



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

How were available services utilized?

Utilization and Average Daily Population

Of the 433 average daily CME slots in Maryland during the first and second quarters of FY2014, the rate of utilization was 65%, with an average daily population of approximately 280 youth. PRTF Waiver, MD CARES, and ICSA were closed for new referrals, and only served youth who had enrolled prior to July 1, 2013. The number of Rural CARES slots decreased from 60 to 55 on October 1, 2013. It should also be noted that the number of slots available for the DHR and DJS populations were both increased from 75 each to 100 each on June 15, 2013 - shortly before the start of this reporting period. See Table 1 for the utilization rates of each population.

Table 1: Utilization of CME Slots

Population	Daily capacity	Average daily population	Utilization
DJS	100.0	51.2	51%
DHR	100.0	51.3	51%
Stability Initiative	100.0	53.3	53%
Rural CARES	57.5*	48.4	85%
MD CARES	26.1*	26.1	100%
PRTF Waiver	47.5*	47.5	100%
ICSA	2.0	2.0	100%

*The capacity changed during the course of the reporting period; the average daily capacity is shown.

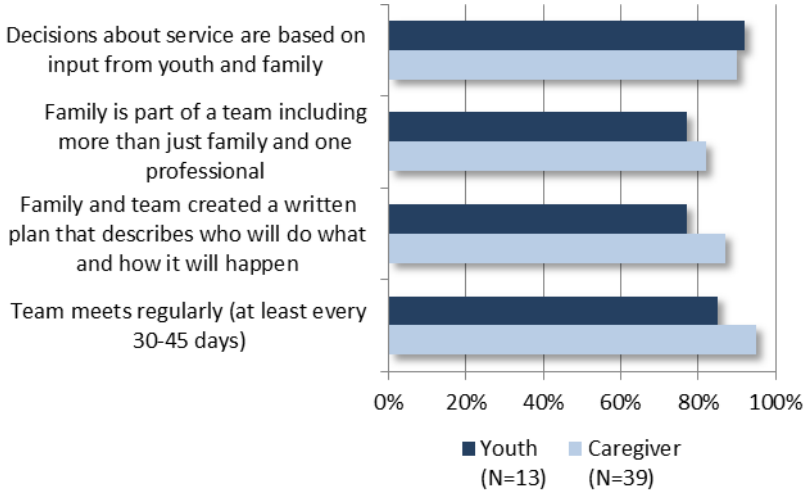
How well were services delivered?

Wraparound Fidelity Index

The quality of services delivered was measured using the Wraparound Fidelity Index - Short Form (WFI-EZ).* During the current reporting period, the WFI-EZ was completed by caregivers at six months (N=35) and 12 months (N=4) into service, and by youth over the age of 10 at six months (N=11) and 12 months (N=2) into service. Because response rates at 12 months post-admission were too low to report independently, the scores of the six- and 12-month responses are reported together in aggregate.

During the first and second quarters of FY14:

Figure 10a: WFI-EZ Basic Information Items



- Most caregivers and youth responded affirmatively to all four items of the Basic Information section (see Figure 10a).
- The average total composite score of the Experiences section was 60% for both caregivers and youth (see Figure 10b), with the highest caregiver score on the Strength-and-Family Driven domain (66%), and the highest youth score on the Needs-Based domain (68%). The lowest score for caregivers and youth was the Effective Teamwork domain (57% and 54%, respectively).
- The average composite scores for the Satisfaction section were 70% and 71%, for caregivers and youth, respectively.
- Most caregivers responded that their children or youth did not experience the negative events captured in the School and Community Outcomes section (see Figure 10c), with the most common problem being suspension or expulsion from school since starting Wraparound services.
- Of the Functional Outcomes items, which measure how child or youth problem behaviors have disrupted family and youth functioning over the past month, average caregiver scores ranged from .97 (participation in community activities) to 1.41 (stress or strain on the family; see Figure 10d). Possible scores in this section range from 0 to 3, with a higher score indicating greater disruption in functioning.

*See Appendix 1 for a description of the WFI-EZ instrument.

Figure 10b: WFI-EZ Experiences Domains

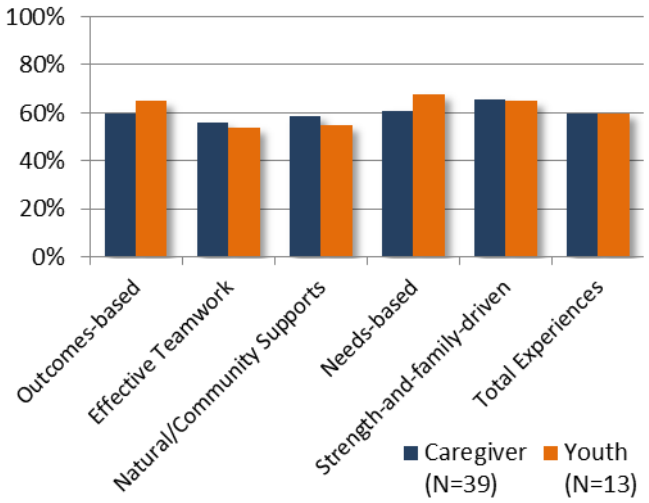


Figure 10c: School and Community Outcomes

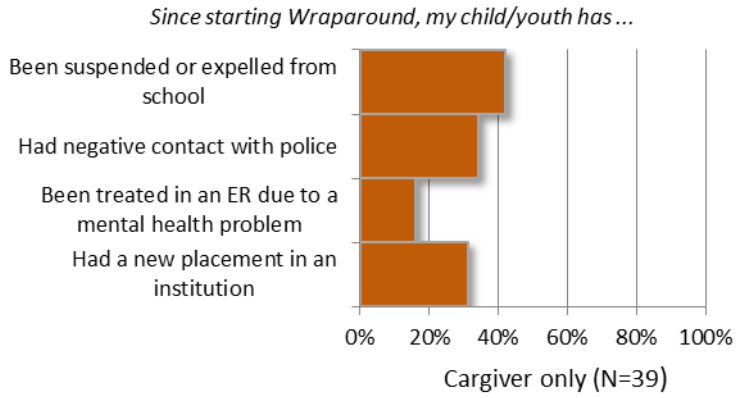
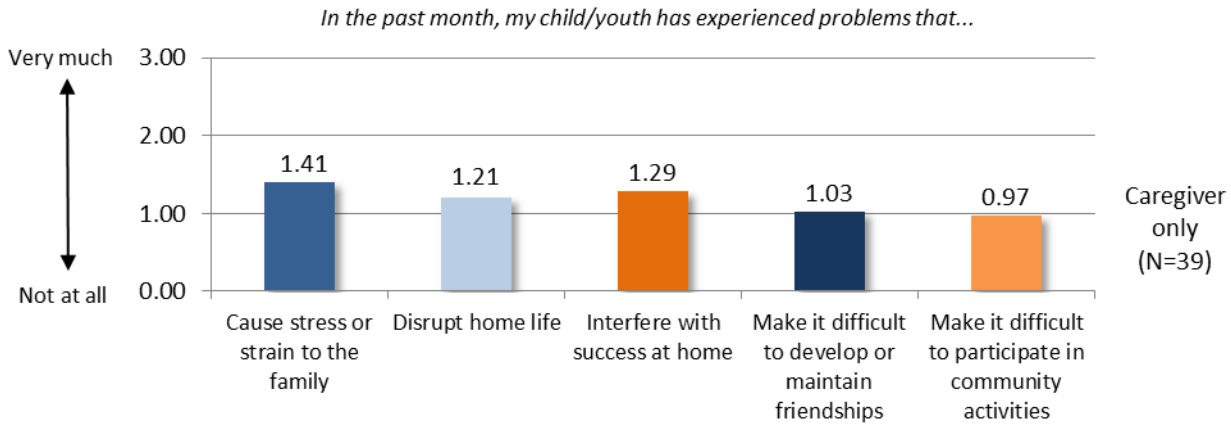


Figure 10d: Functional Outcomes



What were the outcomes of youth served?

Reasons for Discharge

A total of 213 youth discharged from the CME during the first and second quarters of FY14[2]. The most common reasons for discharge included Successful Completion (35%), Disrenrolled at Participant's Request/Failure to Maintain Participation (16%), and More Intensive Level of Treatment Needed (10%). Youth in the PRTF Waiver were most likely to discharge with a Successful Completion (58%), and those in the Stability Initiative were the most likely to be disenrolled at participant's request (21%) or need more intensive treatment (21%). See Appendix 3 for the distribution of all discharge reasons by population.

Compared to youth who discharged during the previous two quarters, the rate of successful completions did not significantly change during this reporting period (34% and 35%, respectively).

[2]This count excludes youth who did not have at least one face-to-face meeting with the care coordinator.

Figure 12: Reasons for Discharge, July - December, 2013

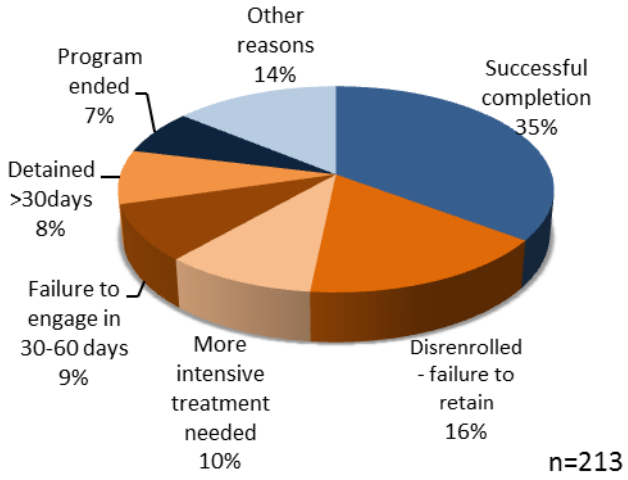
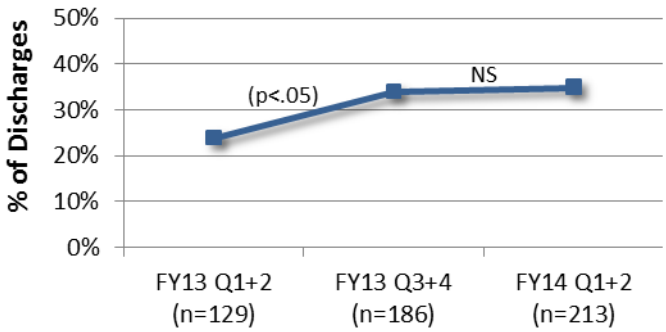


Figure 13: Semi-annual Trend in Successful Completions, July, 2012 - December, 2013



Duration of Services

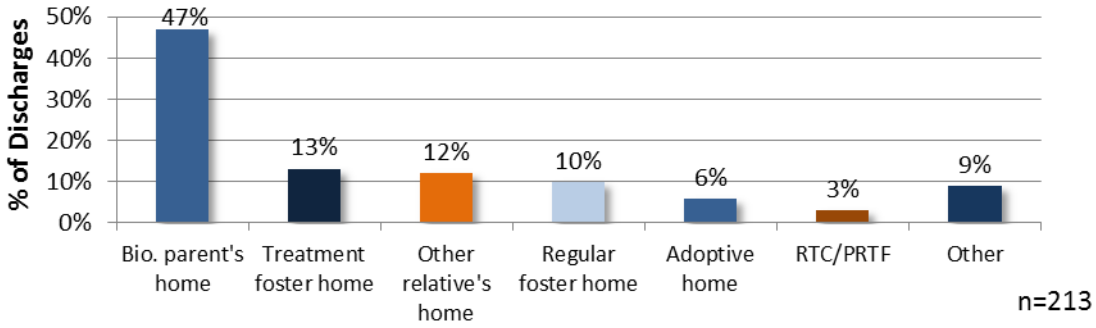
The Statewide average length of stay for all discharged youth[3] was 261.8 days (*sd*=179.26), and ranged by population from a low of 90.3 days (Stability Initiative, *sd*=48.52) to 553.3.1 days (PRTF Waiver, *sd*=132.06). Among youth who discharged with a Successful Completion (n=74), the average length of stay was 383.4 days (*sd*=167.15), ranging by population from 91.0 days (Stability Initiative, *n*=1) to 561.7 days (PRTF Waiver, *sd*=157.84). It should be noted that the Stability Initiative began enrolling youth effective April 22, 2013. Therefore, only those with shorter lengths of stay would have discharged by the current reporting period, thus skewing down the average length of stay for the Stability Initiative population. See Appendix 3 for the breakdown of length of stay by population.

Compared to youth who discharged during the third and fourth quarters of FY13, the average length of stay did not significantly change during this reporting period for all discharges (244.2 days, *sd*=155.32 vs. 261.8 days, *sd*=179.26) or successful completions (331.9 days, *sd*=167.90 vs. 383.4 days, *sd*=152.28).

Living Situation

Of the youth who exited the CME during this reporting period, the most prevalent living situation at discharge was biological parent's home (47%), followed by treatment/therapeutic foster home (13%) and non-biological parent relative's home (12%). Youth in the Rural CARES and DJS populations were the most likely to discharge to a biological parent's home (68% and 63%, respectively), and youth in the MD CARES population had the highest proportion residing in a regular foster home (24%). See Appendix 3 for the full distribution of living situations by population.

Figure 14: Living Situations at Discharge, July - December, 2013



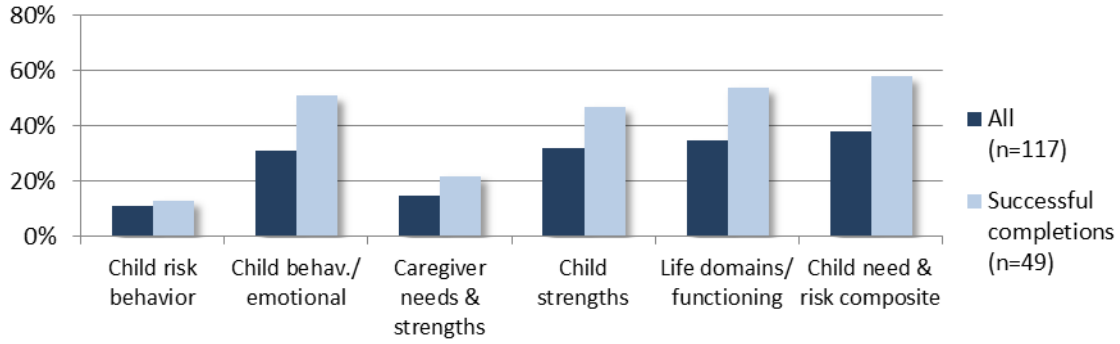
[3]Because Interim Case Service Account cases are served considerably longer than other populations, the one ICSA case that discharged during this reporting period (length of stay=2,784 days) was excluded from the Statewide average length of stay.

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 entry to discharge. Of the youth discharged during this reporting period who had CANS assessments at both entry and discharge (n=117, 55%), 38% showed improvement on Child Need & Risk - a composite scale comprised of items from the Life Domains/Functioning, Child Behavioral/Emotional Needs, and Child Risk Behavior subscales. Youth in the PRTF Waiver and MD CARES populations had the highest rate of improvement (44% and 43%, respectively. The Life Domains/Functioning and Child Strengths subscales were the domains on which youth showed the most improvement (35% and 32%, respectively). See Appendix 3 for the breakdown of improvement on all CANS domains by population.

The rates of improvement for youth who successfully completed were higher than those for all youth who discharged.

Figure 15: Reliable CANS Improvement (90% C.I.) from Entry to Discharge



It should be noted that youth with low CANS scores at baseline have less room for improvement, and are therefore less likely to improve over time, compared to youth with higher baseline scores. Of the 117 youth included in this analysis, those who showed reliable improvement from enrollment to discharge had significantly ($p<.05$) higher scores at baseline than youth who did not show improvement on the Child Need & Risk composite, and on all of the subscales. Thus, baseline scores should be considered when interpreting rates of reliable improvement (see Table 2).

Table 2: Average CANS Scores and Change from Baseline to Discharge

CANS Domain	Average (SD) baseline score	Average (SD) discharge score	Average (SD) change, baseline to discharge	Youth showing reliable improvement
Child Risk Behavior	.38 (.33)	.33 (.35)	-.02 (.34)	13 (11%)
Child Behavior/ Emotional Needs	.89 (.44)	.70 (.52)	-.12 (.52)	33 (31%)
Caregiver Needs & Strengths	.56 (.41)	.48 (.48)	-.03 (.52)	16 (15%)
Child Strengths	1.45 (.52)	1.24 (.67)	-.21 (.69)	37 (32%)
Life Domains/ Functioning	.89 (.42)	.69 (.54)	-.13 (.51)	40 (35%)
Child Need & Risk Composite	.73 (.34)	.57 (.43)	-.09 (.41)	43 (38%)

Implications

Strengths

- Discharge outcomes have shown consistent semi-annual improvement since July 1, 2012. The rate of Successful Completions significantly increased from 24% during the first and second quarters of FY13 to 34% in the third and fourth quarters of FY13. This improvement was sustained during the current reporting period, with 35% of discharges successfully completing services during the first and second quarters of FY14. Only 10% discharged due to the need for a more intensive level of treatment, compared to 21% during the previous reporting period, and 18% during the first and second quarters of FY13.
- Seventy-five percent of youth discharged to a stable, non-restrictive living situation (parent or relative's home, regular foster home, adoptive home, or living independently) during the first and second quarters of FY14. This is an increase from the previous reporting period (68%) and the first and second quarters of FY13 (63%).
- The number of CANS Needs items on which youth demonstrated need for intervention (score of 2 or 3) at discharge has remained consistently low, with an average of 5.5 (*sd*=5.70) out of 41 items during the first and second quarters of FY14 - the lowest over the past three reporting periods.
- These continued improvements in youth outcomes may reflect Maryland Choices, LLC adapting to the demands of serving as Maryland's single Statewide CME provider and working on ways to improve its implementation of the Wraparound model over the past 18 months.

Areas for Improvement

- Compared to the previous reporting period, the rate of admission dropped by about 6%, and disenrollment prior to meeting with a care coordinator increased from 8% to 11%. The most common reasons for non-admission were failure to engage (59%) and disenrollment at participant request (18%), suggesting that difficulty engaging families was a barrier to service delivery during this reporting period.
- On average, it took about 12 days from the date of acceptance for a family to have their first face-to-face meeting with a care coordinator. Although this is an improvement from the previous reporting period (17 days), it is longer than the time frame specified in the contract, which states that initial contact must be made within 72 hours and the first face-to-face meeting should occur in the following seven days. Moreover, the first Child and Family Team meeting was on average 39 days after the date of acceptance, which exceeds the target of 30 days. Reducing the time from admission to contact and initial meeting may help engage families and improve admissions.

Data Limitations

- This was the first reporting period during which the final version of the WFI-EZ was used to measure fidelity, which is considerably different from previous versions of the WFI instrument. Therefore, Wraparound fidelity cannot be compared to previous reporting periods. Future reports will show trends in fidelity over time.
- The six- and 12-month follow-up response rates for the RYDM were 13 and six, respectively; these are too low to compare across different time points. Future reports will compare intake and follow-up resiliency scores.

Training and Coaching

The Institute has continued to host core trainings open to all CME staff to complete their Wraparound Practitioner Certification requirements and refresh skills of those who have attended training in the past. The Institute conducted one three-day Introduction to Wraparound training, two one-day Engagement Within the Wraparound Process training and one two-day Intermediate Wraparound: Improving Wraparound Practice training. Thirty-two staff members from the CME attended one or more of these offered sessions. Unfortunately, twenty seven percent of the trained staff from these past two quarters has turned over by the time of this report. Fewer staff have been trained within this reporting timeframe than in previous reports but more of the trained staff have been retained.

The Institute continues to address engagement issues with families through facilitated coaching and training sessions. Additional training within these two quarters focused on the partnership between the Care Coordinator and the Family Support Partners in their work with families. These trainings were provided regionally and open to CME staff as well as staff from the local Family Organizations. The topic of one session offered within three separate regions was Cultural and Linguistic Competency in working with families facilitated by Dr. Henry Gregory, Cultural and Linguistic Competence Coordinator for Maryland CARES.

Coaching by The Institute has been targeted to focus on the CME's management and supervisory level staff. Leadership meetings have occurred regularly to address systemic issues identified within coaching. In addition to core trainings and group sessions, regular in person and virtual coaching was offered weekly by The Institute to each CME supervisor and their respective team to include field observations, document reviews and supervisory sessions. All the supervisors have been trained in the Wraparound Practice Improvement tools (WPITS) and have been certified to utilize the COMET assessment tool on their staff.

One wraparound practitioner certificate was awarded during this timeframe; however, this staff person has transitioned to a new position and is no longer involved in direct service work. One wraparound practitioner recertification was awarded. One provisional recertification was awarded to supervisor to allow an expanded timeframe for demonstrating the skills sets associated with high-quality implementation of the Wraparound process. At the end of December 2013, there was one staff person in a Care Coordinator role that held a wraparound practitioner certification. This is a decrease from the last reporting period which is due to staff turnover and movement within the agency for those previously certified.

Next Steps

The Institute has provided targeted coaching and follow-up with the CME in an effort to address staff time meeting requirements and engagement issues highlighted in this report. Guidance and recommendations have been provided on organizational policies and procedures within the CME to clarify timeframes and support clear and consistent procedural expectations. Administration monitoring efforts have been restructured to address staff time frames and incentivize high fidelity and quality wraparound implementation. Data on skill acquisition for all frontline staff across the CME is being collected and discussed with the CME's Clinical Team to identify patterns that may require targeted supervision and coaching plans. Additional assistance around procedures related to transitioning families when staff turnover occurs has been provided to support best practice and care for families. An additional coaching opportunity has been added monthly with the Clinical Team at the CME to support ongoing discussion and guidance around implementation issues.

References

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