Care Management Entity

MARYLAND IMPLEMENTATION REPORT

FY14 QTR 3 & 4 • JANUARY-JUNE 2014

Prepared by The Institute for Innovation & Implementation
University of Maryland School of Social Work
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Introduction

Youth with complex needs and their families typically are involved with multiple providers and systems, yet oftentimes no one provider or system is responsible for or resourced to comprehensively address the constellation of needs presented. This leads to multiple plans of care and multiple providers and case managers – leaving the families and workers confused and creating inefficiencies and redundancies in service delivery. Care Management Entities (CMEs) serve as a locus of eligibility determination, plan development and coordination, and accountability for specific populations of children, youth and families with intensive needs to 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. CMEs have been implemented Statewide in Maryland since 2009. Choices, Inc. d/b/a Maryland Choices, LLC (Choices), has served as the state's single CME provider in all 23 counties and Baltimore City since July 2012.

The Institute for Innovation and Implementation (The Institute) collects and analyzes data to monitor and support CME implementation in Maryland. This report provides state and local stakeholders with a summary of utilization, characteristics of youth served, quality of services delivered, and outcomes of youth discharging from the CME between January 1 and June 30, 2014.

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

Data Included in this Report

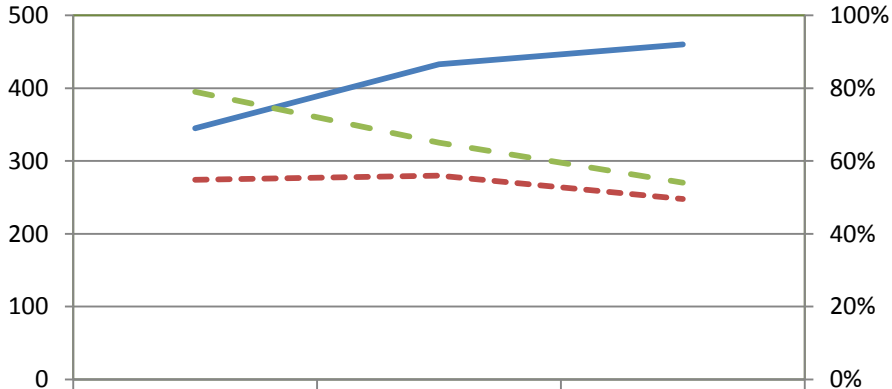
This report includes administrative data provided by Choices, as well as data collected directly from youth and families by The Institute.[1] Choices collects data for all youth and families enrolled in the CME upon intake and throughout their CME involvement until discharge. Additionally, The Institute collects survey data from participating 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 youth and their families. To this end, Choices provided The Institute with contact information for 179 families (85% of 210) who started with the CME during this reporting period. Participants can complete these surveys online, over the phone, or by paper copies via mail; most of the surveys were completed over the phone. Additional details regarding data collection are provided throughout the report. Refer to Appendix 2 for descriptive data presented by population.

[1] The data presented in this report was current as of July 2014; some of the numbers and percentages shown for previous quarters may differ slightly from prior reports due to updated information in the administrative data.

Utilization

While the average number of CME slots available to children and families (i.e., average daily capacity) has increased between January 2013 and June 2014 - from 345 to 460 slots - the average number of children and families served (i.e., average daily census) has decreased from 274 to 248 during the same time period (Figure 1). This substantial increase in slots coupled with a declining average daily census has contributed to a significant decline in average utilization over the past year - from 79% to 54%.

Figure 1. Statewide CME Utilization, January 2013 - June 2014



	FY13 Q3-4	FY14 Q1-2	FY14 Q3-4
Avg. Daily Capacity	345	433	460
Avg. Daily Census	274	280	248
Avg. Utilization	79%	65%	54%

Several populations are served by the CME (Table 1; see Appendix 1 for descriptions). The average utilization rate ranged from 8% to 100% across populations. Some important capacity changes were implemented during this reporting period, which have likely contributed to the declines in average daily census and utilization shown above. Notably, capacity for the Stability Initiative increased incrementally from 100 to 250 slots, and capacity for the Schools and Families Empowering Their Youth (SAFETY) Initiative also increased from 70 to 120 slots on May 5, 2014. Also on May 5th, the Department of Juvenile Services (DJS) Out-of-Home Placement Diversion and Department of Human Resources (DHR) Out-of-Home Placement Diversion populations were closed for new referrals, and the 41 youth who were enrolled in these populations at that time were transferred to the Stability Initiative population. As referral processes are adjusted to align with these changes, it is expected that overall average daily census and utilization rates will increase.

Table 1. Utilization of CME Slots, January - June 2014

Population	Average Daily Capacity	Average Daily Census	Average Utilization
DJS	50.0*	19.0	38%
DHR	50.0*	24.8	50%
Stability Initiative	187.6*	113.5	61%
SAFETY Initiative	85.8*	7.2	8%
Rural CARES	55.0	51.1	93%
MD CARES	8.3	8.3	100%
PRTF Waiver	21.8	21.8	100%
ICSA	2.0	2.0	100%
Total Statewide	*460.5*	*247.7*	*54%*

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

Youth Enrolled

The CME enrolled 252 children/youth between January 1 and June 30, 2014. Of these, 210 (83%) youth and families started services (i.e., had at least one face-to-face meeting with a care coordinator), 35 (14%) did not start services and were disenrolled[2] as of the close of the reporting period, and 7 (3%) were new enrollments who did not have their first face-to-face meeting nor a discharge date (Table 2).

Table 2. Case Processing for Enrolled Youth, January 2013 – June 2014

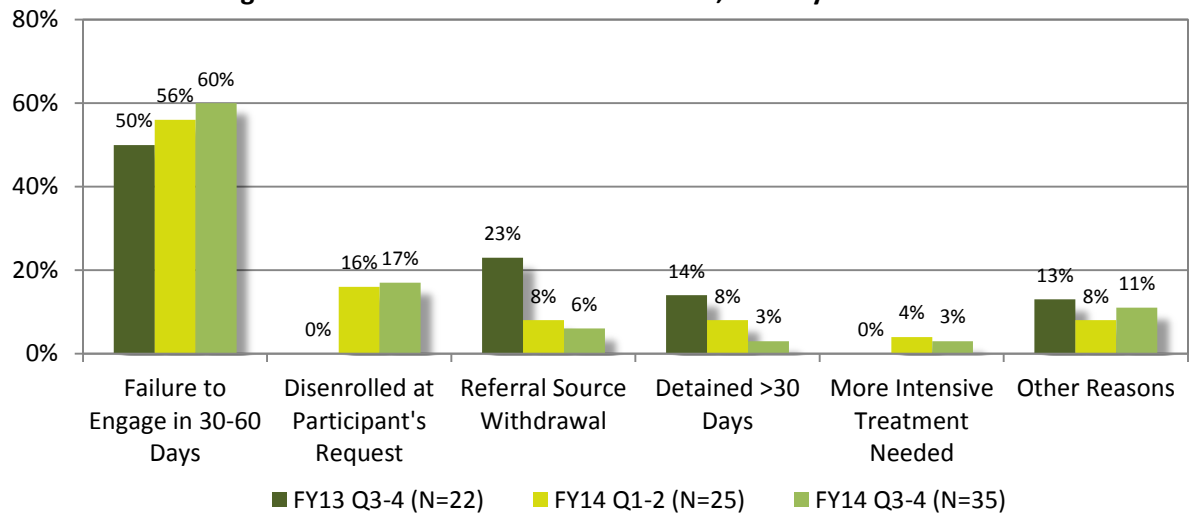
	FY13 Q3-4	FY14 Q1-2	FY14 Q3-4
Total Accepted Referrals	**211**	**192**	**252**
Started	189 (90%)	167 (87%)	210 (83%)
Disenrolled	22 (10%)	25 (13%)	35 (14%)
New enrollments with no face-to-face meeting (or discharge date)	0	0	7 (3%)
Avg. days between referral and enrollment*	6.4 (22.1)	3.0 (9.5)	0.9 (5.0)
Avg. days between enrollment and first face-to-face meeting*	17.9 (18.4)	12.5 (10.3)	11.4 (9.9)
Avg. days between enrollment and first CFT meeting*	41.2 (29.4)	40.7 (23.2)	37.9 (25.8)

*Standard deviations in parentheses.

Once a youth is referred to the CME, it is critical that the enrollment decision is made in a timely manner and that services starts soon thereafter. Accordingly, the CME contract specifies that initial contact shall be made with the family within 72 hours, with the initial face-to-face meeting occurring in the next seven days. Among youth who started services with the CME, it took an average of 11.4 days from the date of enrollment to have the first face-to-face meeting with the care coordinator (Table 2). Of youth with at least one Child and Family Team (CFT) meeting (n=150), the average length of time from enrollment to the first CFT meeting was approximately 38 days.

Of those who were disenrolled this reporting period, the most common reason for disenrollment was *failure to engage within 30-60 days* (60%), which was also the most common reason for the previous two reporting periods (Figure2).

Figure 2. Reasons for CME Disenrollment, January 2013 - June 2014

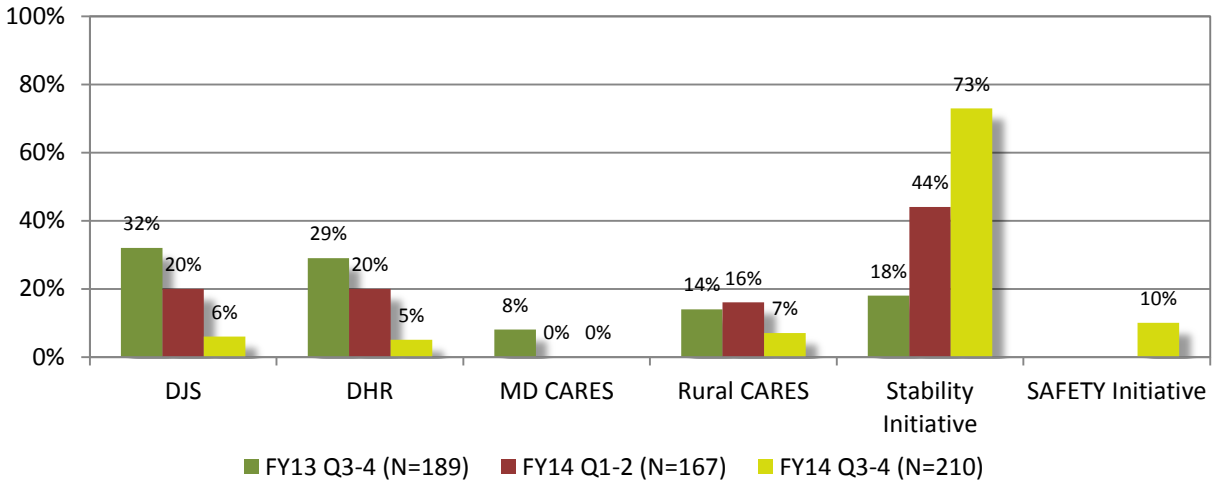


[2] Disenrolled was identified in the data as youth who had a discharge date but no first face-to-face meeting date.

Populations Served

As noted earlier, youth who started with the CME were categorized into different populations including Stability Initiative (73%), SAFETY Initiative (10%), Rural CARES (7%), DJS Out-of-Home Placement Diversion (6%), and DHR Out-of-Home Placement Diversion (5%; Figure 3). SAFETY Initiative opened for referrals during this reporting period. On May 5, 2014, all youth in the DJS and DHR Out-of-Home Placement Diversion populations transitioned to the Stability Initiative population, which increased its capacity to serve youth. As mentioned earlier, the DJS and DHR Out-of-Home Placement Diversion populations were closed for new referrals.

Figure 3. Populations Starting CME, January 2013 - June 2014



Demographic Characteristics

The majority of youth starting with the CME were male (64%), African American/Black (63%), and approximately 14 years old, on average (Table 3). These characteristics are generally similar to those of youth who started CME services during the previous two reporting periods. Youth in the DJS Out-of-Home Placement Diversion population were older than youth in other populations, with an average age of 15.4 years. The DJS Out-of-Home Placement Diversion population also included the largest proportion of African American/Black (92%) youth, and Rural CARES had the largest proportion of Caucasian/White (71%) participants.

Table 3. Demographic Characteristics of Youth Who Started with the CME, January 2013 - June 2014

	FY13 Q3-4	FY14 Q1-2	FY14 Q3-4
Total Youth Who Started	**189**	**167**	**210**
Female	74 (39%)	70 (42%)	76 (36%)
Male	115 (61%)	97 (58%)	134 (64%)
African American/Black	124 (66%)	91 (55%)	131 (63%)
Caucasian/White	49 (26%)	57 (34%)	63 (30%)
Hispanic/Latino	10 (5%)	14 (8%)	8 (4%)
Other	6 (3%)	5 (3%)	6 (3%)
Avg. Age at Referral*	14.3 (2.9)	14.2 (3.3)	14.2 (2.9)

*Standard deviations in parentheses.

Functioning at Enrollment

Diagnosis

Certain populations' eligibility requirements require diagnosis information upon entry into the CME (i.e., Rural CARES); Axis I and II diagnosis might be sufficient for enrollment. Among youth who started with the CME, 110 (52%) had a psychiatric diagnosis indicated within three months of enrollment (Table 4; note: for youth enrolled toward the end of the reporting period, it is likely the diagnosis was not yet provided and/or entered into the database). The primary diagnoses were predominantly attention deficit or disruptive behavior disorders (39%) and mood disorders (25%); these have been the two most common diagnoses in prior reporting periods. Attention deficit or disruptive behavior disorders were more prominent in Rural CARES youth (75%), and mood disorders were most common among youth in the DHR Out-of-Home Placement Diversion population (40%).

A youth's level of psychosocial functioning is also assessed using the Global Assessment of Functioning scale (GAF; American Psychiatric Association [DSM-IV-TR], 2000), which is conducted as part of a full biopsychosocial assessment. GAF scores range from 1 to 100, with 100 representing the highest level of functioning. Only 51 youth (24%) had a GAF score indicated this reporting period; this could be due to the fact that not all mental health assessments include a GAF score. The average score was 48.2 (*sd*=9.0), and scores ranged by population from 44.0 (Stability Initiative, *sd*=5.7) to 57.5 (DJS Out-of-Home Placement Diversion, *sd*=710.6). These scores indicate that youth entering the CME generally displayed symptoms of moderate to serious impairment in social, occupational, and/or school functioning.

Table 4. Diagnosis and Prior Mental Health Services, Youth Who Started between January 2013 - June 2014

	FY13 Q3-4	FY14 Q1-2	FY14 Q3-4
Total Youth Who Started Services	**189**	**167**	**210**
Youth with a Diagnosis Indicated	129 (68%)	116 (69%)	110 (52%)
ADHD/Disruptive Behavior Disorders	40 (31%)	37 (32%)	43 (39%)
Mood Disorders	52 (40%)	42 (36%)	27 (25%)
Anxiety Disorders	4 (3%)	6 (5%)	5 (5%)
Adjustment Disorders	3 (2%)	4 (3%)	3 (3%)
Other Disorders	11 (9%)	7 (6%)	11 (10%)
Diagnosis Deferred	19 (15%)	20 (17%)	21 (19%)
Youth with a GAF Score at CME Enrollment	78 (41%)	73 (44%)	51 (24%)
Avg. GAF Score*	47.4 (9.7)	48.2 (8.7)	48.2 (9.0)
Youth with Prior Mental Health (MH) Service Info.	179 (95%)	155 (93%)	170 (81%)
Had Prior MH Service†	144 (80%)	129 (83%)	139 (82%)
Youth with Age of First MH Service Info	102 (71%)	87 (67%)	79 (57%)
Avg. Age of First MH Service*†	9.7 (4.1)	9.7 (4.5)	9.5 (4.3)

†Of youth with complete information. *Standard deviations in parentheses.

Prior Mental Health Services

Of youth who started with the CME this reporting period, 82% (n=139) had received mental health services prior to CME enrollment (Table 4).[3] The average age of first receiving mental health services was 9.5 years old, which is similar to that of youth who started with the CME during previous reporting periods. Youth in the Rural CARES population had the youngest average age of first receiving mental health services (6.8 years old), and youth in the SAFETY Initiative population had the oldest average age (13.2 years old).

Youth Resiliency

Youth resiliency survey data are collected by The Institute at baseline, six months, and twelve months for youth ages 11 or older, provided that a caregiver has given consent and the youth is functioning at that age level both developmentally and cognitively. Note that response rates are impacted if youth are incarcerated or placed in a Residential Treatment Center during the assessment period.

During the third and fourth quarters of FY14, 58 youth completed the California Healthy Kids Survey's Resilience & Youth Development Module (RYDM)[4] upon entry to the CME (within four weeks; Table 5). This total is notably higher than the previous two reporting periods, though still represents a small share of the youth enrolled in the CME, thus the following findings should be interpreted with caution. On a scale of 1 through 4 (with a higher score indicating greater resilience), the average scores at intake on the domains measuring environmental protective factors ranged from 2.8 (*sd*=0.9) on the Meaningful Participation at Home domain, to 3.5 (*sd*=0.6) on the High Expectations at Home domain. Of the domains measuring personal resilience strengths, average intake scores ranged from 2.8 (*sd*=0.7) on the Problem Solving domain, to 3.5 (*sd*=0.6) on Goals and Aspirations. These scores suggest that youth enrolled in the CME who completed the RYDM at intake generally demonstrated moderate-to-high personal and environmental resilience; again, these youth are not necessarily representative of all CME youth.[5]

Table 5. Resilience & Youth Development Module Domain Scores*, January 2013 - June 2014

		FY13 Q3-4	FY14 Q1-2	FY14 Q3-4
Youth Completing the RYDM at Enrollment		**26**	**22**	**58**
Environmental	Home - Caring Relationships	3.2 (0.9)	3.3 (0.6)	3.2 (0.8)
	Home - High Expectations	3.4 (0.8)	3.6 (0.6)	3.5 (0.6)
	Home - Meaningful Participation	2.9 (0.8)	2.8 (0.9)	2.8 (0.9)
	Peer - Caring Relationships	3.3 (0.6)	3.0 (1.0)	3.3 (0.7)
	Peer - Pro-social/High Expectations	3.0 (0.7)	2.7 (0.6)	3.0 (0.7)
Personal Resiliency	Cooperation and Communication	2.9 (0.6)	2.9 (0.8)	3.0 (0.6)
	Self-efficacy	3.3 (0.6)	3.4 (0.6)	3.1 (0.7)
	Empathy	2.9 (0.7)	2.8 (1.0)	3.0 (0.7)
	Problem Solving	2.6 (0.7)	2.7 (0.8)	2.8 (0.7)
	Self-awareness	3.0 (0.8)	3.3 (0.7)	3.2 (0.7)
	Goals and Aspirations	3.2 (0.7)	3.5 (0.5)	3.5 (0.6)

*Average scores reported; standard deviations in parentheses. All scales range from 1 to 4.

[3] 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.

[4] See Appendix 1 for a description of the RYDM instrument.

[5] Note that due to low response rates, data collection of the RYDM will conclude at the beginning of 2015.

Caregiver Empowerment

The Institute also collects survey data to measure caregiver empowerment at baseline, six months, and twelve months into services. The caregivers of 117 youth who started with the CME this reporting period completed the Family Empowerment Scale (FES)[6] within four weeks of intake (Table 6). Possible scores on the FES range from 1 through 5, with a higher score indicating greater empowerment. Of those who completed the FES, caregivers generally reported feeling most empowered in accessing and participating in services that their children need (mean=4.2, sd=0.5) and least empowered in their community/political involvement in influencing policies around child services (mean=2.9, sd=0.9). These scores were similar to those of the caregivers who completed the FES at intake during the previous two reporting periods, though they are not necessarily representative of all caregivers served by the CME.[7]

Table 6. Family Empowerment Scale (FES) Domain Scores*, January 2013 - June 2014

	FY13 Q3-4	FY14 Q1-2	FY14 Q3-4
Caregivers Completing the FES at Enrollment†	**52**	**54**	**117**
Family Management	3.9 (0.5)	4.0 (0.6)	3.9 (0.6)
Child's Services	4.1 (0.5)	4.3 (0.6)	4.2 (0.5)
Community Involvement	3.0 (0.9)	3.2 (0.7)	2.9 (0.9)

*Average scores reported; standard deviations in parentheses.

Youth and Caregiver Needs and Strengths

The CME care coordinators complete the Child and Adolescent Needs and Strengths (CANS)[8] assessment with youth and families at the start of services in order to inform the plan of care. Of those who started this reporting period, 143 (68%) youth had a completed CANS assessment within 30 days of admission (Table 7).[9] The highest areas of demonstrated need (items with a score of 2 or 3) included anger control (48%), recreation (45%), family functioning (43%), ADHD/impulse control (41%), and oppositional behavior (39%). This suggests that youths' greatest areas of need were in the Life Domain Functioning and Behavioral/Emotional Needs Domains. Youth in the Rural CARES population demonstrated notably higher need for intervention in ADHD/impulse control (75%) and anger control (63%) compared to the Statewide rates. SAFETY Initiative youth had higher need in school achievement (69%) and school behavior (62%), which is to be expected considering some of the risk factors included in the eligibility requirements for this population have a school focus.

[6] See Appendix 1 for a description of the FES instrument.
[7] Note that due to low response rates, data collection of the FES will conclude at the beginning of 2015.
[8] See Appendix 1 for a description of the CANS instrument.
[9] Youth enrolled toward the end of the reporting period may not have yet had a CANS assessment completed at the time of the data download.

Table 7. Child & Adolescent Needs and Strengths (CANS) Assessment—Most Frequently Identified Areas of Needs and Strengths, January 2013 - June 2014

		FY13 Q3-4	FY14 Q1-2	FY14 Q3-4
Total Youth Who Started Services		**189**	**167**	**210**
CANS Completed at Start of Services		149 (79%)	128 (77%)	143 (68%)
Areas of Need (Item Score of 2 or 3)	Anger Control	43%	47%	48%
	Recreational	44%	41%	45%
	Family	43%	43%	43%
	ADHD/Impulse Control	41%	44%	41%
	Oppositional Behavior	39%	47%	39%
	School Achievement	41%	38%	36%
	Living Situation	43%	36%	36%
	School Behavior	44%	46%	33%
	Judgment	32%	35%	33%
Identified Strengths (Item Score of 0 or 1)	Talents and Interests	96%	96%	98%
	Educational	70%	70%	70%
	Optimism	66%	58%	62%
	Relationship Permanence	57%	47%	59%
	Family	47%	42%	52%
	Interpersonal	44%	41%	48%
	Community Life	45%	38%	40%
	Spiritual/Religious	29%	28%	34%
	Vocational	28%	33%	28%

Fidelity to the Wraparound Model

The CME uses Wraparound as the model for intensive care coordination. Fidelity to the Wraparound model was measured using the Wraparound Fidelity Index—Short Form (WFI-EZ),[10] which is collected by The Institute's evaluation team at six months and twelve months into services.[11] The WFI-EZ is completed with caregivers and youth who are over 11 years of age (after a caregiver's consent).

During the current reporting period, the WFI-EZ was completed by 55 (58%) caregivers who were eligible for their six-month surveys and 40 (41%) caregivers who were eligible for their twelve-month surveys, and by 22 (24%) eligible youth at six months and 10 (13%) eligible youth at twelve months into services (Table 8). Thus, the scores do not represent all youth and families served, and may not be fully representative, especially of youth perspectives. Further, youth and families who completed the twelve-month WFI are not necessarily the same participants in the six-month respondent pool.

[10] See Appendix I for a description of the WFI-EZ instrument.

[11] The Institute began collecting the WFI-EZ from youth and families in July 2013. The WFI-EZ replaced a longer version of the instrument that was previously used for fidelity monitoring.

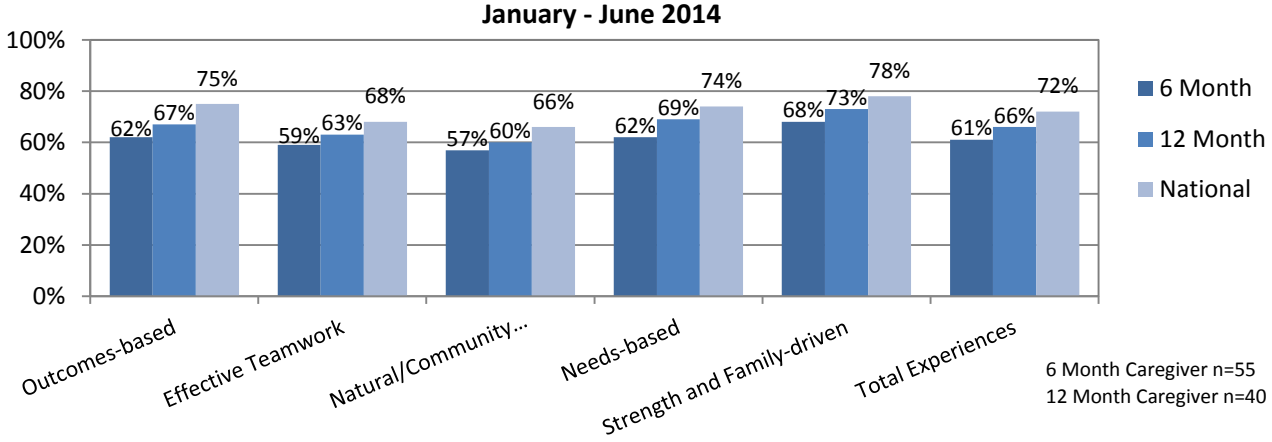
Table 8. WFI-EZ Basic Information, Caregiver and Youth Responses, January - June 2014

	Caregiver		Youth	
	6 Months	12 Months	6 Months	12 Months
Youth/Caregivers Eligible for WFI-EZ	**95**	**97**	**92**	**80**
Youth/Caregivers Completing WFI-EZ	**55 (58%)**	**40 (41%)**	**22 (24%)**	**10 (13%)**
Decisions are based on input from youth and family	94%	90%	86%	100%
Family is part of a team, including more than just family and one professional	91%	88%	96%	100%
Family and team created a written plan that describes who will do what/how it will happen	87%	80%	96%	90%
Team meets regularly (at least every 30-45 days)	87%	85%	86%	90%

The first section of the WFI-EZ includes four items that obtain the caregiver's and youth's perceptions of non-negotiable Wraparound components (i.e., that there is a team, the team meets regularly, there is a plan, and decisions are based on input from the youth and family). These responses should be close to 100% for all four items. As shown in Table 8, less than 90% of caregivers indicated that the family and team created a written plan together that describes who will do what and how it will happen at six months (87%) and twelve months (80%). Less than 90% of caregivers indicated that the team meets regularly (87% at 6 months, and 85% at 12 months). And as of six months, only 86% of youth indicated that they help make decisions about their plan and services, and only 86% indicated that the team meets regularly. Again, with relatively low response rates, these findings should be interpreted with caution. In addition, some of these responses may have been collected post-discharge from the CME, though this is not typical.

The second section of the WFI-EZ measures the respondent's experiences with the details of the Wraparound process, the makeup of the Child and Family Team, and the strategies of the Plan of Care that is developed and implemented by the CFT. These items are divided into five subscales that are based on the key elements of the Wraparound process - outcomes-based, effective teamwork, natural/community supports, needs-based, and strength- and family-driven. There is also a combined experiences score. Figure 4 shows the average caregivers' experiences scores at six months and twelve months, as well as the average score for a national sample of caregivers involved in a similar Wraparound process.[12] Overall, at both time points, the average scores for the Maryland caregivers are lower than the national averages, with averages from the twelve-month cohort of respondents slightly higher than for the six-month cohort.

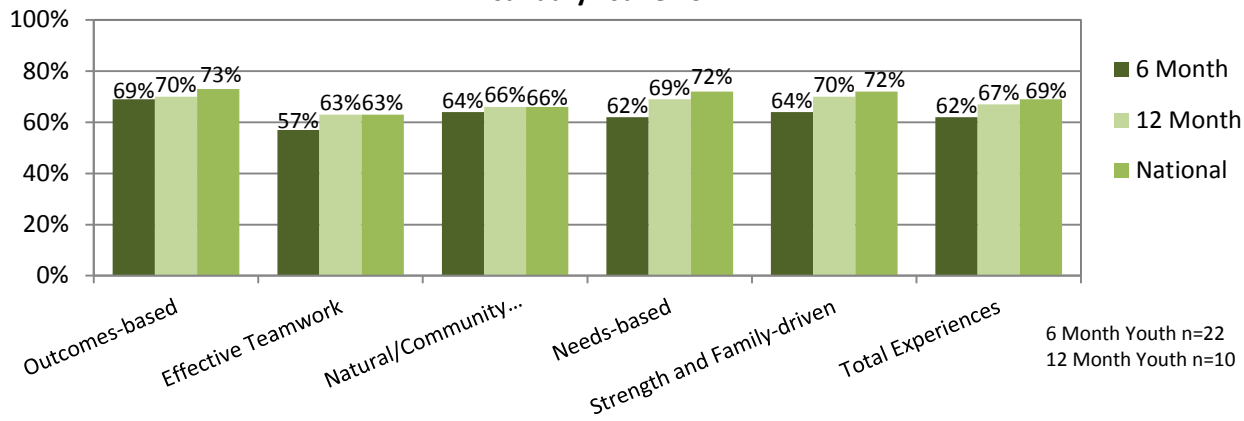
Figure 4. WFI-EZ Experiences in a Wraparound Process, Caregiver Responses, January - June 2014



[12] The national scores were provided by the Wraparound Evaluation and Research Team. The sample includes 1072 responses pooled from 12 sites.

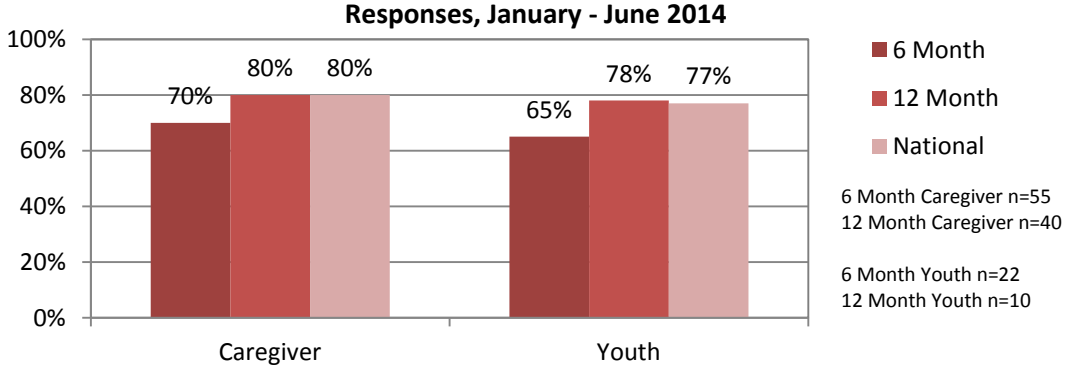
Figure 5 shows the average youths' experiences scores at six months and twelve months, as well as the average score for a national sample of youth involved in a similar Wraparound process.[13] Once again, at both time points, the average scores for the Maryland youth are generally lower than the national averages, though the twelve-month responses are equal to the national averages for effective teamwork and natural/community supports (again, respondents may not be representative of all youth served).

Figure 5. WFI-EZ Experiences in a Wraparound Process, Youth Responses, January - June 2014



The WFI-EZ includes four items to gauge the caregiver's and youth's satisfaction with the Wraparound process and with progress made as a result of the services received; these items are combined into a total satisfaction score. Figure 6 shows the average scores for caregivers and youth at six and twelve months. As of six months, the average caregiver satisfaction score was 70%, and the average youth score was 65%, with average scores slightly higher for both twelve-month cohorts (likely due to lower response rates and the disenrollment of families who may have been less satisfied between 6 and 12 months). The twelve-month rates were comparable to the national averages.

Figure 6. WFI-EZ Satisfaction Subscale Score, Caregiver and Youth Responses, January - June 2014



Finally, the last section of the WFI-EZ captures caregiver-reported progress on select outcomes since the start of the Wraparound process, as well as caregiver perceptions of how the youth's problem behaviors have disrupted family and youth functioning over the past month. These items can be used to assist in interpretation of the fidelity and satisfaction items. A summary of these responses are provided in Table 9.

[13] The national scores were provided by the Wraparound Evaluation and Research Team. The sample includes 371 responses pooled from 5 sites. Demographic information for the national sample was not available.

Table 9. WFI-EZ Outcomes, Caregiver Responses,* January - June 2014

	6 Months	12 Months
Caregivers Completing WFI-EZ	**55**	**40**
Since starting Wraparound, my child or youth has…		
Been suspended from school	22%	30%
Had negative contact with police	15%	26%
Been treated in an emergency room due to a mental health problem	19%	23%
Had a new placement in an institution	19%	30%
In the past month, my child has experienced…**		
Problems that cause stress or strain to me or a family	1.4	1.5
Problems that disrupt home life	1.2	1.2
Problems that interfere with success at school	1.1	1.2
Problems that make it difficult to development maintain friendships	0.9	1.0
Problems that make it difficult to participate in community activities	0.6	0.8

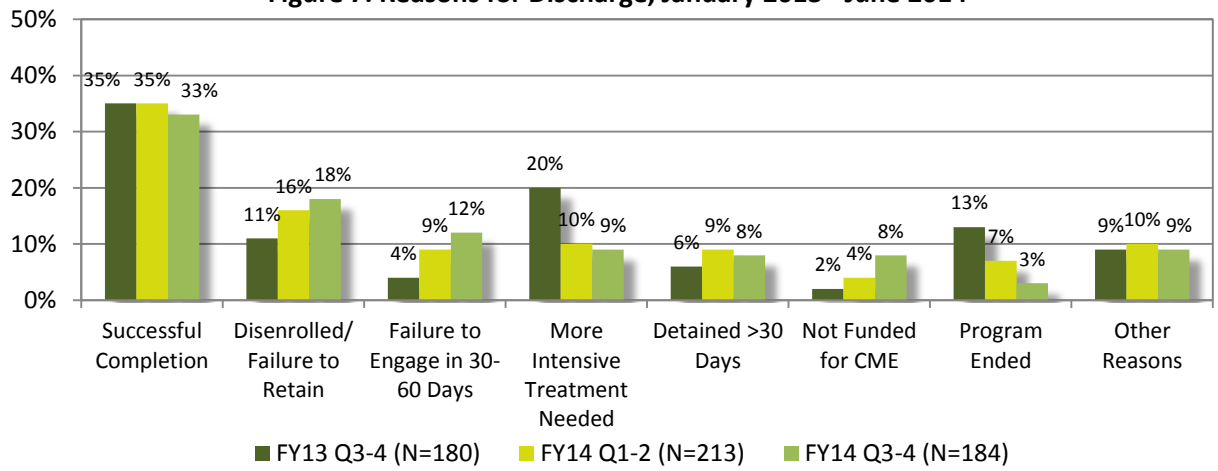
*Youth do not complete the items in the Outcomes section.
**Scores for each item range from 0 (not at all) to 3 (very much).

Youth Discharged

Reasons for Discharge

A total of 184 youth discharged from the CME during the third and fourth quarters of FY14.[14] The most common reasons for discharge included *Successful Completion* (33%) and *Disrenrolled at Participant's Request/Failure to Maintain Participation* (18%; Figure 7). Youth discharging from the Psychiatric Residential Treatment Facility (PRTF) Waiver were most likely to discharge with a *Successful Completion* (71%), and those in MD CARES were the most likely to be *Disrenrolled at Participant's Request/Failure to Maintain Participation* (27%). Compared to youth who discharged during the previous two quarters, the rate of successful completions did not significantly change during this reporting period (35% and 33%, respectively).

Figure 7. Reasons for Discharge, January 2013 - June 2014

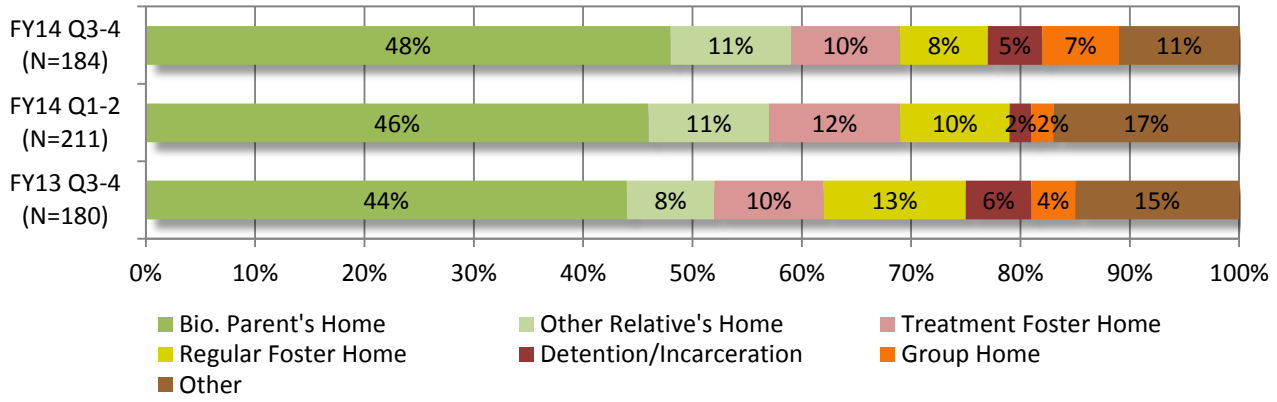


[14] This count excludes youth who did not have at least one face-to-face meeting with the care coordinator.

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 (48%), followed by other relative's home (11%) and treatment/therapeutic foster home (10%; Figure 8).[15] These are similar to the most common living situations at discharge during the first and second quarters of FY14. A majority of youth discharging from the SAFETY Initiative (100%), Interim Case Service Account (ICSA; 100%), Rural CARES (88%), DJS Out-of-Home Placement Diversion (82%), MD CARES (82%), and Stability Initiative (52%) populations discharged to either a biological parent's or non-parent relative's home.

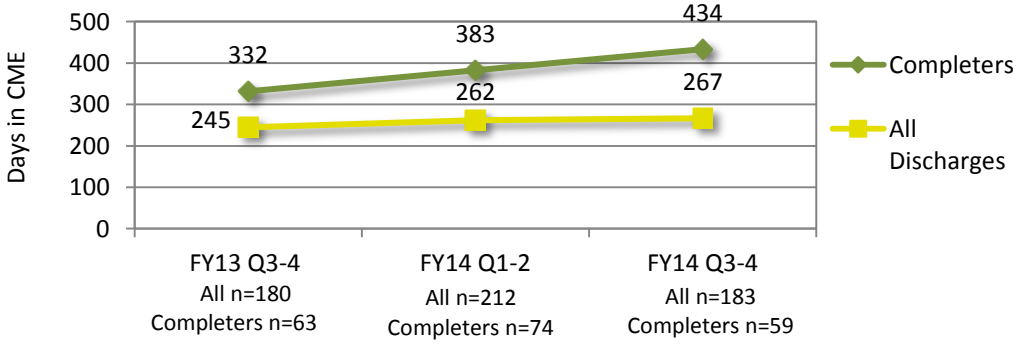
Figure 8. Living Situations at Discharge, January 2013 - June, 2014



Duration of Services

The average length of stay (ALOS) for all discharged youth[16] was 267 days (*sd*=202.4; Figure 9), and ranged by population from a low of 39 days (Stability Initiative, *sd*=14.9, n=2) to 624 days (PRTF Waiver, *sd*=80.2). Among youth who discharged with a Successful Completion (n=60), the ALOS was 383 days (*sd*=167.2) and ranged by population from 91 days (Stability Initiative, n=1) to 562 days (PRTF Waiver, *sd*=157.8). It should be noted that the SAFETY Initiative began enrolling youth at the start of this reporting period, therefore only those with shorter lengths of stay would have discharged by the current reporting period, thus skewing down the ALOS for the SAFETY Initiative population. Compared to youth who discharged during the first and second quarters of FY14, the ALOS for all discharges this reporting period was not significantly different (262 vs. 267 days); nor were there significant differences among youth who had successfully completed services (383 vs. 434 days).

Figure 9. Length of Stay for Discharged Youth, January 2013 - June 2014



[15] "Other" living situations referenced in Figure 8 included: adoptive home (3%), inpatient hospital (3%), residential treatment center (2%), independent living by self (<1%), friend's home (<1%), shelter (<1%), and runaway (<1%).

[16] Because Interim Case Service Account cases were served considerably longer than other populations, the one ICSA case that discharged during this reporting period (length of stay=3,175 days) was excluded from the average length of stay calculations.

Youth and Caregiver Needs and Strengths

Of youth discharged during this reporting period who had CANS assessments completed at both entry and discharge (n=90, 49%), 58% 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 (Table 10); this was a larger share of youth relative to previous reporting periods (49% in FY14 Q1-2, and 43% in FY14 Q3-4). Youth showed the most improvement in Life Domain Functioning (53%). Further, the rates of improvement for youth who successfully completed the program were higher than those for all youth who discharged. Youth in the MD CARES and PRTF Waiver populations had the highest rate of improvement (100% and 95%, respectively).

Table 10. Percent of Families with Fewer CANS Items Indicating Need for Intervention* from Entry to Discharge, Families Discharged, January 3013 – June 2014

	FY13 Q3-4		FY14 Q1-2		FY14 Q3-4	
	All	Completers	All	Completers	All	Completers
Total Discharged Families	**180**	**63**	**213**	**75**	**184**	**60**
Total Families with CANS Collected at Baseline AND Discharge	117 (65%)	43 (68%)	113 (53%)	47 (63%)	90 (49%)	39 (65%)
Child Risk & Need Composite	42%	63%	49%	70%	58%	79%
Life Domain Functioning	41%	56%	47%	65%	53%	71%
Behavioral/Emotional Need	36%	54%	43%	66%	44%	49%
Risk Behavior	26%	30%	19%	22%	33%	37%
Caregiver Needs/Strengths	29%	37%	30%	41%	32%	41%

*A score of 2 or 3 indicates need for intervention on each CANS item.

Training and Coaching Summary

The Institute provides core Wraparound trainings to all CME staff, including care coordinators and supervisors. The core trainings are conducted quarterly (at a minimum) to support new hires as well as help to refresh the skills of those who have previously attended. Twenty-seven (27) staff members from the CME attended one or more of these sessions during this reporting period. Fewer staff were trained within this reporting timeframe than in previous periods.

Overall, 34% of the staff who attended trainings in the past two quarters had turned over by the time of this report. This rate has increased from the last reporting period (27%) and continues to be a concern. It should be noted that this percentage only reflects staff who attended training in this reporting period and is not the retention rate for the entire organization.

Table 11. Core Wraparound Trainings Conducted, January 2014 – June 1014

Date	Training Type	Number of Trainees
2/4/2014	Intermediate Wraparound: Improving Wraparound Practice	10
4/8/2014	Introduction to Wraparound	21
4/23/2014	Engagement in the Wraparound Process	19
5/12/2014	Advanced Wraparound Practice	9

Care coordinators and supervisors employed by the CME must complete a wraparound practitioner certification within two years of hire. Three wraparound practitioner certificates and one wraparound practitioner recertification were awarded during this timeframe. As of June 30, 2014, there were four CME staff in a care coordinator role who held a wraparound practitioner certification and one CME care coordinator supervisor who held a supervisor's certification.

Impact of Training & Technical Assistance

In partnership with the University of Washington and the Wraparound Evaluation and Research Team (WERT), training and technical assistance data are collected through a standardized survey developed by Portland State University and WERT. The Impact of Training and Technical Assistance (IOTTA) tool assesses the perceived quality and impact of a range of different types of training, coaching, or TA activities provided as part of a workforce development effort. Participants indicate the quality of the training, its impact on their practice and/or skills, the ways in which the training or TA affected their practice, and how they expressed their improved practice or mastery of the subject matter. Wraparound trainers administer the baseline IOTTA in person immediately after the training has been completed, and a follow-up survey is sent two to three months after the training. IOTTA responses are anonymous and aggregated to provide feedback to The Institute.

This reporting period, CME trainees indicated slightly lower mastery in Wraparound knowledge and skills than the national mean just prior to training (Existing Mastery), after the training is complete (Post-Training Mastery), and two months later (Current Mastery; Figure 10). At baseline, participants' ratings for the importance of training goals, the credibility of their trainers, their interest in the training, and the organization of the training were high overall, and higher than average ratings from a national sample (Figure 11). Further, they anticipated that the training would have a profound impact on their work and imagined that they would use what they learned to both share with others and make changes at their job. These ratings were slightly higher than the national means (Figure 12). At follow-up, they reported moderate-to-high impacts on their work, with all ratings slightly higher than the national means (Figure 13).

Figure 10. IOTTA Change in Mastery, CME Training Participants, January - June 2014

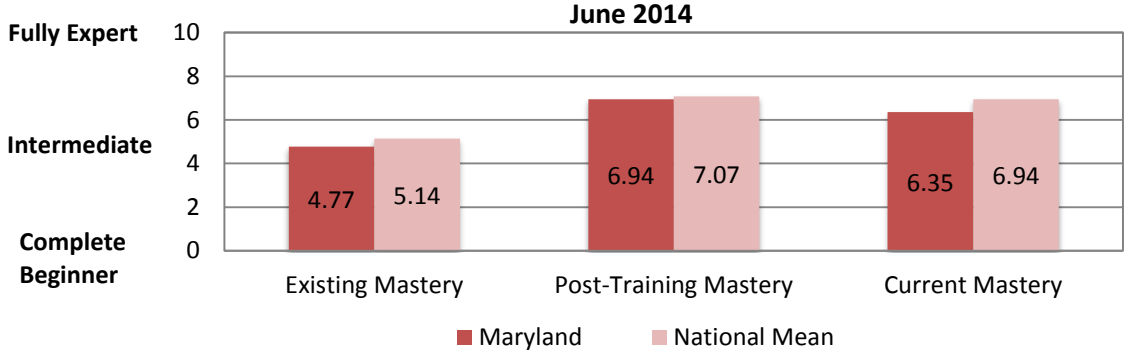


Figure 11. IOTTA Baseline Training Ratings, CME Training Participants, January - June 2014

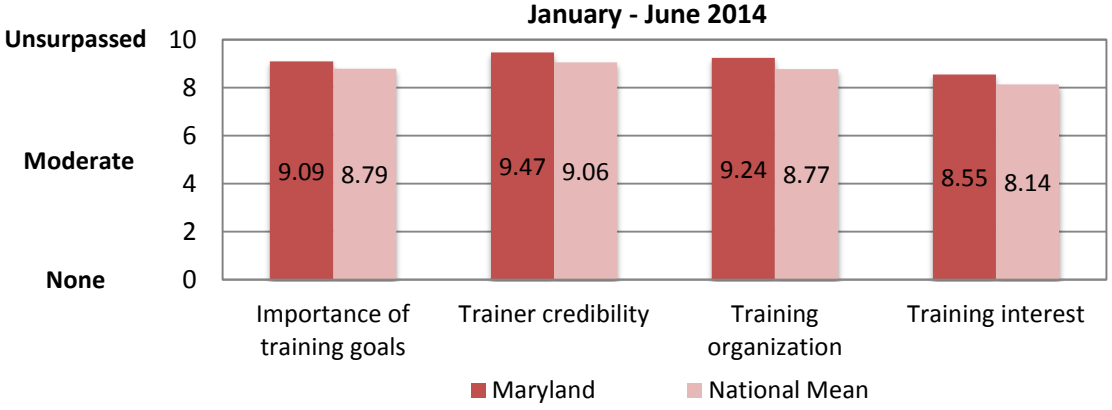


Figure 12. IOTTA Baseline "Impact" Ratings, CME Training Participants, January - June 2014

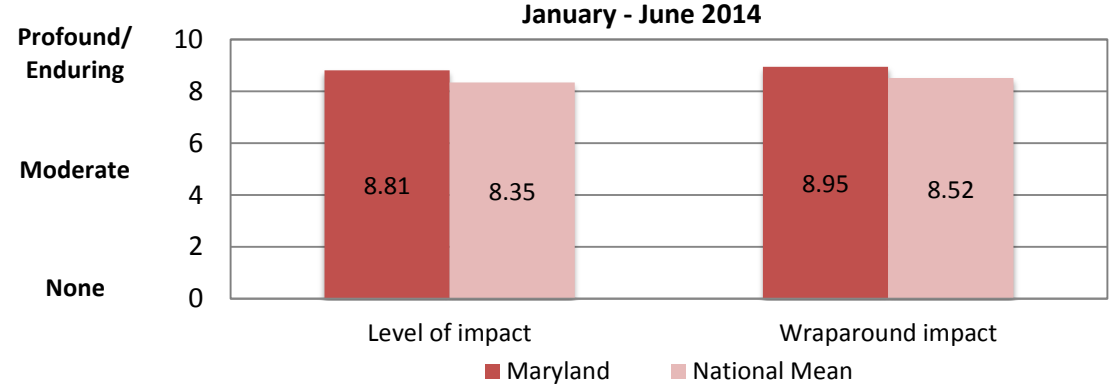
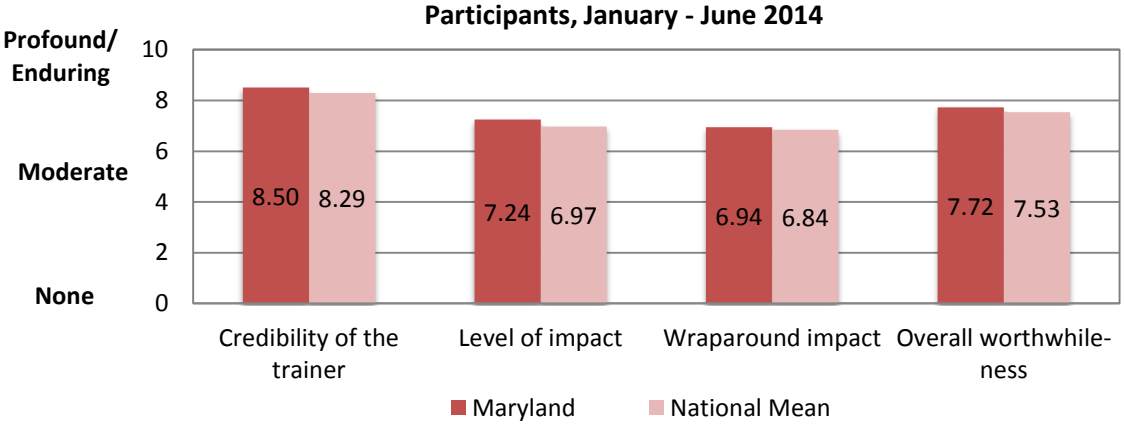


Figure 13. IOTTA Follow-Up Training Impact Ratings, CME Training Participants, January - June 2014



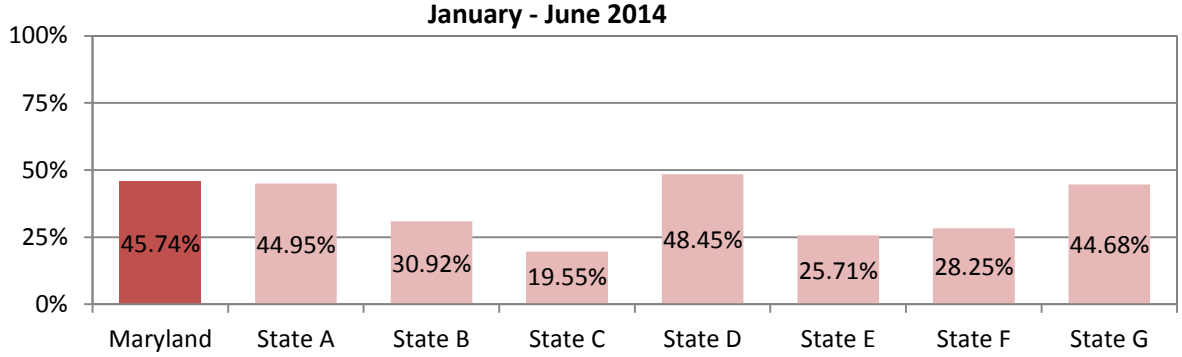
Coaching Observation Measure for Effective Teams

The Coaching Observation Measure for Effective Teams (COMET) is used to assess care coordinators' skill level and provide feedback throughout the four phases of the Wraparound process, as well as frame supervision conversations for developing quality Wraparound practitioners. It outlines 46 skill sets of care coordinators that are crucial to quality Wraparound implementation, and it is utilized by supervisors and coaches as a document, skill,

and process review across a number of settings including team observations, family visit observations and in supervision with facilitators.

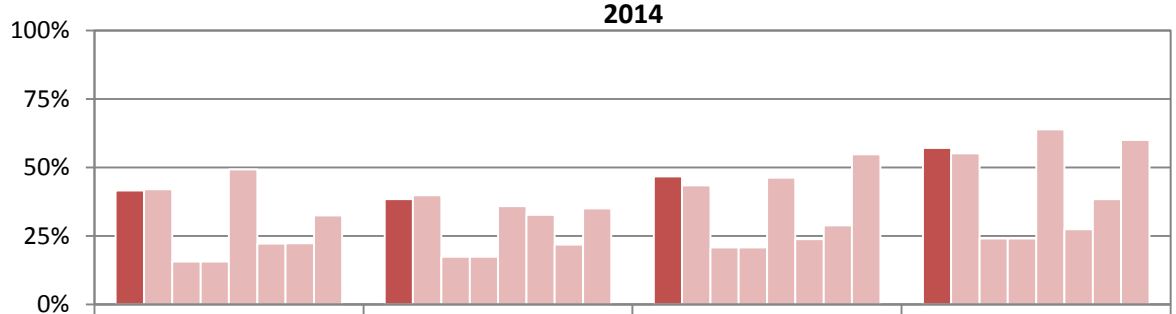
The total COMET score reflects the overall skill attainment of care coordinators.[17] The average COMET score for the CME (45.74%) suggests that care coordinators demonstrate just under half of the skills associated with quality Wraparound practice (Figure 14); this score is comparable to average scores from three other states and higher than several others.

Figure 14. Total COMET Score for the CME and Other States January - June 2014



The COMET's key elements scores indicate skill attainment across the key elements of Wraparound. Maryland's CME care coordinators demonstrated more skills associated with the Determined by Families element and the least for Driven by Underlying Needs (Figure 15). Once again, these scores were comparable to those of other states and ranked among the highest in the sample; however, all scores suggest substantial room for improvement.

Figure 15. COMET Key Element Scores for the CME and Other States, January - June 2014



	Strengths Perspective	Underlying Needs	Team Member	Determined by Families
Maryland	41.64%	38.47%	46.75%	57.18%
State A	42.09%	39.80%	43.46%	55.19%
State B	15.64%	17.36%	20.77%	24.05%
State C	15.64%	17.36%	20.77%	24.05%
State D	49.25%	35.86%	46.23%	63.97%
State E	22.16%	32.65%	23.85%	27.47%
State F	22.32%	21.84%	28.84%	38.46%
State G	32.50%	35.00%	54.76%	60.00%

[17] The Institute is currently working with WERT to develop thresholds for skill proficiency.

Additional Training and Coaching

Ongoing coaching support was provided around the partnership between the care coordinators and the family support partners within the Wraparound process that included a Statewide training for the CME staff as well as the Family Organizations in February 2014. This training was facilitated by Dr. Henry Gregory, Cultural and Linguistic Competence Coordinator for MD CARES, and focused on the differences in cultural perspectives within this partnership and the impact of system mandates on the engagement process with families involved in a Wraparound process. Regional co-coaching days between care coordinators and family support partners were also held.

Coaching by The Institute has been targeted to focus on the CME's management and supervisory level staff. Monthly leadership meetings addressed systemic issues identified within coaching and audit findings. In addition to core trainings and group sessions, in-person and virtual coaching was offered monthly by The Institute to each CME supervisor and their respective team to include field observations, document reviews, and supervisory sessions. All supervisors have been trained in the Wraparound Practice Improvement tools (WPITS) and have been certified to utilize the COMET assessment tool in observations of their staff. As of the end of this reporting period, all current supervisors had completed the core training series; however, there was one vacant supervisor position and once filled, the supervisor will require the full training series and support in developing an understanding of the Wraparound model.

Implementation Data Summary

Utilization & Youth Enrolled

- Overall utilization and the average daily census has declined during this reporting period; however, as referral protocols are adjusted to serve youth in the Stability and SAFETY Initiatives, it is expected for both overall utilization and average daily census to increase.
- Approximately 13% of all accepted referrals over the past three reporting periods were disenrolled prior to a first face-to-face meeting. The most common reason has been *failure to engage with youth within 30-60 days of referral* (60% of all disenrollments in the last reporting period).
- On average, it took approximately 11 days from the date of acceptance for a family to have a first face-to-face meeting with a care coordinator, which is similar to the previous reporting period (12 days). Moreover, the first CFT meeting was, on average, 38 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 increase the number who ultimately starts services with the CME.
- Care coordinators are supposed to complete a CANS Assessment with all youth and families within 30 days of starting services; however, completion rates within this time frame have fallen below 80% the past three reporting periods.
- The majority of youth starting with the CME were male (64%), African American/Black (63%), and approximately 14 years old, on average.

Fidelity

- The youth and caregiver responses to the WFI-EZ Basic Information items suggest that the fundamental components and processes of the Wraparound model (e.g., having a team and plan, meeting regularly) were not consistently provided to all families enrolled in the CME.
- The average youth and caregiver scores for the WFI-EZ Experience scales were substantially lower than those of the national comparison sample, suggesting there are major barriers to delivering the Wraparound model with fidelity.
- Of those who completed the WFI-EZ as of six months into services, the average satisfaction score for caregivers was 70% (compared to 80% for a national sample) and average score for youth was 65% (compared to 77% for a national sample). These data also suggest subpar implementation quality.

Discharges & Outcomes

- Only one-third of families who were discharged from the CME had successfully completed services. Challenges with engaging and retaining families account for approximately 30% of all discharges.
- Just over 70% of youth discharged to a non-restrictive living situation (parent or relative's home, regular foster home, adoptive home, or living independently). This rate is similar to the previous reporting period (75%) and the third and fourth quarters of FY13 (68%).
- The average length of stay for all discharged youth was 267 days. Among youth who discharged with a Successful Completion (n=60), the ALOS was 383 days.
- Approximately half of the youth who discharged from the CME during this reporting period had a CANS assessment completed at the start of services and at discharge.
- The percentage of families with fewer CANS items indicating need for intervention from entry to discharge on the Risk and Need Composite was higher during this reporting period (58%) than FY14 Q1-2 (49%) and FY14 Q3-4 (43%).

Technical Assistance Summary & Recommendations

The Institute provided targeted coaching and follow-up with the CME in an effort to address engagement issues highlighted within this report, with a focus on supporting the supervisors who directly supervise the implementation of the Wraparound process and are less impacted by the low retention rates. Guidance and recommendations have been provided on the CME's organizational policies and procedures, as well as identifying ways to internally provide incentives for good practice and build the morale of their workforce.

Recommendations

- With the high staff turnover rate within Maryland Choices, it is recommended that they identify strategies to minimize the impact of transitioning families from exiting care coordinators. Coaching support has been provided to develop a transition tool that tracks how the supervisor and care coordinator manage these transitions urgently and effectively, while continuing a meaningful proactive process for families. It is recommended that Choices implement such a tool to provide structured oversight to these transitions that may be disruptive to teams and impacting the CME's ability to engage and retain families.
- CME staff recruitment and retention rates should be reviewed across the State. It may be particularly useful to review the retention rates in Baltimore City, as the MD CARES population had the highest rate of disenrollment due to participants' request (27%), and identify areas of needed training, supervision, or day-to-day needs for staff to carry out their job duties.
- The high premature disenrollment rate may also indicate a need to review the enrollment process by which families enter into the CME. Further outreach to referral sources may be warranted to problem-solve how to streamline the referral process and ensure barriers that may impact outreach to families can be addressed.
- Team size and composition should be tracked through attendance at CFT meetings to ensure that an effective team, inclusive of natural supports, is actively involved in planning and implementation of the plan of care. The team size should grow over time and this should be an expectation and a conversation within supervision as family's progress through the phases of the Wraparound process.
- Meaningful oversight around tracking progress in the plan of care should occur within supervision and when clinically indicated (i.e., hospitalization, placement disruption, or other reportable events). If the high-risk behaviors presented at enrollment are not decreasing, then the plan should be shifting. This progress should be seen within the CANS as well with fewer CANS items indicating a need for intervention over time. It may be helpful to develop reports within the data collection system to track progress towards the outcomes within the Plan of Care. A booster with supervisors on how to identify outcomes, track progress, and use this data to inform supervision sessions can be provided by The Institute.

References

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders (4th edition, text revision)*. Washington, DC: Author.