Care Management Entity

MARYLAND IMPLEMENTATION REPORT

FY15 QTR 1 & 2 • JULY-DECEMBER 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 July 1 and December 31, 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

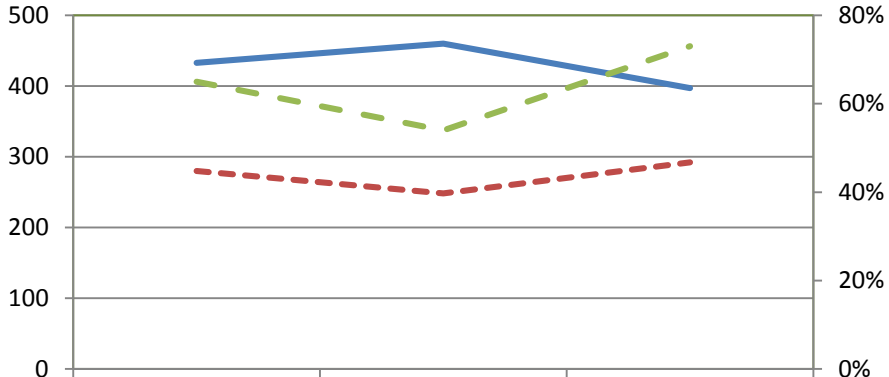
This report includes administrative data provided by Choices, as well as data collected directly from youth and families by The Institute.[1] Choices collects data for all youth and families enrolled in the CME upon intake and throughout their CME involvement until discharge. Additionally, The Institute 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 233 families (85% of 273) 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 were current as of January 2015; 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 decreased from the previous reporting period - from 460 to 397 slots - the average number of children and families served (i.e., average daily census) has increased from 248 to 292 (Figure 1). This decrease in slots coupled with an increasing average daily census has contributed to an increase in average utilization from FY14 Q3-4 to FY15 Q1-2 - from 54% to 65%.

Figure 1. Statewide CME Utilization, July 2013 - December 2014



	FY14 Q1-2	FY14 Q3-4	FY15 Q1-2
Avg. Daily Capacity	433	460	397
Avg. Daily Census	280	248	292
Avg. Utilization	65%	54%	73%

Several populations are currently served by the CME (Table 1; see Appendix 1 for descriptions). The average utilization rate ranged from 70% to 100% across populations. One important capacity change was implemented during this reporting period: at the start of the reporting period, the Stability Initiative had the capacity to serve 250 youth per day, and the SAFETY Initiative had the capacity to serve 120 youth per day. On August 13, 2014, the Stability and SAFETY Initiatives began sharing a combined daily capacity to serve 350 youth. For this reason, the utilization rate for these two populations is reported together in aggregate.

Table 1. Utilization of CME Slots, July - December 2014

Population	Average Daily Capacity*	Average Daily Census	Average Utilization
Stability and SAFETY Initiatives	354.7	249.2	70%
Rural CARES	38.3	38.3	100%
MD CARES	0.9	0.9	100%
PRTF Waiver	3.1	3.1	100%
Total Statewide	*397.0*	*291.5*	*73%*

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

The populations that are closed for new referrals – Rural CARES, MD CARES[2], and PRTF Waiver – continue to ramp down the numbers of youth they are serving. Once all of these youth have discharged, the State will have a single daily capacity shared by the Stability and SAFETY Initiative populations.

[2] The remaining youth who were being served by MD CARES and PRTF Waiver discharged during this reporting period.

Youth Enrolled

The CME enrolled 349 children/youth between July 1 and December 31, 2014. Of these, 273 (78%) youth and families started services (i.e., had at least one face-to-face meeting with a care coordinator), 61 (18%) did not start services and were disenrolled[3] as of the close of the reporting period, and 15 (4%) 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, July 2013 – December 2014

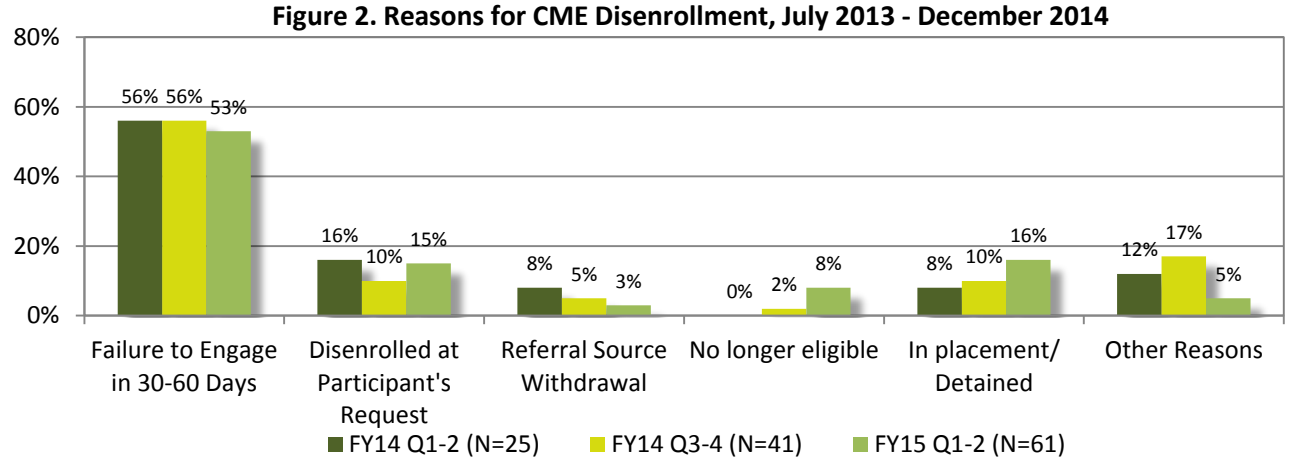
	FY14 Q1-2	FY14 Q3-4	FY15 Q1-2
Total Accepted Referrals	**192**	**252**	**349**
Started	167 (87%)	211 (84%)	273 (78%)
Disenrolled	25 (13%)	41 (16%)	61 (18%)
New enrollments with no face-to-face meeting (or discharge date)	0	0	15 (4%)
Youth with a CFT meeting (% of Started)	137 (82%)	159 (75%)	188 (69%)
Avg. days between referral and enrollment*	3.0 (9.5)	0.9 (5.0)	0.8 (13.0)
Avg. days between enrollment and first face-to-face meeting*	12.5 (10.2)	12.0 (12.4)	15.1 (13.1)
Avg. days between enrollment and first CFT meeting*	40.7 (23.2)	42.1 (31.5)	54.7 (30.0)

*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 15.1 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=188), the average length of time from enrollment to the first CFT meeting was approximately 55 days, which was longer than the previous two reporting periods.

Of the 61 youth who were disenrolled this reporting period, the most common reason for disenrollment was *failure to engage within 30-60 days* (53%), which was also the most common reason for the previous two reporting periods (Figure2).

Figure 2. Reasons for CME Disenrollment, July 2013 - December 2014

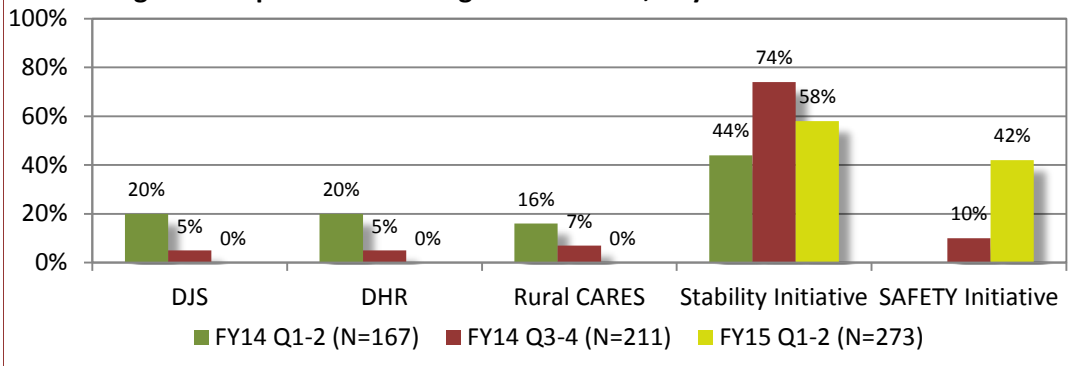


[3] Disenrolled was identified in the data as youth who had a discharge date but no first face-to-face meeting date.

Populations Served

As noted earlier, youth who started with the CME this reporting period were included in the Stability Initiative (58%) and SAFETY Initiative (42%) populations (Figure 3). On May 5, 2014, all youth in the DJS and DHR Out-of-Home Placement Diversion populations transitioned to the Stability Initiative population, which has an increase in capacity to serve additional youth (the DJS and DHR Out-of-Home Placement Diversion populations were closed for new referrals).

Figure 3. Populations Starting with the CME, July 2013 - December 2014



Demographic Characteristics

The majority of youth starting with the CME were male (66%), African American/Black (56%), 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. The Stability Initiative had a greater proportion of African American/Black youth (66% vs. 42%) and a smaller proportion of Caucasian/White youth (26% vs. 45%), compared to the SAFETY Initiative. Youth in the Stability Initiative were also older (14.5 vs. 12.6). The most frequent age at referral was 13 years, and most youth were referral between the ages of 13 and 17 (Figure 4).

Figure 4. Ages, Percent of Youth Who Started With the CME, July - December 2014

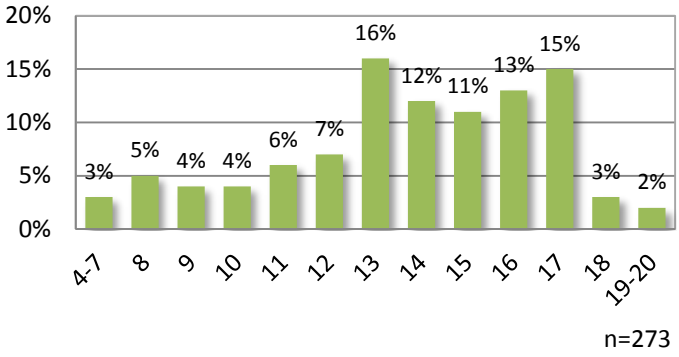


Table 3. Demographic Characteristics of Youth Who Started with the CME, July 2013 - December 2014

	FY14 Q1-2	FY14 Q3-4	FY15 Q1-2
Total Youth Who Started	**167**	**211**	**273**
Female	70 (42%)	75 (36%)	92 (34%)
Male	97 (58%)	136 (64%)	181 (66%)
African American/Black	91 (55%)	134 (64%)	152 (56%)
Caucasian/White	57 (34%)	63 (30%)	91 (34%)
Hispanic/Latino	14 (8%)	8 (4%)	10 (4%)
Other	5 (3%)	6 (3%)	18 (7%)
Avg. Age at Referral*	14.2 (3.3)	14.2 (2.8)	13.7 (3.8)

*Standard deviations in parentheses.

Compared to youth who started with the CME during the previous two reporting periods, there was a larger percentage of youth from the Eastern Shore region (38%) and a smaller percentage of youth from Baltimore City (19%) during this reporting period (Table 4).[4]

Table 4. Regional Distribution of Youth Who Started with the CME, July 2013 - December 2014

	FY14 Q1-2	FY14 Q3-4	FY15 Q1-2
Total Youth Who Started	**167**	**211**	**273**
Baltimore City	50 (30%)	85 (40%)	53 (19%)
Central Maryland	27 (16%)	18 (9%)	34 (13%)
Western Maryland	20 (12%)	22 (10%)	25 (9%)
Eastern Shore	43 (26%)	37 (18%)	104 (38%)
Southern Maryland	8 (5%)	11 (5%)	17 (6%)
Metro Region	19 (11%)	38 (18%)	40 (15%)

Living Situation

Information on the youth's living situation at enrollment was available for most youth who started with the CME during this reporting period (97%, n=264). The most common living situations were biological parent's home (65%), followed by other relative's home (16%). The percentage of youth living with a biological parent at enrollment was higher than the previous two reporting periods (Table 5).

Table 5. Living Situations of Youth Who Started with the CME, July 2013 - December 2014

	FY14 Q1-2	FY14 Q3-4	FY15 Q1-2
Total Youth Who Started	**167**	**211**	**273**
Youth with Living Situation at Enrollment Data	158 (95%)	206 (98%)	264 (97%)
Biological Parent's Home	79 (50%)	120 (58%)	171 (65%)
Other Relative's Home	25 (16%)	29 (14%)	42 (16%)
Treatment Foster Care	20 (13%)	17 (8%)	8 (3%)
Regular Foster Care	10 (6%)	14 (7%)	8 (3%)
Group Home	7 (4%)	8 (4%)	7 (3%)
Other	17 (11%)	18 (9%)	28 (11%)

Functioning at Enrollment

Diagnosis

Among youth who started with the CME, 213 (78%) had a psychiatric diagnosis reported within three months of enrollment (Table 6; 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 Mood Disorder (36%) and Attention Deficit Disorder (25%); these have been the two most common diagnoses in prior reporting periods.

[4] *Central Maryland* includes Carroll, Baltimore, Harford, and Howard counties; *Western Maryland* includes Garrett, Allegany, Washington, and Frederick counties; *Eastern Shore* includes Cecil, Kent, Queen Anne's, Caroline, Talbot, Dorchester, Wicomico, Somerset, Worcester; *Southern Maryland* includes Anne Arundel, Calvert, Charles, and St. Mary's counties; and *Metro Region* includes Montgomery and Prince George's counties.

Mood Disorders were more prominent in youth enrolled in the SAFETY Initiative (42%), and Attention Deficit Disorders were more common among youth enrolled in the Stability Initiative population (30%).

Table 6. Diagnosis and Prior Mental Health Services, Youth Who Started between July 2013-December 2014

	FY14 Q1-2	FY14 Q3-4	FY15 Q1-2
Total Youth Who Started Services	**167**	**211**	**273**
Youth with a Diagnosis Indicated	154 (92%)	192 (91%)	213 (78%)
Mood Disorders	61 (40%)	56 (29%)	77 (36%)
Attention Deficit Disorders	38 (25%)	50 (26%)	53 (25%)
Disruptive Behavior Disorders	10 (7%)	21 (11%)	26 (12%)
Anxiety Disorders	10 (7%)	11 (6%)	10 (5%)
Adjustment Disorders	5 (3%)	8 (4%)	3 (1%)
Other Disorders	10 (6%)	22 (11%)	22 (10%)
Diagnosis Deferred	20 (13%)	25 (13%)	22 (10%)
Youth with Prior Mental Health (MH) Service Info.	155 (93%)	192 (91%)	205 (75%)
Had Prior MH Service†	149 (96%)	169 (88%)	187 (91%)
Youth with Age of First MH Service Info	96 (57%)	124 (59%)	133 (49%)
Avg. Age of First MH Service*†	9.7 (4.5)	9.7 (4.0)	8.5 (4.1)

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

Prior Mental Health Services

Of youth who started receiving CME services this reporting period, 91% (n=187) had received mental health services prior to CME enrollment (Table 6).[5] The average age of first receiving mental health services was 8.5 years old, which is about one year younger than youth who started with the CME during previous reporting periods. Youth in the SAFETY Initiative population were younger when first receiving mental health services, compared to youth in the Stability Initiative (7.8 vs. 9.2, respectively).

Youth and Caregiver Needs and Strengths

The CME care coordinators are required to complete the Child and Adolescent Needs and Strengths (CANS)[6] assessment with youth and families within 30 days of enrollment in order to inform the plan of care. Of those who started services this reporting period, only 143 (68%) youth had a completed CANS assessment within this time frame (Table 7).[7] The highest areas of demonstrated need (i.e., items with a score of 2 or 3) included anger control (46%), family functioning (45%), recreational (43%), and ADHD/impulse control (41%). This suggests that youths' greatest areas of need were in the Life Domain Functioning and Behavioral/Emotional Needs Domains. SAFETY Initiative youth demonstrated higher rates of need than Stability Initiative youth, with the most pronounced differences in family functioning (53% vs. 37%), living situation (48% vs. 29%), social resources (39% vs. 23%), and anxiety (33% vs. 15%).

[5] 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.
[6] See Appendix 1 for a description of the CANS instrument.
[7] 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—Areas of Need, July 2013 - December 2014

		FY14 Q1-2	FY14 Q3-4	FY15 Q1-2
Total Youth Who Started Services		**167**	**211**	**273**
CANS Completed at Start of Services		127	157	129
Life Domains/ Functioning	Family	56 (44%)	69 (44%)	58 (45%)
	Recreational	53 (42%)	70 (45%)	55 (43%)
	Living Situation	47 (37%)	55 (35%)	50 (39%)
	School Achievement	47 (38%)	60 (39%)	50 (39%)
	School behavior	58 (47%)	51 (33%)	45 (35%)
	Social Functioning	29 (23%)	29 (19%)	27 (21%)
	Medical	2 (2%)	7 (5%)	5 (4%)
	Sexuality	10 (8%)	7 (5%)	3 (2%)
	Legal	0	2 (1%)	2 (2%)
Caregiver Needs & Strengths	Social Resources	44 (36%)	46 (30%)	40 (31%)
	Supervision	31 (25%)	20 (13%)	31 (24%)
	Organization	14 (11%)	12 (8%)	15 (12%)
	Knowledge	13 (11%)	10 (6%)	13 (10%)
	Physical Caregiver Needs	4 (3%)	9 (6%)	10 (8%)
	Involvement	5 (4%)	6 (4%)	8 (6%)
	Mental Health	7 (6%)	5 (3%)	7 (5%)
	Residential Stability	7 (6%)	10 (6%)	4 (3%)
Child Behavioral/ Emotional Needs	Anger control	58 (47%)	70 (45%)	59 (46%)
	Attention Deficit/Hyperactivity/ Impulse Control	55 (44%)	60 (39%)	54 (42%)
	Oppositional Behavior	58 (47%)	62 (40%)	39 (30%)
	Anxiety	26 (21%)	32 (21%)	31 (24%)
	Adjustment to Trauma	28 (23%)	27 (17%)	28 (22%)
	Conduct	36 (29%)	33 (21%)	22 (17%)
	Depression	24 (19%)	32 (21%)	20 (16%)
	Psychosis	7 (6%)	5 (3%)	2 (2%)
	Substance Abuse	0	3 (2%)	2 (2%)
Child Risk Behavior	Judgement	42 (34%)	53 (34%)	42 (33%)
	Crime/Delinquency	10 (8%)	14 (9%)	11 (9%)
	Runaway	4 (3%)	6 (4%)	8 (6%)
	Danger to Others	7 (6%)	7 (5%)	7 (5%)
	Other Self-harm	5 (4%)	3 (2%)	3 (2%)
	Sexual Aggression/Abusive Behavior	2 (2%)	1 (<1%)	3 (2%)
	Danger to Self/Suicide Risk	9 (7%)	5 (3%)	1 (<1%)
	Self-mutilation	4 (3%)	3 (2%)	1 (<1%)
	Fire Setting	4 (3%)	1 (<1%)	0
Cultural/ Spiritual	Cultural Stress	7 (6%)	1 (<1%)	9 (7%)
	Ritual	5 (4%)	2 (1%)	8 (6%)

All youth were identified as having at least one strength in their CANS assessment, and most (95%) had at least two strengths. The most common strengths included talents and interests (99%), educational (71%), relationship permanence (59%), and optimism (57%), all of which were identified in the majority of youth (Table 8). These strengths were similar to those identified in the CANS assessments of the previous two reporting periods.

Table 8. Child & Adolescent Needs and Strengths (CANS) Assessment—Identified Strengths, July 2013 - December 2014

		FY14 Q1-2	FY14 Q3-4	FY15 Q1-2
Total Youth Who Started Services		**167**	**211**	**273**
CANS Completed at Start of Services		127	157	129
Identified Strengths	Talents and Interests	120 (96%)	153 (98%)	128 (99%)
	Educational	89 (71%)	107 (68%)	91 (71%)
	Relationship Permanence	59 (47%)	92 (59%)	76 (59%)
	Optimism	72 (58%)	93 (59%)	73 (57%)
	Interpersonal	50 (40%)	72 (46%)	65 (50%)
	Family	52 (42%)	80 (51%)	63 (49%)
	Community Life	47 (38%)	62 (40%)	46 (36%)
	Vocational	40 (32%)	42 (27%)	34 (26%)
	Spiritual/religious	38 (30%)	51 (33%)	21 (16%)

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),[8] which is collected by The Institute's evaluation team at six months and twelve months into services.[9] The WFI-EZ is completed with caregivers and youth who are over 11 years of age (with a caregiver's consent).

During the current reporting period, the WFI-EZ was completed by 80 (67%) caregivers who were eligible for their six-month surveys and 43 (47%) caregivers who were eligible for their twelve-month surveys, and by 22 (20%) eligible youth at six months and 17 (20%) eligible youth at twelve months into services (Table 9). 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-EZ are not necessarily the same participants in the six-month respondent pool.

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 9, at twelve months less than 90% of caregivers (86%) and youth (88%) indicated that the team meets regularly, and 89% of caregivers indicated that decisions are based on input from the family. At six months, only 84% of youth indicated that the team created a written plan about services. 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.

[8] See Appendix 1 for a description of the WFI-EZ instrument.

[9] 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 9. WFI-EZ Basic Information, Caregiver and Youth Responses, July – December 2014

	Caregiver		Youth	
	6 Months	12 Months	6 Months	12 Months
Youth/Caregivers Eligible for WFI-EZ	**119**	**92**	**111**	**87**
Youth/Caregivers Completing WFI-EZ	**80 (67%)**	**43 (47%)**	**22 (20%)**	**17 (20%)**
Decisions are based on input from youth and family	95%	89%	100%	94%
Family is part of a team, including more than just family and one professional	92%	94%	95%	100%
Family and team created a written plan that describes who will do what/how it will happen	92%	94%	84%	100%
Team meets regularly (at least every 30-45 days)	95%	86%	100%	88%

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 5 shows the average caregivers' experiences scores at six months and twelve months, as well as the average scores for a national sample of caregivers involved in a similar Wraparound process.[10] Overall, at both time points, the average scores for the Maryland caregivers are lower than the national averages.

Figure 5. WFI-EZ Experiences in a Wraparound Process, Caregiver Responses, July - December 2014

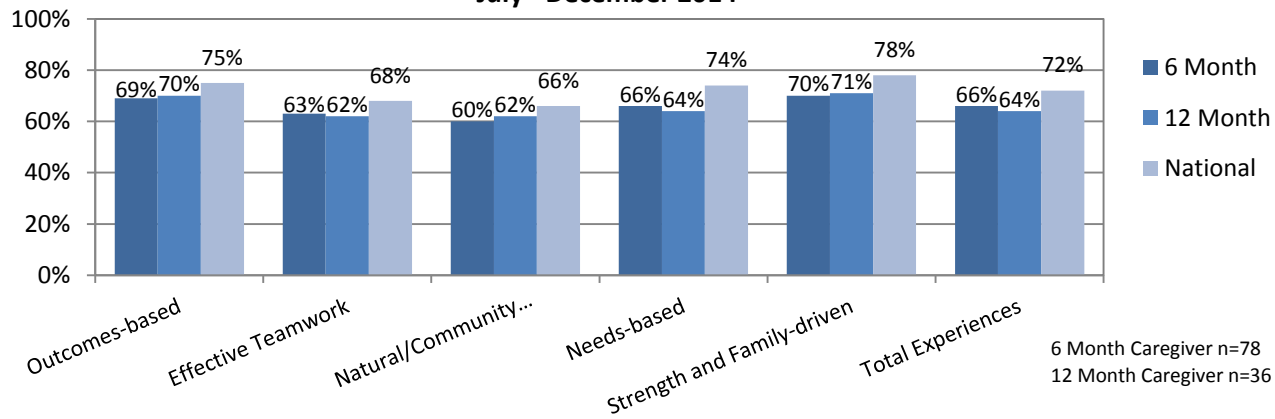
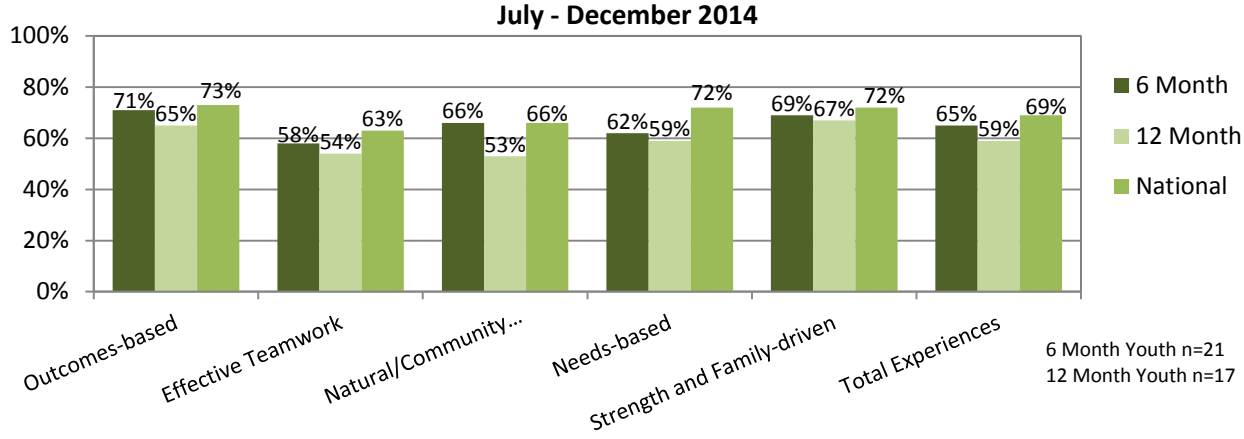


Figure 6 shows the average youth experiences scores at six months and twelve months, as well as the average scores for a national sample of youth involved in a similar Wraparound process.[11] Once again, at both time points, the average scores for the Maryland youth are generally lower than the national averages, though the six-month average is equal to the national averages for natural/community supports (again, respondents may not be representative of all youth served).

[10] The national scores were provided by the Wraparound Evaluation and Research Team. The sample includes 1072 responses pooled from 12 sites; data were extracted in February 2015.

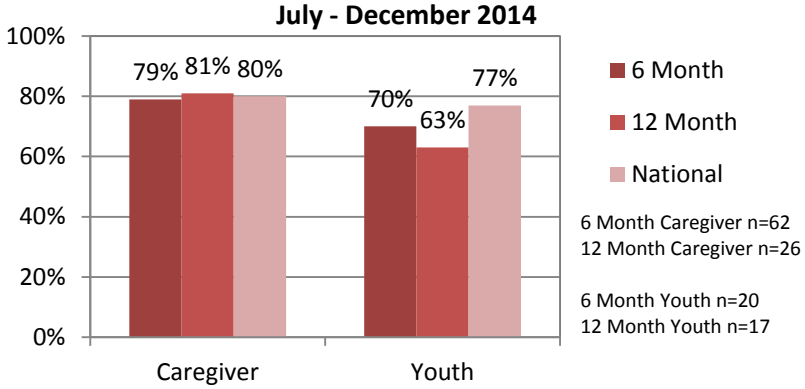
[11] The national scores were provided by the Wraparound Evaluation and Research Team. The sample includes 371 responses pooled from 5 sites. Demographic information for the national sample was not available.

Figure 6. WFI-EZ Experiences in a Wraparound Process, Youth Responses, July - December 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 7 shows the average scores for caregivers and youth at six and twelve months. For caregivers, the average satisfaction scores were 79% at six months, and 81% at 12 months – both similar to the national average. For youth, average satisfaction scores were lower at 12 months (63%) than at six months (70%), and both were below the national average.

Figure 7. WFI-EZ Satisfaction Subscale Score, Caregiver and Youth Responses, July - December 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 10.

Table 10. WFI-EZ Outcomes, Caregiver Responses,* July - December 2014

	6 Months	12 Months
Caregivers Completing WFI-EZ	**78**	**35**
Since starting Wraparound, my child or youth has…		
Been suspended or expelled from school	16%	37%
Had negative contact with police	27%	35%
Been treated in an emergency room due to a mental health problem	18%	27%
Had a new placement in an institution	29%	35%
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	1.1	1.2
Problems that interfere with success at school	1.2	1.2
Problems that make it difficult to development maintain friendships	.8	1.0
Problems that make it difficult to participate in community activities	.8	1.2

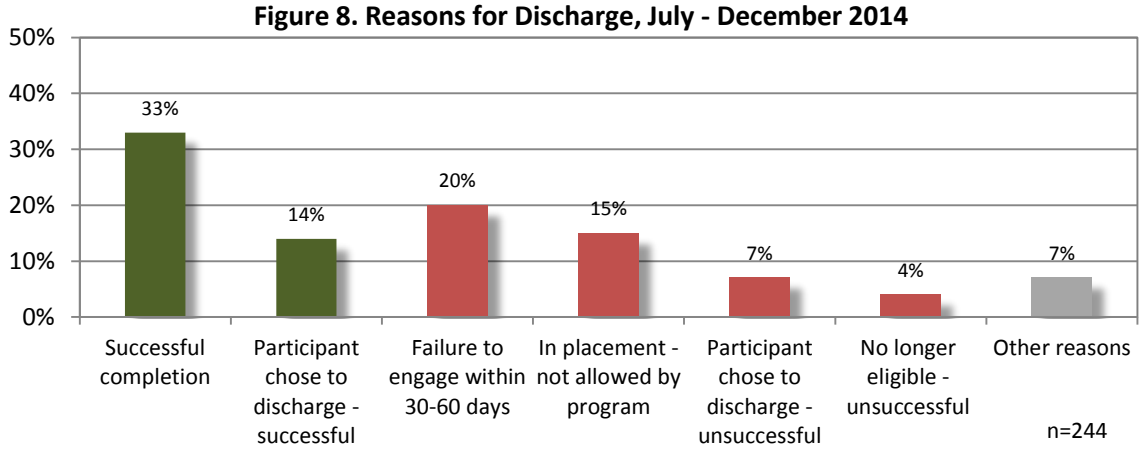
*Youth do not complete the Outcomes section. **Scores for each item range from 0 (not at all) to 3 (very much).

Youth Discharged

Reasons for Discharge

A total of 244 youth discharged from the CME during the first and second quarters of FY15.[12] The most common reasons for discharge[13] included *Successful Completion* (32%), *Failure to Engage within 30-60 days* (20%), and *In Placement – not allowed by program* (16%; Figure 8). Youth discharging from the Psychiatric Residential Treatment Facility (PRTF) Waiver were most likely to discharge with a *Successful Completion* (100%), and those in SAFETY Initiative were the most likely to be *Failure to Engage within 30-60 days* (40%). 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 32%, respectively). The most common reasons for not completing were *Failure to Engage within 30-60 days* (20%), *In placement–not allowed by program* (15%), and *Participant chose to discharge–successful* (14%).

Figure 8. Reasons for Discharge, July - December 2014



Living Situation

Information on the youth's living situation at discharge was available for most youth who exited the CME during this reporting period (98%, n=239). Eighty-seven percent of youth who discharged during this reporting period went to a family-based living situation. This was similar to the rates in the previous two reporting periods (Table 11).

Table 11. Living Situations of Youth Discharging from the CME, July 2013 - December 2014

	FY14 Q1-2	FY14 Q3-4	FY15 Q1-2
Total Youth Who Discharged	**213**	**184**	**244**
Youth with Discharge Living Situation Data	208 (98%)	181 (98%)	239 (98%)
Biological Parent's Home	97 (47%)	88 (49%)	144 (60%)
Other Relative's Home	24 (12%)	20 (11%)	34 (14%)
Treatment Foster Care	25 (12%)	17 (9%)	15 (6%)
Group Home	4 (2%)	12 (7%)	11 (5%)
Adoptive Home	12 (6%)	6 (3%)	8 (3%)
Other	46 (22%)	38 (21%)	27 (11%)
Family-based living situation*	178 (86%)	146 (81%)	208 (87%)

*Includes biological parent's home, non-biological parent relative's home, family friend's home, adoptive home, regular foster home, and treatment/therapeutic foster home.

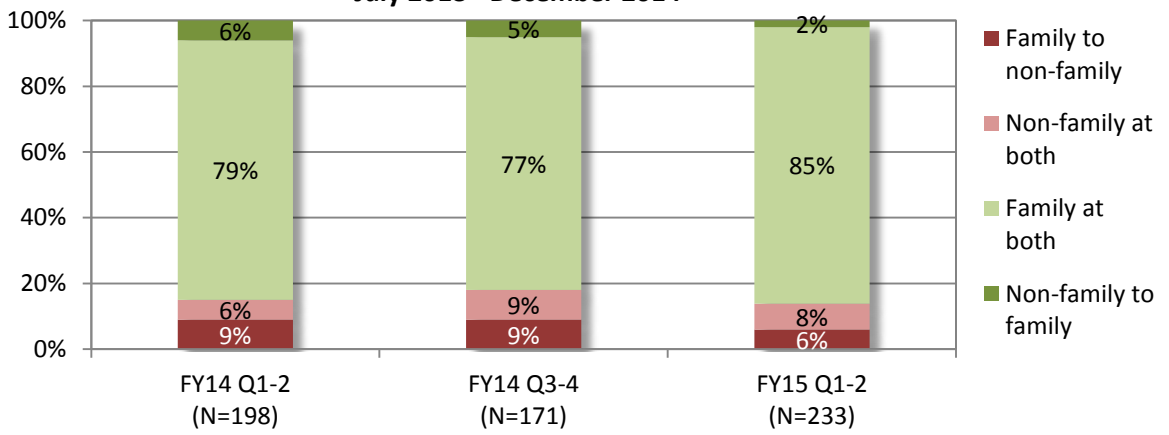
[12] This count excludes youth who did not have at least one face-to-face meeting with the care coordinator.

[13] Discharge reasons were revised during this reporting period. Trends in discharge reasons across reporting periods will be added to future reports.

The most prevalent living situation at discharge was the biological parent's home (60%), followed by other relative's home (14%) and treatment/therapeutic foster home (6%; Table 11).[14] A greater proportion of youth discharged to a biological parent's home during this reporting period, compared to the third and fourth quarters of FY14 (60% vs. 49%, respectively). A majority of youth discharging from the SAFETY Initiative (88%), Rural CARES (88%), PRTF Waiver (88%), and Stability Initiative (69%) populations discharged to either a biological parent's or non-parent relative's home.

Of youth for whom information on living situation at both enrollment and discharge were available (n=233, 95%), most were in family-based settings at enrollment and discharge (Figure 9). These rates were similar to the previous two reporting periods.

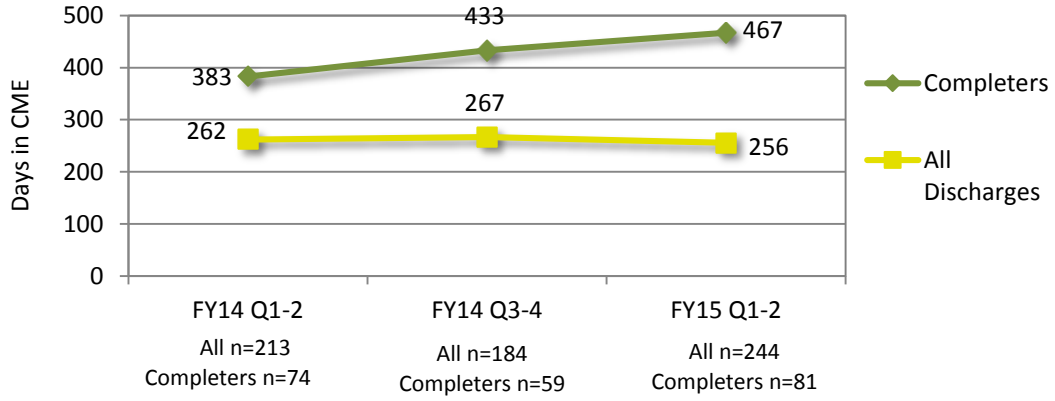
Figure 9. Change in Family-Based Living Situations from Enrollment to Discharge, July 2013 - December 2014



Duration of Services

The average length of stay (ALOS) for all discharged youth[15] was 256 days (*sd*=205.2; Figure 10), and ranged by population from a low of 102 days (SAFETY Initiative, *sd*=14.9, n=25) to 716 days (PRTF Waiver, *sd*=12.0). Among youth who discharged with a *Successful Completion* (n=81), the ALOS was 467 days (*sd*=151.6) and ranged by population from 370 days (Stability Initiative, n=39) to 716 days (PRTF Waiver, *sd*=12.0).

Figure 10. Length of Stay for Discharged Youth, July 2013 - December 2014



[14] "Other" living situations referenced in Table 11 included: residential treatment center (3%), regular foster home (3%), inpatient hospital (2%), independent living (1%), detention/commitment facility/incarceration (1%), friend's home (<1%), drug/alcohol rehab center (<1%), and runaway (<1%).

[15] Due to the individualized nature of wraparound services, there is no benchmark length of stay by which services are expected to terminate.

The ALOS for all discharges has not significantly changed over the past three reporting periods. The ALOS for completers, on the other hand, has steadily increased with the average for the current reporting period (467 days, *sd*=151.6) being significantly longer than two reporting periods ago (FY14 Q1-2; 383 days, *sd*=152.3).

Youth and Caregiver Needs and Strengths

Of youth who discharged during this reporting period, only 98 (40%) had a CANS assessment completed at discharge. Of those who had CANS assessments completed at both entry and discharge (n=82, 34%), 60% 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 12); this was a larger share of youth relative to previous reporting periods (58% in FY14 Q3-4, and 49% in FY14 Q1-2). Youth showed the most improvement in Life Domain Functioning (52%). Further, the rates of improvement for youth who successfully completed the program were higher than those for all youth who discharged.

Table 12. Percent of Families with Fewer CANS Items Indicating Need for Intervention* from Entry to Discharge, Families Discharged, July 2013 – December 2014

	FY14 Q1-2		FY14 Q3-4		FY15 Q1-2	
	All	Completers	All	Completers	All	Completers
Total Discharged Families	**213**	**75**	**184**	**60**	**244**	**81**
Total Families with CANS Collected at Baseline AND Discharge	108 (51%)	45 (60%)	91 (49%)	39 (65%)	82 (34%)	39 (48%)
Child Risk & Need Composite	51%	71%	58%	79%	60%	77%
Life Domain Functioning	45%	66%	52%	71%	52%	64%
Behavioral/Emotional Need	43%	64%	45%	51%	47%	58%
Risk Behavior	19%	21%	32%	37%	26%	34%
Caregiver Needs/Strengths	29%	38%	33%	43%	31%	47%

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

Of the most common areas of need at baseline, fewer youth demonstrated need at discharge (Table 13). The greatest decreases in need were in social resources (a 62% decrease), living situation (a 53% decrease), and ADHD/hyperactivity/impulse control (a 50% decrease).

Table 13. CANS Items Indicating Need at Baseline and Discharge, July - December 2014

CANS Item	Youth with Baseline and Discharge Assessments (N=82)	
	Baseline	Discharge
Anger Control	33 (40%)	25 (31%)
Family	37 (45%)	22 (27%)
Recreational	31 (38%)	19 (24%)
ADHD/Hyperactivity/Impulse Control	28 (34%)	14 (17%)
Living Situation	30 (37%)	14 (17%)
School Achievement	29 (35%)	23 (28%)
School Behavior	27 (33%)	22 (27%)
Social Resources	26 (32%)	10 (12%)

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. Forty-three (43) staff members from the CME attended one or more of these sessions during this reporting period. This is an increase in the number of staff trained within this reporting timeframe relative to previous periods.

Overall, 35% of the staff who attended trainings in the past two quarters had turned over by the time of this report. This rate is similar to the last reporting period (34%) 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. It does indicate, however, the difficulty to train staff through the entirety of the Wraparound certification process and to build a skilled workforce.

Table 14. Core Wraparound Trainings Conducted, July 2014 – December 1014

Date	Training Type	Number of Trainees
7/23/2014	Intermediate Wraparound: Improving Wraparound Practice	11
8/4/2014	Introduction to Wraparound	49
9/9/2014	Engagement in the Wraparound Process	21
9/23/2014	Introduction to Wraparound	28
10/29/2014	Engagement in the Wraparound Process	32
12/1/2014	Introduction to Wraparound	18
12/15/2014	Introduction to Wraparound	15

Care coordinators and supervisors employed by the CME must complete a wraparound practitioner certification within two years of hire. One wraparound practitioner certificate and one wraparound practitioner recertification were awarded during this timeframe. As of December 31, 2014, there were five 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. At the time of this report there are currently two CME care coordinator supervisors with a supervisor's certification and four Care Coordinators with a 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 11). 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 slightly higher than average ratings from a national sample (Figure 12). Further, they anticipated that the training would have a profound impact on their work (Figure 13) and imagined that they would use what they learned to both share

with others and make changes at their job. These ratings were similar or slightly higher than national means (Figure 14). At follow-up, they reported moderate-to-high impacts on their work, with all ratings slightly higher than the national means (Figure 15).

Figure 11. IOTTA Change in Mastery, CME Training Participants, July - December 2014

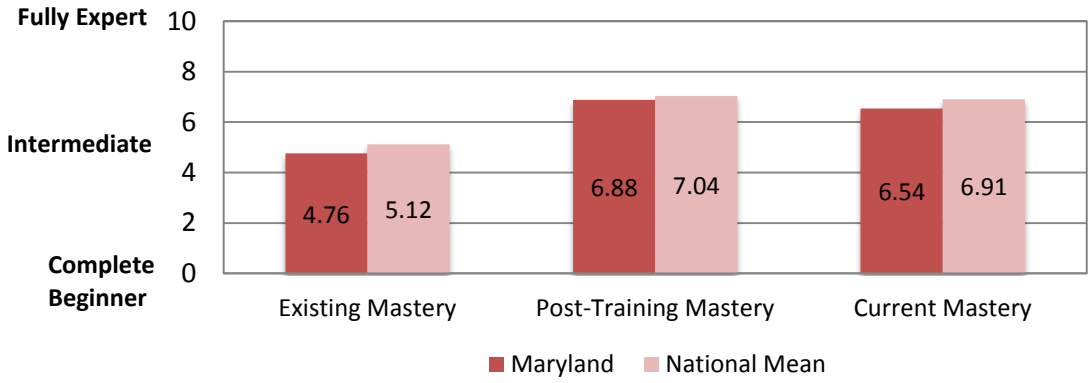


Figure 12. IOTTA Baseline Training Ratings, CME Training Participants, July - December 2014

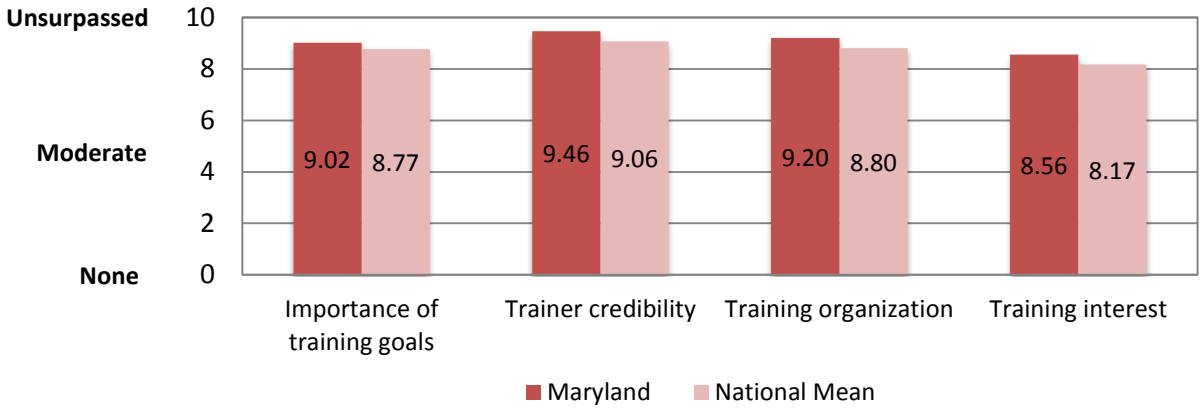


Figure 13. IOTTA Baseline "Impact" Ratings, CME Training Participants, July - December 2014

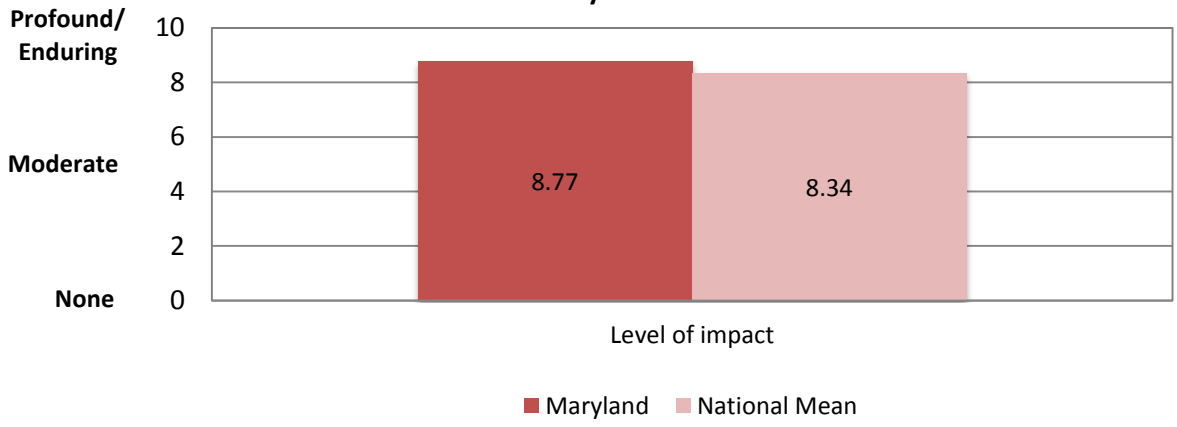


Figure 14. IOTTA Baseline Application of Training Ratings, July - December 2014

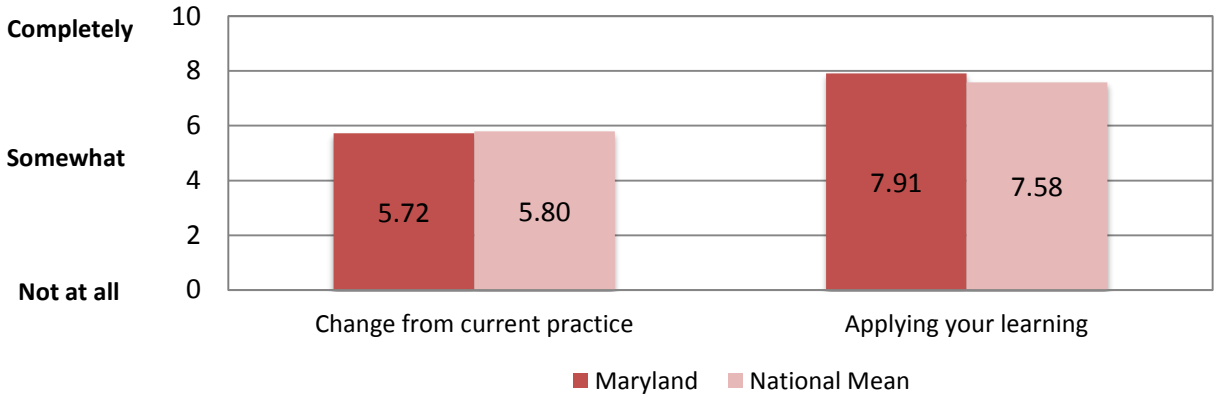
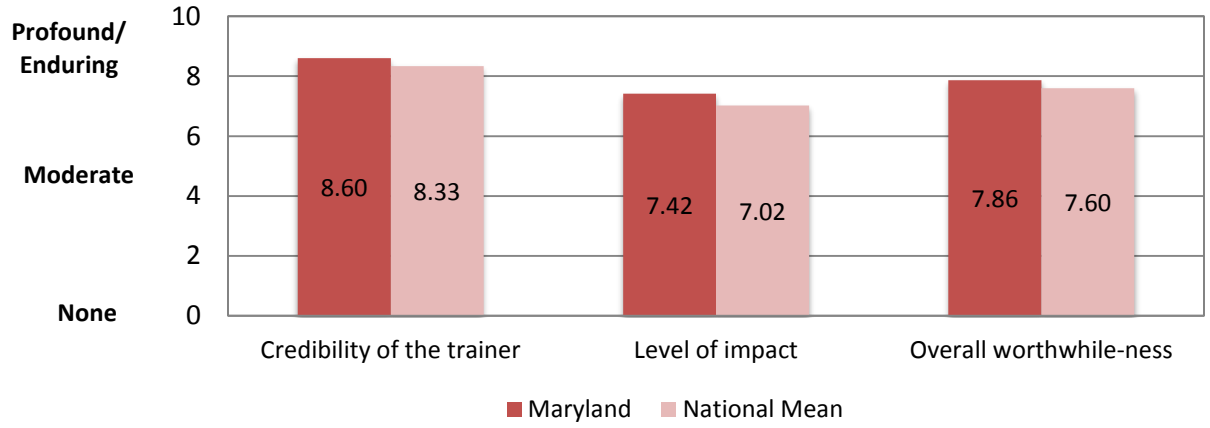


Figure 15. Follow-Up Training "Impact "Ratings - Maryland, July - December, 2014



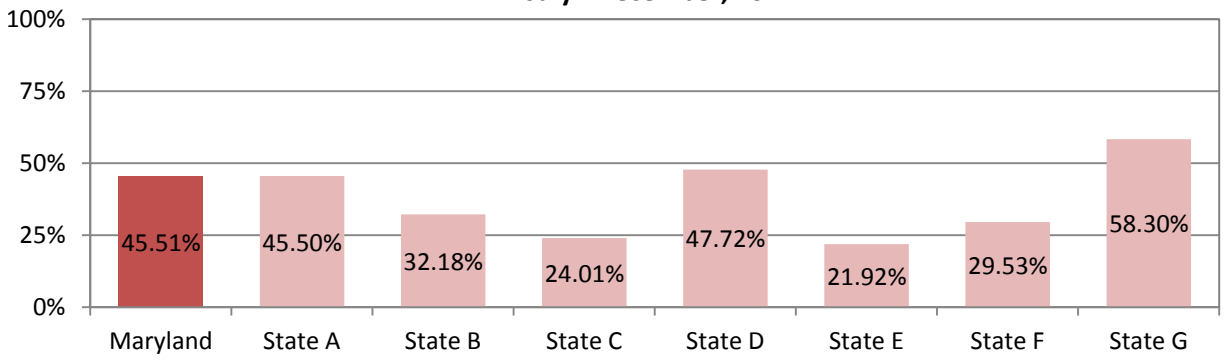
Coaching Observation Measure for Effective Teams

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.[16] 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 16); this score is comparable to average scores from two other states and higher than several others.

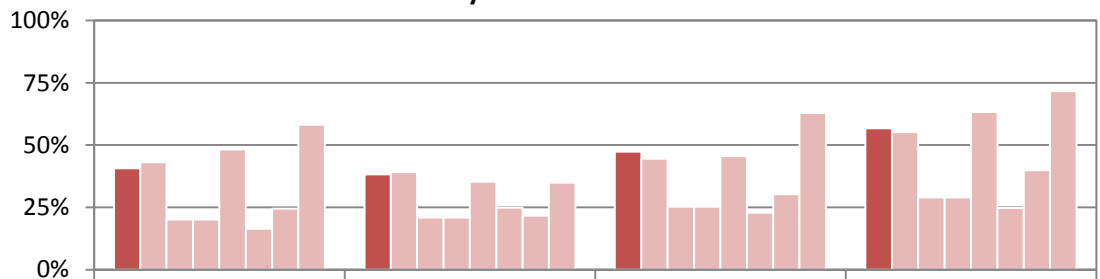
[16] The Institute is currently working with WERT to develop thresholds for skill proficiency.

Figure 16. Total COMET Score for the CME and Other States
July - December, 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 17). 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 17. COMET Key Elements Scores for the CME and Other States,
July - December 2014



	Strengths Perspective	Underlying Needs	Team Member	Determined by Families
Maryland	40.67%	38.23%	47.38%	56.79%
State A	43.08%	39.16%	44.54%	55.19%
State B	20.13%	20.89%	25.25%	28.93%
State C	20.13%	20.89%	25.25%	28.93%
State D	48.32%	35.27%	45.55%	63.24%
State E	16.38%	24.88%	22.77%	24.75%
State F	24.43%	21.61%	30.21%	39.87%
State G	58.14%	34.91%	62.87%	71.70%

Additional Training and Coaching

In addition to the training series for care coordinators and supervisors, coaching support occurs regularly between The Institute's trainer and the CME. Coaching was provided in the field to support skill development in care coordinators in home visits and Child and Family Team meeting observations. The supervisor is present during all The Institute's observations of care coordinators. Monthly coaching sessions also occur in supervision, in person and virtually, to support the supervisor's ability to reinforce the values of wraparound and build skill within the care coordinators. In addition, the supervisors submit COMETs regularly and this data is tracked and provided to the CME leadership team to inform organizational needs and action plans through quarterly meetings.

Implementation Summary & Recommendations

Utilization & Youth Enrolled

Summary

- Overall utilization and the average daily census have increased during this reporting period. Average daily capacity has decreased, as MD CARES and the PRTF Waiver have stopped serving youth, and Rural CARES and continues to ramp down the number of youth they are serving.
- Approximately 16% 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* (53% of all disenrollments in the last reporting period).
- On average, it took approximately 15 days from the date of enrollment for a family to have a first face-to-face meeting with a care coordinator, which is slightly longer than the previous two reporting periods (12 days). Moreover, the first CFT meeting was, on average, 55 days after the date of enrollment, which exceeds the target of 30 days.
- 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.
- Of those youth with a CANS completed at the start of services, the highest areas of demonstrated need (i.e., items with a score of 2 or 3) included anger control (46%), family functioning (45%), recreational (43%), and ADHD/impulse control (41%).
- The majority of youth starting with the CME were male (66%), African American/Black (56%), and approximately 14 years old, on average. The largest share of youth who started reside on the Eastern Shore (38%), followed by Baltimore City (19%). The smallest percentage of youth resides in Southern Maryland (6%).

Recommendations

- The timeframes noted above indicate a need to provide more intensive oversight and tracking around the activities of the care coordinators. Timely and persistent outreach to families to engage them and a thorough assessment of their needs through the development of the family story and completion of the CANS assessment should be occurring within the first 30 days of enrollment. Internal review of more stringent expectations and timelines is warranted. The care coordinators may benefit from having a tracking tool that they present during supervision that includes activities such as CANS assessments, family story completion, and number of completed contacts to each family.
- It might be helpful to survey families after the first 30-45 days of enrollment (done by an outside party or management level staff) to identify why families disenroll prematurely. Surveying feelings around the type of relevant and timely support and unique interactions, and in the way they feel their voice was heard, appreciated, and understood, may be appropriate.

Fidelity

Summary

- 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 notably lower than those of the national comparison sample, suggesting there are 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 79% (similar to 80% for a national sample) and the average score for youth was 70% (compared to 77% for

a national sample).

- Currently, the number of COMET submissions by supervisors within a Child and Family Team Meeting Observation is significantly lower than the recommendations that have been set forth by The Institute as well as the protocol the CME has set up regarding supervisor observations and COMET submissions.

Recommendations

- It is recommended that care coordinators are observed in the field within each phase of the wraparound process quarterly by their supervisor and assessed using the COMET. This will not only provide additional data around the quality of the meetings the families are receiving but this activity will raise the level of expectation that care coordinators understand within their role.
- Youth satisfaction (WFI-EZ) was markedly lower than the national average, and the Underlying Needs section of the COMET continued to rate as lowest of wraparound elements understood by the care coordinators. The Institute can provide a booster training that targets underlying needs and identifying the context around youth behavior to avoid focusing on deficits within the wraparound process, which may be contributing to a lack of engagement and satisfaction by the youth.

Discharges & Outcomes

Summary

- One-third (33%) of families who were discharged from the CME had successfully completed services, and an additional 14% of families discharged from the CME voluntarily and were considered successful. Challenges with engaging and retaining families account for approximately 27% of all discharges.
- A majority of youth (87%) discharged to a family-based living situation (parent or relative's home, family friend's home, or regular or treatment foster home). This rate is slightly higher than the previous two reporting periods (81% and 86%). Most youth were in a family-based setting at both enrollment and discharged.
- The ALOS for all discharged youth was 256 days. Among youth who discharged with *Successful Completion* (n=81), the ALOS was 467 days.
- Only one-third (34%) 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 during this reporting period (60%) was similar to FY14 Q3-4 (58%), and higher than FY14 Q1-2 (43%).

Recommendations

- It may be helpful to review whether the services and supports being built around families are sustainable and meet their needs, and to identify whether more creative and individualized strategies should be put into action.
- CANS assessments should be completed at discharge even if the youth requires a higher level of care and/or discharges early.
- It is important that families believe the help they are receiving is relevant to their needs. Progress tracking around outcomes is done at every Child and Family Team Meeting and documented within the Plan of Care and/or the minutes. This can also be used as a supervisory tool to identify if supports and services are increasing as progress is declining or stagnating.

References

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