



HIGH FIDELITY WRAPAROUND PRACTICE RESEARCH BRIEF: Factors Associated with Time to first Child and Family Team Meeting

Introduction.

High Fidelity Wraparound (HFW) is a care coordination process that recommends rapid engagement and plan development. Quick movement is thought to provide stabilization, instill ownership of the HFW process, and promote team cohesion (Walker et al., 2004). Recent research, however, demonstrates high variability in the time it takes families to complete the required steps before reaching the first Child and Family Team Meeting (CFTM; Schreier & Kaufman, 2019). The focus of this research brief is to examine this variability within the New York State System of Care pilot implementation and the reasons for this variability.

Research Approach.

The analysis used data from 2017 through 2019 of the NYS SOC pilot using a mixed-methods approach. Quantitative analysis utilized enrollment data for 126 families to explore relationships between several program- and family-level variables and days to first CFTM to identify factors associated with longer or shorter timeframes. Qualitative analysis involved review of care manager notes on reasons for “delays” in meeting any early milestones. This work served to identify contextual factors that may explain how or why the variables identified in the quantitative analysis impact timeframes.

Quantitative Findings.

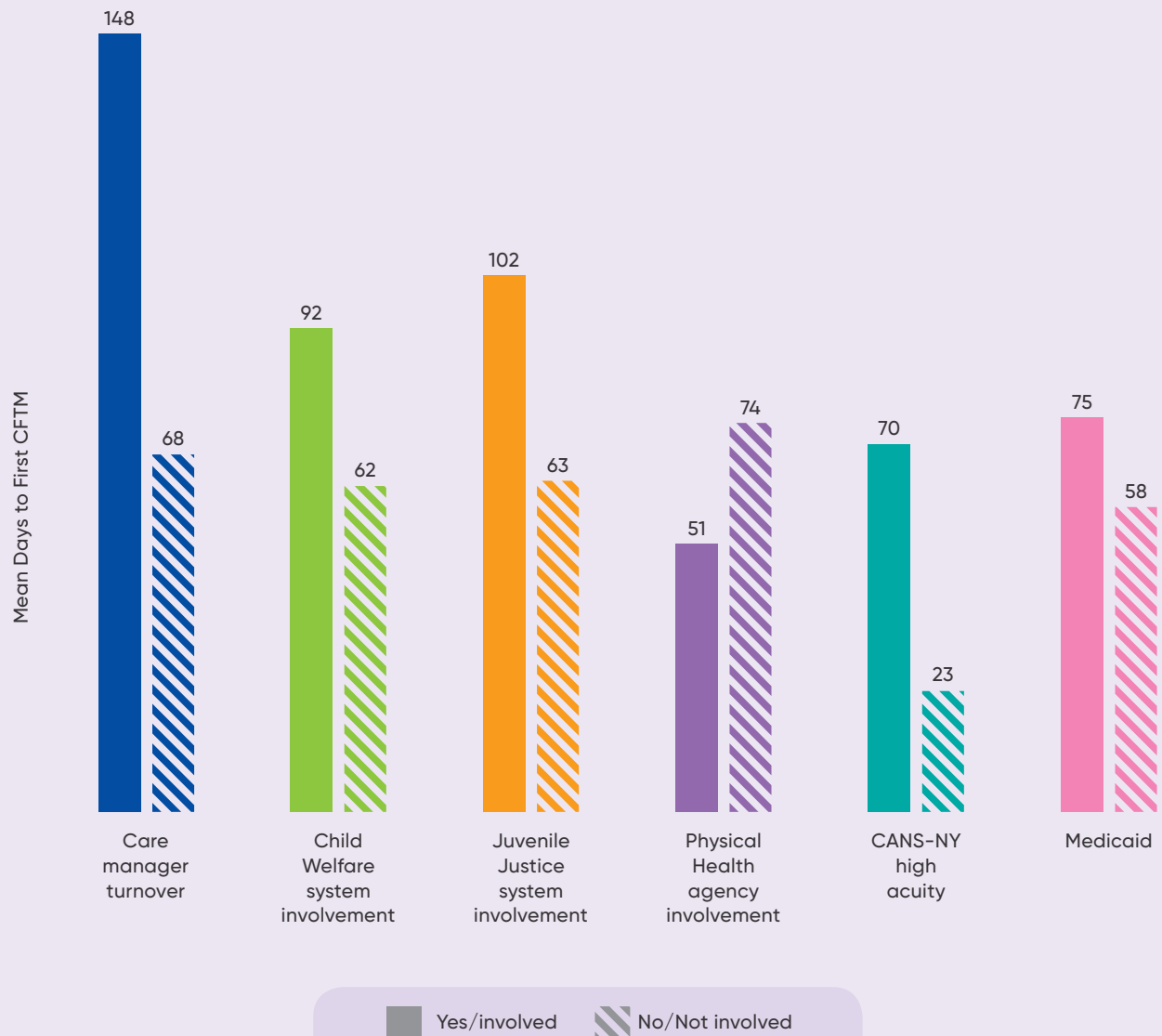
Among the 126 youth and families who had reached a first CFTM, the average time from enrollment was 70 days, but the range of days spanned from two days to 340. About 26% of families reached the first CFTM within the timeframe expected under the National Wraparound Initiative standard (40 days), but 20% took more than 100 days to meet this requirement, with a few (N=4) taking more than six months.

Several variables were identified whose associations with time to first CFTM were at least marginally significant ($p \leq 0.6$; see Figure 1):

- Programmatically, the three families who had **turnover in their care manager** before their first CFTM took significantly longer to reach their first CFTM than those who had a consistent care team. This change may necessarily pause the HFW process, as families must rebuild the intimate relationship required with a new person before they can progress to the next expected milestones. However, as this situation cannot be predicted when a family first enrolls in HFW, these families were excluded from further group analyses so as to not skew other results based on their especially long timelines.

- Participants involved in the **Child Welfare** or **Juvenile Justice** systems were slower to achieve a first CFTM; those involved with a **Physical Health** agency were faster. In the first two cases, families involved in these systems may be dealing with additional issues that either take a significant amount of time or interfere with the HFW process, or the systems themselves may be less willing to cooperate directly with HFW. In contrast, the Physical Health system may be better able to coordinate with the HFW process, as both have some medical focus, particularly as most youth were enrolled in both Health Homes and HFW.
- Families who did not score as **High Acuity** on the CANS-NY (an assessment tool aimed at determining the specific needs and strengths of the youth and family), or who were not **Medicaid** eligible or enrolled, were faster to achieve a first CFTM. These families may have more resources that enable movement through some of these early activities with less difficulty. Notably, almost all (N=119) families were High Acuity, as this was the target population of the implementation; thus, this variable had a marked impact even with limited variability.

Figure 1. Mean days to first CFTM, for youth and families meeting and not meeting criteria for each variable significantly related to CFTM timing beyond individual county impacts.



Qualitative Results.

We analyzed the reasons for “delays” during the early stages that were recorded by care managers. In total, 100 notes pertaining to 55 families within 16 agencies were used.

Five major categories of reasons for delays were identified from the care manager notes:

- **Misalignment of schedules:** Team could not identify a time when all partners were available.
- **Challenges with participating in the process:** Youth and families reportedly found some aspect of the HFW process unaccommodating or inflexible, limiting participation and resulting in delays.
- **Adverse family circumstances:** Significant family setbacks, such as adverse mental and/or medical events (e.g., youth hospitalization) or loss of basic needs (e.g., housing, phone coverage).
- **HFW team administrative difficulties:** Challenges faced by members of the HFW team, including having to wait to engage families in HFW activities until youth complete a transfer from one Health Home to another or to a higher level of care, and having to adjust when a facilitation team member departs.
- **Weather:** Meeting cancellations due to inclement weather, which pushed back the time to the next milestone.

Two major categories of solutions were identified:

- **Practice-level solutions:** These can be implemented on an individual basis through changes to current HFW practice, i.e., via interactions between the facilitation team (care managers and, where applicable, youth and family peer advocates) and the youth and family. Practice-level solutions include providing a comprehensive description of HFW to help families better understand the process to which they will be committing and coordinating calendars to schedule future meetings and identify deadlines.
- **Organization-level solutions:** These would require additional resources or policy changes from local or state agencies. Organizational solutions include extending or adapting timely engagement standards when unforeseen family adversity or HFW team turnover occurs and conducting meetings between team members via virtual alternatives when it is difficult or impossible to meet.

Summary and Conclusions.

This report identifies factors impacting the time from enrollment to first CFTM, or through the early HFW steps, using both quantitative and qualitative data. These findings have implications for practice. First, the family-level components can be identified at HFW enrollment; care teams can thus work to proactively schedule these first meetings and complete activities with families likely to need more time, or develop strategies to ameliorate these situations for all enrollees. Other factors cannot be known from the outset of participation (e.g., care team turnover, adverse family events, weather), but steps may be taken to mitigate their effect on activities and maintain timely progress; for example, technology for tele-meetings may be considered to support continued communication even when travel is not possible.

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