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YEAR TWO

New York State System of Care
Wraparound Evaluation Report



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INTRODUCTION

This report focuses on the implementation of the New York State System of Care Expansion (NYS SOC) project in the first two years of the four-year grant. The report is organized by themes that emerged from interviews with providers, surveys with non-provider staff and administrators, and other relevant data sources.

PROJECT OVERVIEW

The project is funded through a System of Care Expansion grant provided by the Substance Abuse and Mental Health Association (SAMHSA). Funding began in late 2016, and this report marks the half-way point of the grant. The project design examines the feasibility of a statewide wraparound care coordination practice model, its integration of wraparound within Health Homes Serving Children (HHSC) for youth and young adults with high mental health needs, and the strengthening of the NYS children's system using the Systems of Care framework. Project partners include the Research Foundation for Mental Hygiene, the New York State Office of Mental Health (OMH), and the New York State Department of Health's Health Home program and other state and local child-serving agencies, family representatives, youth partners, human service provider agencies, social marketing professionals, academic evaluators, and experts in cultural competence and linguistic access.

YEAR TWO CONTEXT

This section of the report describes the notable activities that occurred in year two, to help provide context for the findings of the report.

ENROLLMENTS AND COUNTY INVOLVEMENT

104 families were referred to participate by the end of year two, resulting in 76 total project enrollments. At the end of year two, all participating wraparound teams were serving 44 families. On average, all families enrolled had been in the project for 4.8 months.

Six counties served families in year two: Cayuga, Erie, Rensselaer, Orange, Rockland, and Westchester. In addition, one county left the project: Erie.

TRAINING AND COACHING

Providers are required to participate in wraparound training. In addition to training, NYS Wraparound certification requires participation in training, coaching, webinars, and completing family specific documentation. The training is designed to coincide with serving families.

Two full training series were completed in the past year. The training series consisted of six sessions (one per month), and each lasting two to four days (i.e., 16 days total over six months). Topics in the training include:

- Foundations of Wraparound
- Four Phases of Wraparound
- Documentation
- Wraparound Practice using Fidelity Standards
- Child and Family Team Meetings
- Trauma Informed Care
- Cultural Competence and Health Habitus

In addition, conference calls followed each training session to provide a summary of information for supervisors. Cayuga, Rensselaer, Erie, and Chautauqua counties participated in the initial training series. Westchester, Rockland, and Orange counties participated in the second training series. A third training series began toward the end of year two, however, no families were enrolled for this group by the end of year two. Coaching from the trainers, Family Peer Advocate (FPA) lead, and Youth Peer Advocate (YPA) lead accompanied the training process. Coaching occurred two to four times per month during the training (i.e., over initial six months), followed by coaching that was less frequent post-training.

DOCUMENTATION

During year two, providers began using project-specific templates for documenting the wraparound process. This documentation was designed to facilitate wraparound work by guiding providers through the wraparound process to ensure they were completing each component. Documentation included “the tracker” which was comprised of templates for crisis plans, the plan of care, the transition plan, and care manager contact notes. Additional documentation included templates for peers to document their contact notes. Procedures dictated that documentation was uploaded to the Health Commerce System (HCS) monthly for review by the training and coaching team.

REPORTS AND PLANS

The original pilot counties received reports from the evaluation team in year two. Reports included status in the certification process, policy adherence, families served, and how well practices followed fidelity standards. Other activities included implementation of the Social Marketing Plan and development of a Sustainability Plan.

DATA SOURCES

The findings below incorporate data from several different sources including administrative records, child and family interviews, fidelity assessments, provider interviews, non-provider project staff surveys, county monthly reports, and case notes. A brief description of each source is provided below, with a more detailed description in Appendix A.

- **Administrative records:** Administrative records collect some data on every family as completed by the wraparound team using records data. This information is collected at baseline, six-month reassessments, and discharge.
- **Youth and family interviews:** Child and family interviews are offered to each participating family at baseline, six-month reassessments, and discharge. These interviews are optional and include assessments of functioning, social support, empowerment, hope, and satisfaction.
- **Fidelity assessments:** Observation and survey fidelity assessments are offered to families from the third team meeting to six months post enrollment. Document review is conducted once a case has closed (if there are at least two CFTs). These tools measure the extent to which practice reflects the wraparound model.
- **Provider interviews:** Interviews with wraparound providers are conducted at the end of each year of the project. During interviews, providers describe their experiences with the project over the previous year.
- **Non-provider, project staff surveys:** This survey is offered to individuals who are not providers but are participating in implementation to solicit feedback regarding their experiences with the project over the previous year.
- **County monthly reports:** Monthly activity reports are collected from county representatives including a county lead, CM supervisor, FPA supervisor, and YPA supervisor
- **Case notes:** Case notes are completed by wraparound team members to track their work with families; this includes the trackers and peer notes.
- **Cohesion surveys:** Cohesion surveys are collected from care managers, youth peers, and family peers to understand how they function as a team.

FINDINGS

The findings below are organized into three major categories: (1) NYS Wraparound model features, (2) NYS Wraparound preparation, and (3) NYS Wraparound practice. Each section includes information on the associated data sources as well as strengths and recommendations.

NYS WRAPAROUND MODEL FEATURES

The following section describes findings on the innovative features specific to the NY model. These features include triad facilitation, incorporation of the family’s Health Habitus into the plan of care, and integration of wraparound within HHSC.

Triad Facilitation Team

Data Sources:

- Non-provider, project staff surveys
- Provider interviews
- Youth and family interviews
- Cohesion surveys

The triad facilitation team is a feature of wraparound in NYS that broadens the facilitation of the process from a single, independent care manager to include both the family peer advocate and youth peer advocate.

The triad emerged as the NYS model’s most unique feature in provider interviews and administrator surveys. Nearly every county administrator reported that having the youth peer and family peer as part of the triad was a positive addition to the NYS model. Most providers felt the triad was one of the greatest strengths of the NYS wraparound model and that their roles within the triad leveraged their strengths.

Many interviewees found an immense benefit from having youth peers on the facilitation teams in particular. They felt that YPAs were uniquely able to form special connections with and quickly engage youth in wraparound.

The value of peers was also evident in youth and family interviews on items addressing youth and family peer contributions to the wraparound process. The averages on all items scored above the scale midpoint indicating that respondents’ agreement with the various items specific to youth and family peers contributions. The figures below indicate the highest and lowest scoring items.

Figure 1. Family Peer Advocate Items (N=16)

Highest scoring items (mean > 4.5)	Lowest scoring items (mean ≤ 4.0)
<ul style="list-style-type: none"> • Was trustworthy • Met with you at a convenient time and place • Was reliable 	<ul style="list-style-type: none"> • Related to you • Shared with you their experiences with mental or behavioral health system
<ul style="list-style-type: none"> • Helped your child get involved in community activities that your child is interested in 	<ul style="list-style-type: none"> • Assisted you in finding friends and family who could help you

Figure 2. Youth Peer Advocate Items (N=13)

Highest scoring items (mean > 4.5)	Lowest scoring items (mean ≤ 4.0)
<ul style="list-style-type: none"> • Encouraged you to say what’s important to you in meetings 	<ul style="list-style-type: none"> • Helped you to make progress on your wraparound goals
<ul style="list-style-type: none"> • Showed you how to lower your stress 	<ul style="list-style-type: none"> • Helped you get involved in things that you like to do in the community

Although the triad is a key part of wraparound, providers indicated the model could be improved by reducing role confusion among triad members. Participants requested clarity regarding potential hierarchies and role responsibilities. Providers conveyed that role confusion was pronounced in CM-peer relationships where CMs sometimes assumed responsibilities that may be more appropriate for the peers' supervisors. These extra duties strained care managers and introduced undesired hierarchies. Peers felt such hierarchies implied peer work was less-esteemed and supplemental, rather than central to the wraparound process. Family and youth peers reported underutilization of their skills and wished they could contribute more. Triad members' responses about factors that facilitated and inhibited their ability to work as a cohesive group revealed the following themes:

- **Positive Factors:**

- All members following the lead of the family
- Valuing each member's opinions equally
- Meeting regularly to discuss families

- **Negative Factors:**

- Interpersonal relationships (e.g., holding grudges, etc.)
- Avoidance within team (e.g., allowing issues to go unaddressed)
- Insufficient notice or communication of the need to change plans (e.g., canceling a meeting)
- Inconsistent sharing or consulting across entire wraparound team

More clarity on roles, addressing potential hierarchies, finding ways to harness every team members' skills, providing space for open and honest discussions of difficulties, and sticking to a plan to meet regularly are all potentially helpful ways to promote teamwork and support the strengths and challenges of each role in the triad.

Takeaways:

Strength: The triad facilitation team is a major strength of the NYS wraparound model. Peers are recognized as indispensable assets, especially in the critical engagement phase of rapport-building and information-gathering.

Recommendations:

- Clarify each member's role in the triad facilitation team.
- Address potential hierarchies.
- Provide space for open and honest discussions of difficulties.
- Stick to a plan to meet regularly.

Health Habitus

Data Sources:

- Non-provider, project staff surveys
- Case notes

Health Habitus is another unique feature of the NYS wraparound model. Health Habitus is defined as a "set of tendencies or inclinations in relation to taking care of our health; how we manage our mental, emotional and physical wellbeing." Peer advocates were taught to identify youth's and caregivers' Health Habitus to uncover attitudes towards health practices and services in order to inform the plan of care.

When asked whether each NYS wraparound feature was a positive or negative addition to the model, Health Habitus received the most "don't know" responses (53%, 9 out of 17 indicated "don't know"). This finding was unsurprising since survey respondents were county staff (e.g., county leads and SPOA) who did not participate in trainings or coaching calls where Health Habitus was taught. County level administrators and leaders could use additional information about Health Habitus.

Peer notes evidenced use of Health Habitus in all counties where peer notes were available (Rensselaer, Cayuga, Westchester, Orange, and Rockland), though only 26 out of 533 (4.9%) peer notes were marked as Health Habitus. While FPAs are integrating Health Habitus into their work, YPAs are not yet using Health Habitus. Many of these notes reflected discussions related to family story mentioning health and discussions of health behaviors, but not necessarily the tendencies or attitudes underlying them (e.g., discussions of symptoms). Fewer notes reflected tendencies or inclinations towards both health systems and non-health systems (e.g., churches, CPS). FPAs are making efforts to incorporate Health Habitus into their documentation but may need some additional assistance with documenting notes to reflect Health Habitus.

Takeaways:

Strength: FPAs in all the participating counties are trying to incorporate Health Habitus into their wraparound work.

Recommendations:

- Provide county administrators with additional information describing Health Habitus and its value within wraparound.
- Provide FPAs with additional assistance in documenting notes to reflect Health Habitus.
- Offer YPAs additional practice and encouragement to begin using and documenting the Health Habitus strategy in their work.

Health Homes Serving Children

Data Sources:

- Non-provider, project staff surveys
- Provider interviews
- Administrative records

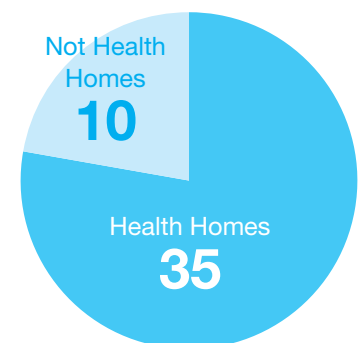
The integration of wraparound into HHSC is another feature of the NYS model. HHSC is available to Medicaid-enrolled youth. This project aimed to serve Medicaid and non-Medicaid youth and to integrate the wraparound pilot into HHSC for those youth who are Medicaid-eligible.

Figure three indicates that 78% of the Medicaid youth served were also enrolled in HHSC. Of those enrolled in HHSC, about half were newly enrolled in HHSC as wraparound commenced, with the remaining half of youth enrolled in HHSC prior to enrolling in wraparound.

Some county administrators felt that the integration of HHSC with wraparound was not positive. In general, providers felt they did not have enough information to provide feedback regarding the integration and impacts of wraparound and HHSC on each other. Some also note family confusion, such as not knowing they are in HHSC or, once they transition to HHSC care coordination only, wondering why wraparound services/features are removed (e.g., peer advocates).

Providers noted that meeting HHSC and wraparound documentation requirements is challenging. Further, the two documentation systems require disparate intervention language: HHSC requires deficit-based language whereas wraparound requires strengths-based language. In the absence of a single documentation system, it would be helpful to use a common framework (that satisfies requirements for HHSC and wraparound) for both systems to reduce CM burden.

Figure 3. Health Home Status of Medicaid Youth (N=45)



Takeaways:

Strength: The majority of Medicaid youth in this project were also enrolled in HHSC.

Recommendations:

- Provide more education for both providers and families to understand the HHSC program.
- Explore adjusting language to fulfill the requirements for both HHSC and wraparound to limit documentation burden for CMs.

NYS WRAPAROUND MODEL PREPARATION

The following section describes findings relevant to preparation activities for practicing wraparound. These includes training, coaching, and additional preparation for peers.

Training

Data Sources:

- Provider interviews

Overall, providers reported positive reactions to training, describing it as helpful and enjoyable. Some identified training as the most helpful support for providing wraparound. Providers also offered suggestions for improvement. The recommendations fell into several categories:

- Adjust structure
- Include a more user-friendly manual
- Create trainings for additional audiences
- Other training suggestions

Adjust Structure: Two structural recommendations were reported. First, changing the order of training sessions, such as introducing documentation and skills trainings prior to needing to use them. Second, delaying family enrollment until several training sessions are completed.

Include a more user-friendly manual: Providers sought a more comprehensive manual that could also be easily referenced for their work (e.g., more definitions and examples of plans of care that meet fidelity standards; page numbers and a table of contents for easy reference). As written, the workbook is helpful during training, but difficult to use as a reference guide later on.

Create trainings for additional audiences: Providers felt offering additional training to others in their organizations and communities would strengthen their practice and help promote a common understanding of concepts and practices. They recommended offering specific trainings for (1) community providers regarding general wraparound and (2) supervisors regarding coaching to the wraparound model.

Training for supervisors on how to provide effective guidance to their staff would be beneficial. Providers found it uncomfortable to criticize supervisors on poor practice instruction. While providers and supervisors noted supervisors wanted to provide more assistance to their staff, they felt they had insufficient knowledge about the wraparound process to provide adequate support. In addition, YPA and FPA supervisors have also requested training in some instances. All supervisors could benefit from more training opportunities overall, and a wider array of training topics. For example, it would be helpful to have documentation trainings so that supervisors are able to review the wraparound team's documentation in an informed way. Online venues may be more convenient for some supervisors, since travel may be burdensome. An alternative is to provide notes of coaching sessions or "fact sheets" on covered topics. For instance, if "strengths in strategies" is the coaching topic, supervisors and providers could be given a one-pager describing how to incorporate a strength with relevant examples of when strategies have not incorporated strengths. This ensures everyone is on the same page and has a resource to refer if they need a refresher on wraparound concepts.

Other training suggestions: Some providers offered ideas for additional training topics or to emphasize components of current training.

- Training on HHSC for all facilitation team members
- Care manager training on working with peer team members (e.g., how to anticipate and work with their needs)
- Deeper focus on developing care plans
- More focus on team building
- How to work efficiently as a triad during child and family team meetings (CFTs)

Takeaways:

Strength: Providers enjoyed training and felt it was an important support for providing wraparound.

Recommendations:

- Adjust training structure so that families are enrolled at a later stage of training.
- Provide documentation training earlier on.
- Revise training manual for use as a reference after training.
- Create trainings for non-provider audiences, particularly for supervisors, and consider alternatives to full training.
- Cover additional topics in training (e.g., HHSC).

Coaching

Data Sources:

- Provider interviews

During year two of the project, coaching was provided individually to each of the providers, with the trainers coaching CMs, the FPA Lead coaching FPAs, and the YPA Lead coaching YPAs.

Coaching was cited as the most helpful support for providing wraparound, though they expressed mixed experiences. Some found it reliable and regular, while others found it inconsistent. Providers offered some suggestions and thoughts around coaching:

- Providers found regular and consistent coaching to be most beneficial; some providers desired more frequent coaching.
- Providers requested clarity on whether coaching was intended to continue, preferring that it did.
- FPAs preferred group coaching over individual coaching. Group coaching provides the opportunity for FPAs to learn from each other.
- CMs indicated a preference to include supervisors on coaching calls to promote common conceptualizations of cases.

One recommendation is to provide upfront information and standards around a coaching schedule, mode of coaching, and expectations, so providers have a clear idea of what to expect.

Takeaways:

Strength: Coaching was the most helpful support for providers in practicing wraparound.

Recommendations:

- Provide upfront information and standards on the format, structure, and regularity of coaching.
- Consider inviting supervisors on coaching calls, especially group calls, to ensure teams are on the same page.

Additional Preparation for Peer Advocates without Experience

Data Sources:

- Non-provider, project staff surveys
- Provider interviews

To realize the full benefits of YPAs in the triad model, interviewees noted peers may need additional preparation before being able to effectively assume their role. Whereas CMs and most FPAs came into their roles with experience, most YPAs had no prior role-related work experience. Without experience, YPAs required pre-training preparation to serve effectively in their role. The lack of availability of this pre-training may have contributed to turnover in YPA positions. While some suggested that the role might benefit from more rigorous standards, (e.g., college course completion in a relevant field, prior work experience, etc.), others felt training enhancements would be adequate to fill knowledge gaps. Interviewees recommended methods for enhancing readiness of YPAs and FPAs without prior experience. Guidance fell into several categories:

- Mental health and systems knowledge preparations
- Professional behavior guidance
- Boundary guidance

Mental health and systems knowledge: One YPA noted that this was the YPA's first position in the field, and, as such, lacked knowledge in the services and terminology, leading to a steep learning curve. This type of information is not covered in the training, and this YPA wished there was a more general mental health and other child serving systems training or guidance available for YPAs such as information about child serving systems when dealing with challenging situations (e.g., crisis calls, CPS, probation, hospitalizations).

Professional behavior guidance: One CM noted that YPAs were, at times, unreliable. They often faced transportation challenges and took frequent personal days. While sympathetic to these difficulties, CMs found it challenging to coordinate triad and family schedules, especially when inadequate notice was given. One YPA noted that YPAs could use assistance with organizing and scheduling. More guidance on expectations regarding scheduling and notification of schedule changes could be helpful.

Boundary guidance: Several YPAs described their relationship with the youth they work with as a friend or sibling-like relationship. Conceptualizing YPA-youth relationships as friends may lead to boundary issues. YPAs could benefit from guidance on striking a balance between being friendly and relatable while still being professional.

Takeaways:

Strength: Peers who come into the role with prior peer advocate experience seem to be well-prepared for their role in wraparound.

Recommendations: Provide peers with an additional suite of trainings focusing on mental health and systems knowledge, professional behavior, and boundaries.

NYS WRAPAROUND PRACTICE

The follow sections address findings related to the practice of wraparound, including identifying families who will thrive in wraparound, reaching full caseloads, practicing the phases of wraparound, fidelity to the national wraparound model, documenting wraparound, meeting timeliness standards, and communication.

Identifying Families Who Will Thrive in Wraparound

Data Sources:

- Provider interviews
- Non-provider, project staff surveys
- Case notes
- Administrative records
- County monthly reports

Typically, families are referred to their county's Single Point of Access (SPOA) Coordinator, who confirms a youth's eligibility (including diagnosis and functional limitations necessary for HHSC's serious emotional disturbance definition). In addition, a CANS-NY is completed to ensure that the family has a high acuity level of need. Once a family agrees to participate, the family is referred to a wraparound care manager.

Although providers agreed the families they were serving met the eligibility criteria and had high needs, they felt some families were not a good fit for intensive care coordination due to other reasons (e.g., time commitment required). Wraparound requires involvement and buy-in from the entire family system to which some families cannot, or do not want to, commit.

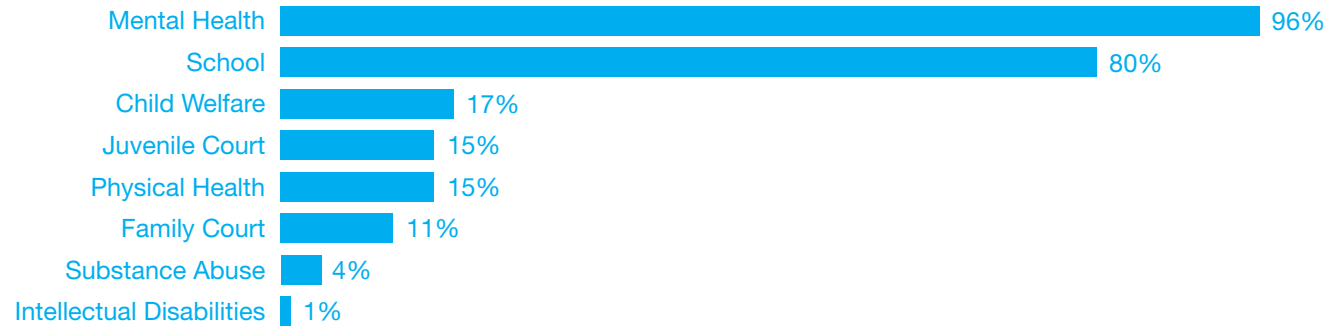
Many providers noted that a primary way to ensure the "right" families are being enrolled in wraparound is to provide better information to families before they select wraparound. Providers felt that families need to be fully informed and oriented to the wraparound process before making a commitment. Families making an informed decision will be more likely sustain engagement.

In our survey of county administrators and trainers and interviews with providers, many (38% of administrators and 65% of providers) felt the project is not serving the "right" families. Youth peers were more likely than other roles to feel that the "right" families are in the wraparound pilot. Other providers felt changes to the eligibility criteria could improve family selection. These suggestions include:

- Youth that are meeting high acuity due to high parent needs are not appropriate; youth with high acuity scores based primarily on the youth's needs are more appropriate. If high acuity stems from parenting issues, services focused on parenting may be more appropriate.
- High acuity families are not appropriate as the complexity of their needs can hinder participation in action steps; low and medium acuity families would be a better fit
- Some youth needs prevented full participation in wraparound (e.g., trauma, sexual deviancy, etc.).
- Younger youth (e.g., 12) are too young to participate meaningfully in the process (e.g., to work with an YPA and to work on goals).
- Although multi-system involvement is an eligibility criteria, many multi-system-involved-youth remain unserved. Youth who are Juvenile Justice (JJ)-involved (with mental health challenges) may be a better fit. The figure below supports this idea that few youth with JJ involvement were enrolled in wraparound. Sometimes JJ-involved youth may not yet have a mental health diagnosis. Putting processes in place to facilitate assessments for these youth to meet wraparound eligibility criteria could be beneficial.

Figure four displays system involvement at baseline for families served in the project so far.

Figure 4. System Involvement at Baseline (N=71)



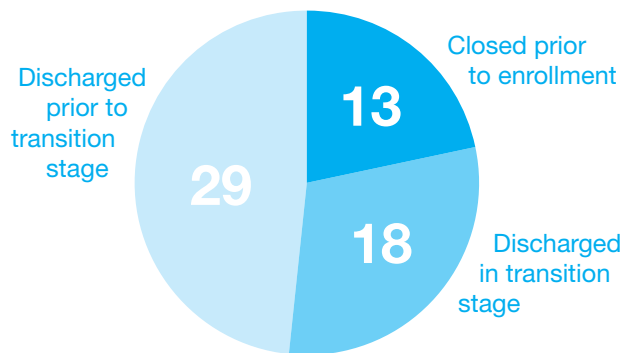
Although many of families agreed to wraparound and met the criteria, providers and administrators felt some families were more appropriate for other services or care coordination processes. The following describes interviewees’ and survey respondents’ reasons why families may not be a good fit for wraparound:

- Families who seems like they may want a service other than to participate in wraparound (e.g., they really want waiver or an RTF placement, but feel like they need to “go through” other services/programs first).
- Families who find the time commitment of the wraparound process burdensome.
- Complexity of the model may be overwhelming for some families/caregivers, resulting in low levels of family participation.
- Families’ needs are sufficiently high that they require a higher level of care than the pilot’s current iteration of wraparound can offer.
- Families want only pieces of wraparound that are either perceived to be available (e.g., respite) or are actually available (e.g., peers).

Family selection processes may also be a contributor to selection of families who exit wraparound early. Figure five displays the point at which families exited wraparound.

Sixty families have “closed out” of wraparound. Of these, about a third successfully made it to the transition phase, though this number may be artificially reduced due to the sudden ending of Erie County participation in the pilot which accounts for a large proportion of discharges. National standards prescribe a goal of at least 50% of families discharging in the transition phase (for new programs, <9 mos. old) and a goal of at least 70% of families discharging in the transition phase for more experienced programs (Schurer, Coldiron, Bruns, Hensley, & Paragoris, 2016). At the end of year two, 38% of families were discharged in the transition phase, falling short of these standards.

Figure 5. Status at Case Closure (N= 60)



Families that enrolled in wraparound but discharged prior to the transition phase often did not progress far into the wraparound process. About 1.5 of closed cases are families who dropped out in the very early stages prior to signing consent forms. Because many of these families were high needs and may have been in crisis at the start of the process, connecting them to the best-fit care coordination possible is vital. On average, families who discharged prior to transition completed 2.5 CFTs. However, this number is amplified by Erie County, who on average completed 3.5 CFTs with these families. The average for all other counties was slightly less than 1 CFT (.92), indicating families who end participation early often end before or after the first CFT, and before working on a plan of care.

One reason for early discontinuation of wraparound may be due to misunderstandings of wraparound before enrollment. A recommendation is to provide additional clear and concise information up front so that families can make more informed decisions about the wraparound process. For instance, creation of a family-friendly chart clearly depicting the unique features and differences between the three options for high needs families (i.e., HCBS Waiver, wraparound in HHSC, and the regular HHSC model), and what the expectations and time commitment of the family are. Information should be brief so as to not overwhelm families, but ensure all the relevant information needed to make an informed decision is included.

Some providers felt the team was better able to select successful families for the program as they gained more experience in wraparound. It may be helpful to facilitate a discussion with providers about their intuitions about the right families in order to improve precision of eligibility criteria.

Other possible additions to explanatory materials could be made based on currently available data. Some examples are listed below.

- Wraparound can be intensive, sometimes requiring weekly in-person meetings with peers, as well as monthly group CFTs. Does this sound like something you are interested in?
- Wraparound is a process aimed at improving the entire family system and dynamic, which requires regular involvement of multiple members of the family. Does this sound like something you are interested in?
- Everyone on the team will have tasks they need to do between meetings. Meetings typically occur once per month. Can you commit to working on tasks each month?
- We will invite other service providers you may be working with to participate in the process; we will also ask you to invite other people who are important to you—extended relatives, a friend, a neighbor, etc.—to help out. Does this sound like something you are interested in?

Takeaways:

Strength: Some providers, mostly YPAs, felt the right families are being served and felt that the intense process of wraparound is appropriate for the high needs youth they are working with. Providers are becoming more adept at identifying successful families.

Recommendations:

- Focus more on selecting families that currently have multiple plans of care due to multi-systems involvement (e.g., mental health and juvenile justice).
- Provide thorough information up front about the requirements of the wraparound process (e.g., time, effort, vulnerability), such as the examples provided above.

Challenges with Reaching and Maintaining a Full Caseload

Data Sources:

- Provider interviews
- Administrative records

Project guidelines indicate that teams should maintain a caseload of ten families. This caseload was selected as it similar to the recommended caseload for high acuity cases in HHSC (12).

Few wraparound teams have reached their goal of ten families per team, and even fewer have been able to keep to that caseload for any length of time. While teams are supported by grant funding, this issue is less important. However, the issue will become critical as sustainability via available funding models (e.g., Medicaid reimbursement) will be necessary. Providers report feeling pressured to enroll families quickly, leading to selection of some families who could have benefited from a service alternative. This may have contributed to the delays in wraparound progress described in the next section.

Figure six indicates the percentage towards a full caseload for each county. Note, Rensselaer's caseload is over the maximum (10) because they have a single care manager who is serving 12 families. This care manager was previously

coordinating care with 10 families, but took on an additional two from a care manager who recently departed. Figure seven displays the length of time that each county has been providing wraparound in the NYS SOC pilot.

Figure 6. % to Full Caseload (N=43)

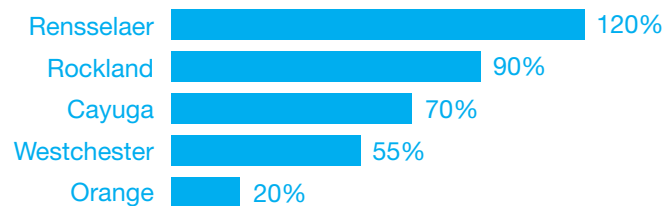
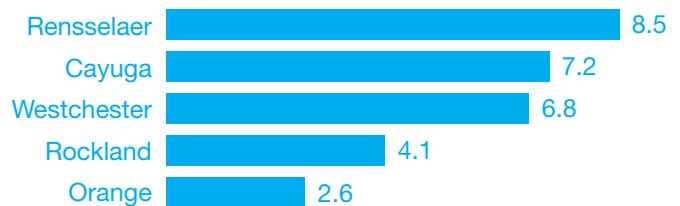


Figure 7. Months Providing Wraparound



It is possible that counties do not have full caseloads because several were still participating in training at the time of analysis for this report. Providers enroll families more slowly while they are participating in training, allowing providers to ease into their work. It is possible that counties would be closer to full caseload if the analysis was performed after all training was completed. In general, counties with a fuller caseload had also been providing wraparound for a longer period of time.

Steps can be taken to ensure full caseloads are met faster and maintained more consistently. One possible solution is to have a caseload range goal, e.g., a minimum of 10 and maximum of 12, with instructions to keep within this range. However, in provider interviews, many mention that they felt a caseload of 10 should be the max, with some preferring a caseload of 8. (It is important to note that many had not yet reached a caseload of 8-10 yet when providing these perspectives.) A few FPAs felt they could succeed with a larger caseload.

Another strategy is to reduce the time span of training, so that full enrollment can begin sooner, for example, “frontload” the training to include more online and classroom sessions in the first month or two with sporadic refreshers, so that full enrollment can be attained sooner. Full caseloads may also be delayed because of barriers to current outreach efforts, which limit the number of eligible families. Review of referral sources and outreach could increase the number of eligible families. A larger pool of eligible families may enhance processes to identify families who could benefit most from wraparound. This would have the potential to increase program tenures and lead to more successful caseload maintenance (see strategies above for selecting appropriate families for wraparound).

Takeaways:

Strength: Counties participating in the project longer are close to or meeting the full caseload requirements.

Recommendations:

- Set a caseload range goal (e.g., a minimum of 10 and maximum of 12, with instructions to keep within this range).
- Reconfigure training to include more online and classroom sessions earlier on, so that full enrollment can begin sooner.
- Improvements in family selection may lead to increased program tenure and, in turn, better caseload maintenance.

Meeting Wraparound Timeliness Standards

Data Sources:

- Provider interviews
- Case notes

Wraparound standards allow for a 1-2 week engagement period. “The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible” (Walker & Bruns, 2008, pg.4). The next phase, plan development, is designed to last

an additional 1-2 weeks and is intended “to promote team cohesion and shared responsibility toward achieving the team’s mission or overarching goal” (Walker & Bruns, 2008, pg. 7).

The wraparound standard regarding these early phases indicates there should be no more than 35 days between the first face to face meeting and the first plan of care, which is finalized after the first CFT (DART item D6). However, as Table one shows only about a quarter of teams for which documentation was available are currently meeting this standard; the average time to the first plan of care is almost twice as long as the standard (standard=35 days).

Table 1. DART Item D6 (N=31)

	N	
% of cases who meet D6 criterion	31	26%
Avg. # of days b/n 1st face to face and 1st POC	31	59 days

Providers echoed these findings, recommending a 2-month period for engagement prior to the first CFT. It is possible teams have felt they couldn’t start plan development until they “checked every box” in the tracker, which has prolonged the engagement phase beyond the timely engagement standards. These findings suggest tension exists between the task of information-gathering and meeting the model’s timely engagement standards. Some changes to the approach to building the plan of care which may reconcile this tension include:

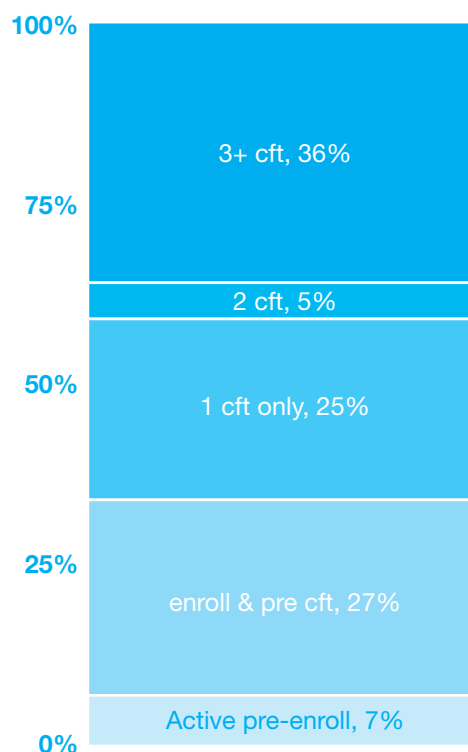
- Identify one strength per team member, and offer opportunities to add strengths at subsequent CFTs
- Draft a brief family story and add details as wraparound continues.
- Create and assign tasks during the plan development phase and then continue through later phases.

In addition to timely engagement, many providers felt the timelines were too condensed. Providers felt that monthly CFTs are too frequent to allow families time to make progress between meetings, which is discouraging for families. Provider suggestions ranged from 45-60 days between CFTs.

Data confirms that it has been challenging for providers to maintain the intended momentum through wraparound. Figure eight displays where currently enrolled families are in the wraparound process. Active and pre-enrollment indicates families have not yet agreed to participate in wraparound; enroll and pre-CFT indicates the family is still in the engagement phase (phase one of the process); one and two CFTs only indicate the family is beginning to create and implement their plan of care; and three plus CFTs indicates the family is well into the third phase, plan implementation.

About two-thirds of currently active families have completed at least one CFT. Families were similarly distributed across the wraparound process, with a similar percentage of families in the early, mid, and later phases of wraparound. Based on length of time since enrollment and fidelity standards, families are over-represented in the engagement phase (i.e., enroll & pre-CFT). About 7% of families are within 30 days of enrollment, while over a quarter are still in this engagement/pre-CFT phase. Similarly, based on the timeline and the fidelity standards (30 days to first CFT, and then 35 days between CFTs-95 days total) and how long families have been in wraparound, it would be expected that about 70% of families should be in the three plus CFT category, whereas only about half that many are actually to that point of wraparound. This indicates that, on average, families are moving more slowly through the wraparound process than anticipated based on fidelity standards (Wraparound Document Assessment and Review Tool, 2016).

Figure 8. Status of Active Families (N=44)



Providers felt a 3-day turnaround for notes and documentation was not long enough. They also felt it was difficult and time consuming to update the plan of care after each CFT. However, constant updates to the plan of care are a necessary feature of determining the steps needed for progress. This allows constant reassessment and strategizing to keep program goals attainable. Peer advocates can help with this process by regularly monitoring action steps to encourage a family’s successful progression and aid in reassessment of goals.

Another strategy that may benefit providers with timelines is practice creating action steps that are small enough to be accomplishable in the 30-day period. (e.g., search online and make a list of community basketball programs, print up a FAFSA application, etc.). The steady progress towards goals encourages families and helps the wraparound process maintain momentum.

Takeaways:
Strength: Providers are focusing on thorough engagement with families and are working to meet the timely engagement standards created by NWI.

Recommendations:

- Start tasks during the engagement phase while understanding these tasks will be completed during a later phase.
- Consider training providers to use action steps that can reasonably be accomplished in 30 days.
- Consider emphasizing the concept that plans of care are “living” documents during training and coaching. Providers may thereby feel less stuck by the desire to create the perfect plan of care before getting started.

Practice Fidelity to the National Standards

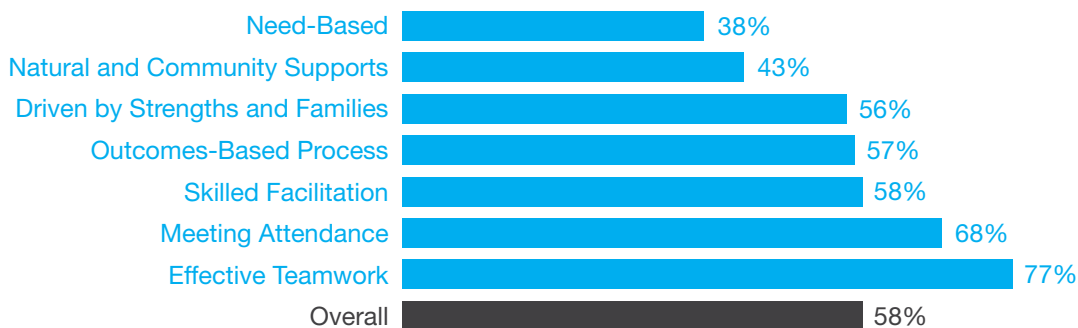
Data Sources:

- Fidelity Assessments (TOM 2.0 and WFI-EZ)

Wraparound is a national care coordination model with specific standards of practice. Adherence to these standards acts as an indication of adherence to wraparound principles. This section provides information about the extent to which the pilot facilitation teams adhered to the practice standards of wraparound and offers recommendations. Findings from fidelity assessments are presented in the seven domains from the TOM 2.0 ordered by lowest to highest fidelity with percentages indicating the level of fidelity achieved:

- Needs-Based
- Natural & Community Supports
- Driven by Strengths and Families
- Outcomes-Based Process
- Skilled Facilitation
- Meeting Attendance
- Effective Teamwork

Figure 9. Fidelity as a percentage of a perfect score on TOM 2.0 domains and overall (N =21)



By Domain (ordered by lowest to highest)

- 1 Needs-Based.** This domain focuses on the underlying needs of everyone for whom a strategy was created and the strategies that aim to meet those needs. Fidelity in the needs-based domain was low primarily because care managers were not consistently identifying the challenges the team was working on as rooted in deeper, underlying difficulties. Only 20% of meetings met this fidelity standard. Another practice care managers fulfilled infrequently (31% of meetings) was established and/or revisited the family's description of how they would know when their needs have been met. In contrast, one fidelity standard care managers implemented more consistently (60% of meetings) is brainstorming how to address underlying needs, (i.e., surfacing multiple strategies instead of identifying one and moving on).
- 2 Natural & Community Supports.** This domain focuses on incorporating members of the family's natural social network and community organizations and institutions that provide recreational or youth development activities. This domain was one of the lower domains in large part because natural supports (e.g., extended relatives, friends, neighbors, business owners, etc.) were infrequently included in program strategies. Only 18% of meetings included such discussion. Further, only a third of meetings included discussion of families' current level of connection to natural supports and explore ways to foster connections. This finding fit with team member perceptions, as this was the lowest rated domain on the WFI-EZ.
- 3 Driven by Strengths and Families.** This domain focuses on leveraging family perspectives, needs, and strengths to personalize wraparound to each family and youth. Care managers consistently adhered to some practice standards but less consistently to others. Care managers were skilled in eliciting constructive involvement by caregivers (seen in 100% of meetings) and, to a lesser extent, youth (seen in 66% of meetings). However, they infrequently (14% of meetings) built strategies on functional strengths (i.e., specific skills, interests, or abilities).
- 4 Outcomes-Based Process.** This domain focuses on creating and monitoring progress toward specific, measurable goals, underlying needs, and the family vision, as well as discussing progress on action steps contributing to each strategy. Care managers adhered to three of the five practice standards in this domain at least 50% of the time, including monitoring progress toward vision (50% of meetings), reviewing progress on action steps since the last meeting (60%), and monitoring progress on meeting needs (85%). One suggestion for improvement is describing goals in specific and measurable terms (observed in only 40% of meetings).
- 5 Skilled Facilitation.** This domain focuses on using practices that promote a positive, focused, and productive meeting process. All practice standards in this domain were observed in at least 50% of meetings. Two standards occurred less frequently, including printing and distributing the needed documents for the meeting (e.g., plan of care or crisis plan) and introducing and then sticking to an agenda (either a verbal summary at the beginning or a hard copy document). However, care managers were observed to excel at dynamically engaging team members in the process and maintaining momentum (81% of meetings) and resolving conflict in ways that ensured all opinions were heard (seen in 91% of meetings where conflict occurred).
- 6 Meeting Attendance.** This domain focuses on whether all relevant team members are attending meetings. This includes: youth, caregivers, school representatives, child welfare, juvenile justice, and other providers (as appropriate or relevant), peer advocates, and natural support people. Youth and caregivers attended almost all meetings (youth at 100%; caregivers at 95%). However, mental health and other providers who were on teams only participated in 41% of meetings and natural supports only participated in 10% of meetings.
- 7 Effective Teamwork.** This domain focuses on team members working to create a single plan of care for participating youth, who are often involved in multiple service systems. It also emphasizes meaningful involvement by all team members in meetings and completion of action steps outside of meetings. Four of the five practice standards were implemented in at least three-quarters of the meetings, including agreeing to importance of a single plan (seen in 81% of meetings), well distributed discussion among team members (90%), team members taking responsibility for tasks (76%), and willingness to compromise when disagreement occurred (81%). The one practice that occurred less frequently, seen in 55% of meetings, was team member follow through since the last meeting. Team member perceptions and data collector observations were not in agreement on this domain, as it was the second-lowest domain on the WFI-EZ, and the only survey domain that had a lower fidelity score (70.9% of total possible fidelity) than the corresponding domain on the TOM 2.0. Although the instruments assess slightly different criteria, the differences in perception may be a fruitful point of discussion in coaching meetings.

Overall

Findings from the fidelity assessment offer several takeaways for wraparound in NYS SOC counties. Domain percentages were lower than national averages on every domain for which national data are available. Because providers are in the early stages of implementation, it is likely that fidelity scores will rise with continued practice. In general, care managers appear to do better with the “soft skills” of wraparound practice (e.g., dynamically engaging team members, ensuring all team members are contributing, assigning tasks, etc.), but could use more assistance with wraparound’s key concepts:

- Underlying needs
- Functional strengths
- Natural and community supports

First, fidelity could be raised by consistently conveying the purpose of the process (i.e., pursuing strategies to address needs); further, needs should be described as underlying difficulties (i.e., beyond surface-level behavioral challenges or symptoms, such as “youth needs to feel like she is a valuable member of her family” or “caregiver needs to know her son is safe”). Second, fidelity could be raised by identifying strengths that are specific skills, interests, and abilities such as “likes music” or “is good with computers” rather than general personality characteristics or attributes such as “compassionate”, “hard-working”, and “organized”. Finally, providers and members of families’ natural support networks should both be involved in the planning and implementation process. Fidelity scores in this area could be raised if providers and natural and community support people (e.g., neighbor, friend, mentor, coach, etc.) were involved in strategies, even if they are unable to attend meetings.

Takeaways:

Strength: Providers have consistently used the “soft skills” (e.g., ensuring discussing is well-distributed, making sure meetings maintain momentum) that promote positive and engaging meetings. These skills are reflective of High Fidelity Wraparound.

Recommendations:

- Articulate needs when discussing strategies and describe needs as underlying difficulties (e.g., “youth needs to feel like she is a valuable member of her family”).
- Identify strengths that are specific skills, interest, and abilities (e.g., “likes music” or “is good with computers”) rather than general personality characteristics or attributes (e.g., “compassionate” or “hard-working”).
- Involve providers and members of families’ natural support networks in the planning and implementation process. Simply asking other providers and natural and community support people (e.g., neighbor, friend, mentor, coach) to assist with strategies (even if they couldn’t come to meetings) would boost fidelity.

Documenting Wraparound

Data Sources:

- Provider interviews

Documentation templates, referred to as a “tracker”, were introduced this year to guide wraparound practice. Care managers completed the tracker, which included sections for crisis plans, plans of care, and transition plans, as well as records for CFTs and other contacts. Peer advocates received templates to record contacts with families.

Providers were motivated to complete documentation but identified several challenges with the current system.

- Documentation demands were high, especially given the combined high volume of demands for HHSC and wraparound, and the inability to use the same documentation for both systems.
- Providers requested additional training and feedback for documentation as they were unsure if they were completing documentation correctly.
- Providers suggested creating a reference guide with specific and detailed guidance to lay out the documentation

process. This could be a portion of the manual as described in the NYS SOC Wraparound Preparation: Training section above. Providers felt the current workbook was not sufficient as a guide for completing paperwork.

- Peers want a method to document effort that did not lead to a contact, (e.g., voicemail messages, canceled meetings, etc.).
- Providers did not like that the CM, FPA, and YPA had documentation in different places, leaving some peers without regular access to the plan of care. Providers felt that all team members should have access to all documentation for a family, not just the care manager.

Takeaways:

Strength: Providers are motivated to complete documentation and are looking for means to improve.

Recommendations:

- Give providers a detailed manual on how to complete documentation.
- Offer providers feedback on their documentation.

Communication

Data Sources:

- Provider interviews
- Non-provider, project staff surveys

Interviewees had several suggestions for improving communication.

- **From the state team:** Providers and administrators desired clearer communication and guidance. Some noted a standard brochure and message to give to families would be helpful in providing clear information. The state team has a project brochure, but some participants are unaware of this brochure or find it does not meet their needs.
- **From the evaluation team:** More frequent feedback and data to allow for mid-course corrections.
- **Triad facilitation team:** According to interviews, some facilitation teams are not regularly communicating with each other when planning for work with the family. One solution might be to create guidelines on expected frequency of communication. It would be beneficial to have at least one triad meeting prior to the first CFT to draft components of the plan of care, and to plan team member contributions. It may also be beneficial to meet prior to each CFT to review the plan of care and brainstorm amongst the triad.
- **Supervisors of facilitation team members:** Supervisors for CM, FPA, and YPA within the county should be a “team” and have regular communication and a consistent message. Some providers noted that supervisors did not provide much feedback, because they had less of an understanding of the NYS wraparound model. This team-based care coordination requires high levels of coordination among the care team, corresponding supervisors, and between supervisors and providers.

Takeaways:

Strength: Providers are highly invested in the wraparound project and want to communicate better.

Recommendations: Suggestions to improve communication include:

- Modifying the state’s wraparound brochure to meet the needs of all teams.
- Creating guidelines or schedules to increase frequency of facilitation team discussions.
- Encouraging supervisors to meet more frequently to develop consistent messaging.

CONCLUSION

To summarize the major findings across topic areas, boxes are provided below that include all strengths and recommendations included in the report.

Strengths:

- The triad facilitation team is a major strength of the NYS wraparound process. Peers are recognized as indispensable assets, especially in the critical engagement phase of rapport building and information gathering.
- FPAs in all the participating counties are trying to incorporate Health Habitus into their wraparound work.
- The majority of Medicaid youth in this project were also enrolled in HHSC.
- Providers enjoyed training and felt it was an important support for providing wraparound.
- Coaching was the most helpful support for providers in practicing wraparound.
- Peers who come into the role with prior peer advocate experience seem to be well-prepared for their role in wraparound.
- Some providers, mostly YPAs, felt the right families are being served and felt that the intense process of wraparound is appropriate for the high needs youth they are working with. Providers are learning the nuance of what a successful family in wraparound looks like.
- Counties participating in the project longer are close to or meeting the full caseload.
- Providers are focusing on thorough engagement with families and are working to meet the timely engagement standards created by NWI.
- Providers have consistently used the “soft skills” (e.g., ensuring discussing is well-distributed, making sure meetings maintain momentum) that promote positive and engaging meetings. These skills are reflective of High Fidelity Wraparound.
- Providers are motivated to complete documentation and are looking for means to improve.
- Providers are highly invested in wraparound and want to communicate better.

Recommendations:

Triad Facilitation Team

- Clarify each member’s role in the triad facilitation team.
- Address potential hierarchies.
- Provide space for open and honest discussions of difficulties.
- Stick to a plan to meet regularly.

Health Habitus

- Provide county administrators with additional information describing Health Habitus and its value within wraparound.
- Provide FPAs with additional assistance in documenting Health Habitus.
- Offer YPAs additional practice and encouragement to begin using the Health Habitus strategy in their work.

Health Homes Serving Children

- Provide more education for both providers and families to understand the HHSC program.
- Explore adjusting language to fulfill the requirements for both HHSC and NYS SOC to limit documentation burden for CMs.

Training

- Adjust training structure so that families are enrolled at a later stage of training.
- Provide documentation training earlier on.
- Revise training manual for efficient use as a reference after training.
- Create trainings and other resources for non-provider audiences, particularly for supervisors, and consider alternatives to full trainings.
- Cover additional topics in training (e.g., HHSC).

Coaching

- Provide upfront information and standards on the format, structure, and regularity of coaching.
- Consider inviting supervisors on coaching calls (especially group calls) to ensure teams are on the same page.

Additional Preparation for Peer Advocates without Experience

- Provide peers with an additional suite of trainings focusing on mental health and systems knowledge, professional behavior, and boundaries.

Identifying Families Who Will Thrive in Wraparound

- Focus more on selecting families that currently have multiple plans of care due to multi-systems involvement (e.g., mental health and juvenile justice).
- Provide thorough information up front about the requirements of the wraparound process (e.g., time, effort, vulnerability).

Challenges with Reaching and Maintaining a Full Caseload

- Set a caseload range goal, e.g., a minimum of 10 and maximum of 12, with instructions to keep within this range.
- Reconfigure training to include more online and classroom sessions earlier on, so that full enrollment can begin sooner.
- Improvements in family selection may lead to increased tenure in the program and lead to better caseload maintenance.

Meeting Wraparound Timeliness Standards

- Start tasks during the engagement phase while understanding these tasks will be completed during a later phase.
- Consider training providers to use action steps that can reasonably be accomplished in 30 days.
- Consider emphasizing the concept that plans of care are “living” documents during training and coaching. Providers may thereby feel less stuck by the desire to create the perfect plan of care before getting started.

Practice Fidelity to the National Standards

- Articulate needs when discussing strategies and describe needs as underlying difficulties (e.g., “youth needs to feel like she is a valuable member of her family”).
- Identify strengths that are specific skills, interest, and abilities (e.g., “likes music” or “is good with computers”) rather than general personality characteristics or attributes (e.g., “compassionate” or “hard-working”).
- Involve providers and members of families’ natural support networks in the planning and implementation process. Simply asking other providers and natural and community support people (e.g., neighbor, friend, mentor, coach) to assist with strategies (even if they couldn’t come to meetings) would boost fidelity.

Documenting Wraparound

- Give providers a detailed manual on how to complete documentation.
- Offer providers feedback on their documentation.

Communication

- Modify the state’s wraparound brochure to meet the needs of all programs.
- Create guidelines or schedules to increase frequency of facilitation team discussions.
- Encourage supervisors to meet more frequently to develop consistent messaging.

Appendix:

Overview of Methods Included

DESCRIPTION OF METHODS

Administrative records

Administrative records are completed by service providers for every family at baseline, 6-month reassessments, and discharge. Both SAMHSA and the Children's Mental Health Initiative (CMHI) require that this information is collected on every participant at every time point, using the NOMs Child Client-Level Services Measure (NOMs) and the Child and Family Outcomes Study (CFOS). These records include demographic characteristics, services received, agency and systems involvement, insurance, and youth diagnosis(es). NOMs data is entered into the SPARS data system and CFOS is entered into the CMHI Portal. The evaluation team also added questions to the administrative record to capture more information about the wraparound process. This information is entered into the Survey Monkey data system. The evaluation team collects the administrative records from the providers and then notifies the on-site data collectors about pursuing interviews with the family.

Youth and family interviews

Interviews are offered to both the youth and caregiver by the data collector at baseline, 6-month reassessments, and discharge. If a youth and/or caregiver choose to participate, the data collector will schedule a date, time, and location to meet that is convenient for the family. On the day of the interview, the data collector reviews the consent process, completes the interview, and gives a \$20 gift card to each participant. The youth and caregiver each receive an incentive for every interview they complete while enrolled in the project.

The interview protocol includes the federally mandated measures, NOMs and CFOS. NOMs asks questions on functioning, housing, education, perception of care, social connectedness, and services information. CFOS includes family and living arrangements, Caregiver Strain Questionnaire, Columbia Impairment Scale, and the Pediatric Symptoms Checklist. The evaluation team added other measures to this protocol in order to collect more information regarding the family's experiences with the services they received. These questions include the Family Empowerment Scale, Youth Empowerment Scale, Children's Hope Scale, Family Peer Advocate Tool, Youth Peer Advocate Tool, and Wrap-around Items. This information is entered into the Qualtrics data system.

Fidelity assessments

In addition to interviews, families have the opportunity to participate in the fidelity components of the evaluation. The fidelity assessments are used to measure the extent to which practice reflects the wraparound model and includes observation of a team meeting, a survey, and document review.

Observation and survey fidelity assessments are offered to families at the 3rd team meeting. If the 3rd team meeting is not possible, data collectors have until 6 months post-enrollment to do the observation and administer surveys. Observations help inform how well teams are working together toward the family's goals and surveys allow families to give feedback on their service experiences. Data collectors coordinate with care managers about the date, time, location, and team attendees of the team meeting.

On the day of the team meeting, the data collector reviews the consent process with the family and team. In addition to the in-person observation by the data collector, families are given the option to have their team meeting video-recorded. All team members must consent in order for the data collector to observe the meeting. Data collectors use the Team Observation Measure (TOM 2.0) to score and record notes. The TOM 2.0 looks at the following elements of the team meeting: full meeting attendance, effective teamwork, strengths and family driven, based on priority needs, use of natural and community supports, outcomes, and skilled facilitation. The evaluation team double-codes video-recorded meetings to discuss discrepancies and reconcile scores. TOM 2.0 data is entered into WrapTrack.

At the end of the meeting, data collectors administer the Wraparound Fidelity Index EZ (WFI-EZ) surveys to all team members. Surveys are specific to the respondent, including youth, caregiver, facilitator, and team member versions of the WFI-EZ. Questions on the survey ask about basic wraparound information, the respondent's experiences in wraparound, and their satisfaction with the wraparound process. Data collectors collect the surveys when completed and enter data into WrapTrack.

When a family has discharged from services and the case has closed, a full document review is conducted using the Document Assessment and Review Tool (DART). At least 2 team meetings had to have occurred in order to complete a DART review. Data sources, such as Fidelity EHR, trackers, peer notes, and team meeting notes/agendas are used to score the DART. The DART looks at timely engagement, wraparound model key elements (driven by strengths and families, natural and community supports, needs-based, and outcomes-based process), safety planning, crisis response, transition planning, and outcomes. The evaluation team double-coded DARTs to ensure scoring consistency and entered data into an Excel spreadsheet.

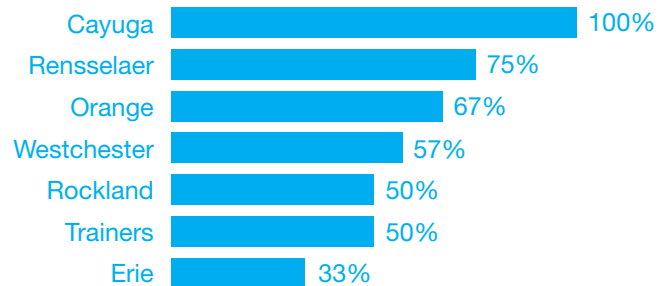
The fidelity assessment included 21 families, including 13 from Erie, four from Rensselaer, three from Westchester, and one from Rockland. Findings are primarily based on data from one of the three Wraparound Evaluation and Research Team's (WERT) fidelity assessment instruments CHSR employs for fidelity assessment, the Team Observation Measure 2.0 (TOM 2.0). At the time of analysis, responses to the fidelity assessment survey, the Wraparound Fidelity Index EZ (WFI-EZ), were available for only five wraparound teams outside of Erie County, including four from Rensselaer and one from Westchester. Thus, because survey data were limited, responses were examined impressionistically to identify possible areas of convergence with observation data (e.g., similar areas of strength/improvement). Data from non-Erie counties were also insufficient to use WERT's Document Assessment and Review Tool (DART), so document review data are excluded from this report ¹.

Administrator's survey

The evaluation team created a survey for administrators to complete as a complement to the annual provider interviews. Survey items addressed similar topics as the provider interviews, leaving out items reflective of direct service. Topics covered include: features of wraparound, reaching the "right" families, integration of wraparound into HHSC, areas of success, and areas needing improvement.

A survey was administered online via Qualtrics to county administrators and training staff that was available to complete between 8/22/2018-9/22/2018. Representatives from Westchester, Erie, Orange, Rockland, Cayuga, and Rensselaer counties were invited to the survey. Thirty people were invited to complete the survey, and 17 provided responses, giving an overall 57% response rate. Respondents are represented from each of the counties, and the training team.

Survey Response Rates (N=17)



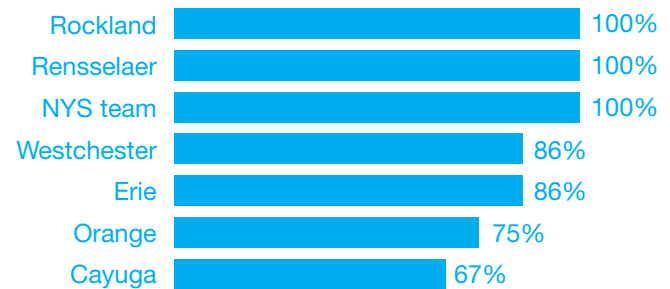
Provider interviews

The evaluation team created interview questions for care managers, family peer advocates, and youth peer advocates to complete regarding the planning and implementation of NYS wraparound model during Year 2. In addition to the topics included in the administrator's survey, the provider interviews focused on the successes and challenges of serving families in their role under the NYS wraparound model.

¹ Erie County received a separate report which included document review data. Readers of this report who wish to see Erie County's document review findings will be provided a copy of the Erie report upon request. Additionally, Rensselaer and Westchester Counties have received research briefs ("WrapStats") with document reviews that were based on an adaptation of the DART. CHSR will continue to update these briefs for these counties, and will provide document review briefs for Rockland County; Orange County will also receive a review once enrollment increases and documentation is available for more families.

The evaluation team conducted interviews with providers between 8/23/2018-10/9/2018, using the GoToMeeting platform. This allowed interviews to be audio-recorded, with permission of the interviewee, in addition to notes being taken simultaneously by the evaluation team. Representatives from Cayuga, Erie, Orange, Rensselaer, Rockland, and Westchester counties were invited to complete an interview. 26 out of the 30 people invited completed an interview, giving an overall 87% response rate. Respondents are represented from each of the counties and the NYS team.

Interview Response Rates (N=26)



County monthly reports

Each month, the evaluation team collects information from county representatives regarding activity for that month. A survey is administered online via Qualtrics to the county lead, CM supervisor, FPA supervisor, and YPA supervisor. Information on staffing, training, caseload, flex funds, challenges and successes of implementation, and policy changes, are included in the survey. The evaluation team compiles this information and reports out to the project directors each month. During Year 2, Chautauqua, Cayuga, Erie, Orange, Rockland, Rensselaer, and Westchester counties completed monthly reports.

Case Notes

Peer notes are recorded after peers have interactions with family members or staff. On a monthly basis, the peer notes are uploaded onto HCS. During Year 2, 533 peer notes were uploaded by providers and recorded and coded by the evaluation team. Between January and September 2018, peer notes were completed on 55 cases by 14 peers, 8 FPAs (57%) and 6 YPAs (43%). These include notes from all counties except for Erie (i.e., Westchester, Rensselaer, Cayuga, Orange, and Rockland).

Care managers complete trackers which document the elements of wraparound implementation. Information on the trackers include timely engagement dates, crisis plan, family narrative, team members, team attendance, team mission and ground rules, plan of care, transition plan, meeting minutes, and contact notes. Care managers uploaded trackers onto HCS. During Year 2, Cayuga, Orange, Rensselaer, Rockland, and Westchester counties completed trackers. Erie County used Fidelity EHR to document activity on their cases.

Cohesion Surveys

Cohesion surveys were comprised of 25 Likert-style items asking about a variety of processes reflective of team cohesion (i.e., how well individuals worked together toward a common goal). Surveys also included three open-ended items asking respondents to provide descriptions about what it looked like when their teams a) worked well together, b) didn't work well together, and c) suggestions for improving cohesion. Surveys were administered with training surveys to upstate and downstate counties during their training cycles after their fourth and final training sessions. The number of respondents to these surveys was insufficient to conduct a formal quantitative analysis; open-ended responses were examined by question type to identify common responses reflecting facilitators, barriers, and improvements for team cohesion.

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