'20

YEAR THREE

New York State System of Care Wraparound Evaluation Report

Center for Human Services Research
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Table of Contents

Introduction **3**
- Introduction to the NYS SOC Pilot Implementation 3
- Improving SOC Statewide: Changes in Implementation Over Grant Period 3
- NYS SOC High Fidelity Wraparound Pilot 4
- CHSR data collection and evaluation activities 6
- Data Sources 7

Section I: System of Care Development **9**
- Current Implementation 9
- Current Findings 10
- Potential Next Steps 12

Section II: Training and Workforce Development **14**
- Current Implementation 14
- Current Findings 15
- Potential Next Steps 18

Section III: Fidelity to High Fidelity Wraparound Model **19**
- Current Findings 19
- Potential Next Steps 28

Section IV: Family Success **29**
- Current Findings 29
- Potential Next Steps 32

Section V: Health Habitus Integration Training for High Fidelity Wraparound Teams **33**
- The Social Determinants of Health framework and the Health Lifestyle Theory 33
- Elements of the Cultural and Structural Competence (CSC) training 34
- Mixed Methods Evaluation of CSC Training 35
- Preliminary Data Summary and Next Steps 38

Section VI: Cross-Cutting Themes and Conclusions **39**

References **42**

Appendix: Table of Data Sources used in Report **43**

INTRODUCTION TO NYS SOC PILOT IMPLEMENTATION

This report focuses on the evaluation of the implementation of the New York State System of Care Expansion project in the first three years of the four-year grant. Current data and evaluation findings across the project are included and discussed, and potential next steps and conclusions are provided.

The Substance Abuse and Mental Health Services Administration (SAMHSA) funds the System of Care (SOC) Expansion Grant. The grant supports the implementation, expansion, and integration of the SOC approach through the creation of infrastructure and services, with the goal of improving mental health outcomes for children and youth with mental health challenges. A System of Care is defined as "a coordinated network of community-based services and supports organized to meet the challenges of children and youth and their families" (Burwell, Enomoto, et al., 2015). The New York State (NYS) Office of Mental Health (OMH) received the current SOC expansion grant in October 2016, and has since focused the majority of its activities in two areas: 1) the strengthening of the NYS Children's System using the Systems of Care framework through broad efforts as well as county-specific attention, and (2) creating and operating a NYS SOC High Fidelity Wraparound Pilot within Health Homes Serving Children (HHSC) for youth and young adults with severe mental health needs.

IMPROVING SOC STATEWIDE: CHANGES IN IMPLEMENTATION OVER GRANT PERIOD

Effort toward meeting these two grant goals has evolved over the past three years. Broadly, efforts around improving the Children's System statewide have used the SOC framework to focus on relationship-building, the dissemination of SOC information, and local SOC assessment and capacity building.

STATE EFFORTS TOWARD SOC IMPLEMENTATION

Infrastructure, Development, Prevention and Mental Health Promotion (IPP) data collected from county representatives and the State Team on infrastructure activities, policy development, and organizational partnerships aimed at integrating the SOC framework statewide were used to determine shifts over the grant period. Changes that were reflective of SOC development and implementation are summarized here.

Building relationships with key partners is an important component of the SOC approach. Throughout this project, policies and agreements were established or adjusted between counties and community organizations to facilitate greater collaboration by streamlining referral and enrollment processes, facilitating workflow, and discussing areas of challenge and confusion. Efforts to integrate the SOC framework within schools in particular was evidenced by collaborations on both the state and county level. NYS OMH partnered with NYS Department of Education to work on Project AWARE, a program aimed at promoting the healthy development of school-aged youth and preventing youth violence by focusing on building partnerships and expanding collaboration between state and local systems; this work was funded by a separate SAMHSA grant. School districts in one county also added policies on "how to use SOC" to their handbooks. The Project Director has also delivered an introductory "SOC 101" presentation to many of the Project AWARE sites, thus strengthening SOC knowledge in schools.

NYS OMH also began to internally manage Regional Interagency Technical Assistance Teams' (RiTAT) activities to tie them more closely to SOC efforts statewide. RiTATs are comprised of state regional representatives from different state agencies that help support cross-systems work throughout NYS: they act as liaisons between stakeholders, identify and address regional barriers, provide cross-systems training and technical assistance on local and regional levels, and promote services that are reflective of SOC values.

SOC INFORMATION DISSEMINATION

An important resource for local SOC development is the availability of information about SOCs. The project uses multiple methods to distribute SOC information. The NYS Systems of Care Pilot & Wraparound Training Institute

Monthly Update e-mail relays current information on the NYS SOC, including updates on the SOC Affinity group, the SOC Virtual Learning Collaborative, Social Marketing, Evaluation, and the Wraparound Training and Implementation Institute (WTII). This newsletter was first implemented in November 2017. The SOC Virtual Learning Collaborative presents webinars to the full NYS SOC community on a quarterly basis. This series began in January 2019 and highlights SOC topics such as "Family and Youth Voice in System of Care Governance" and "County activities since the SOC Summit."

LOCAL SOC ASSESSMENT & CAPACITY BUILDING

Efforts were made to increase counties' capacities to expand their own local SOCs. In late 2017 and early 2018, the marketing firm Overit Media, LLC (Overit) began creating SOC materials for the statewide promotion of SOC values and principles that could be personalized for county use. Overit distributed marketing toolkits to four local communities to use in promotion, staff recruitment, and/or education in September 2018.

The NYS SOC Summit was also held in September 2018. This event focused on sharing information on SOC and served as a venue for county-wide SOC development and planning. The Summit was also a forum for representatives across the state to make recommendations to enhance the statewide SOC; these recommendations informed several Year Three grant activities. First, a state-level Cross-Systems SOC Subcommittee was formed in December 2018; it was designed to work collaboratively to respond to the county/regional recommendations resulting from the 2018 NYS SOC Summit to strengthen the statewide SOC. Further, in January 2019, baseline SOC implementation was assessed statewide through a survey (see Section I for some key findings from this survey). The subsequent report helped counties to determine their level of SOC implementation both in an absolute sense, as well as compared to other counties in NYS. A follow-up assessment is planned for Year Four.

Another activity resulting from the Summit was the creation of a standardized "SOC 101" training in February 2019. The project director delivered this training to six groups in Year Three. An additional standardized SOC 201 training, targeted at county governance's efforts to assess SOC implementation and sustainability, was released in March 2019. These trainings included a facilitator guide and a slide deck; these materials were expected to be used by county staff to hold local SOC presentations and conversations.

At the end of Year Three, Policy Research Associates designed a curriculum to be used in local SOC planning efforts. The curriculum is based on the Sequential Intercept Model, originally developed to help communities map the flow of children and services and supports within the juvenile justice system. Within the SOC framework, the goals of these workshops are to bring together high-level system stakeholders to understand the flow of children through various child-serving systems, while identifying strengths and gaps in the systems and network. This curriculum is designed for local facilitators to plan and implement SOC workshops in their communities. Facilitator training and local implementation will be piloted in Year Four of the project.

The ideas gathered at the Summit also led to the delivery of local SOC technical assistance by the Project Director. This assistance began in April 2019 and was delivered to Essex and Yates counties, with the goal of supporting them as they build their local SOC capacity. In Year Four, Rockland County will also receive local SOC technical assistance. Finally, as of September 2019, C-SPOAs began acting as coordinators of their local SOCs (see Section I for more detail). This shift will contribute to having a consistent point of contact and local lead for future SOC opportunities throughout the state.

NYS SOC HIGH FIDELITY WRAPAROUND PILOT

Another portion of NYS' activities focus on implementing a pilot of High Fidelity Wraparound (HFW). HFW is an intense form of team-based care coordination that is designed for youth with complex mental health needs and their families and represents an individualized way a community can implement SOC values in their care coordination. The National Wraparound Initiative's (NWI) High Fidelity Wraparound is the model which guides HFW providers' efforts. Several changes in the practice and training have taken place over the course of implementation.

SERVICE POPULATION

The pilot has expanded rapidly over the duration of the grant. Wraparound was initially implemented in four agencies across three pilot counties, and is currently being implemented in 15 agencies across 14 counties, and two RTF providers. The first youth and family was enrolled in HFW in April 2017; 192 families were enrolled by the end of Year Three. Initially, HFW delivery was restricted to those not already served through Waiver, but in July 2018, HFW was expanded to families that were eligible for waiver services. In June 2019, the population served by HFW expanded again to include youth in Residential Treatment Facilities (RTFs). As of the end of Year Three, NYS SOC HFW is currently delivered throughout the Central, Hudson River, and New York City regions (NYS OMH regions). Expansion to additional OMH regions is expected over Year Four.

PRACTICE

Several practice changes have been integral in the delivery of HFW. Sites were provided an initial “monitoring tool” in the winter of 2018. In September 2018, the HFW delivery method formally shifted away from a “triad” facilitation model, with shared facilitation between the care manager, youth peer support service provider, and family peer support service provider, to one with the care manager as the team facilitator and peer support service providers as facilitation team members.

Care managers also began using a website (WRAP-NY) in November 2018 to document their wraparound work. This system helps service providers organize needed information to carry out the HFW process. The centralization of HFW documentation is also beneficial for evaluation and coaching.

TRAINING

Work on the six-month comprehensive NYS SOC Wraparound Certification Training for care managers and supervisors began in April 2017; training for the first cohort began in November 2017. While there were some shifts in training protocols over the initial three years of the project (see Section III for more information), five cohorts from four OMH regions have so far received the complete HFW training; a fifth region (Long Island) will begin early in Year Four. OMH Certification requirements were created to accompany this training to increase and refine the HFW skills learned in training for care managers.

The Wraparound Training and Implementation Institute (WTII) also created and piloted an additional training to help support peers in serving families involved with HFW. The three-session Wraparound Peer Readiness and Implementation Training began in February 2019, and by the end of Year Three had been completely piloted in three cohorts and started in a fourth. In Year Four, one cohort will complete the pilot training, and Regional Parent Advisors and Regional Youth Partners will be trained to teach the material and will begin to deliver the peer training across the state. The transfer of training to the Regional Partners will increase the reach and the sustainability of the training.

Ten standalone Cultural and Structural Competence (CSC) trainings have also been conducted by the Center for Research on Cultural and Structural Equity in Behavioral Health (C-CASE) at the Nathan Kline Institute for Psychiatric Research (NKI), with more planned through Year Four; the last seven of these trainings are reported on in the report.

The Wrapaganza event held in August 2019 served as a celebration of SOC and HFW practices as well as a learning and networking opportunity for the NYS SOC HFW providers.

TIMELINE

The timeline below is a visual representation of the highlights of SOC expansion and the HFW pilot across the first three years of the grant.

Year 1	
Quarter 1 (Oct. 2016 – Dec. 2016)	• SOC Expansion grant received
Quarter 2 (Jan. 2017 – March 2017)	• Initial meetings with sites, partners, and cross-systems committees held • Enrollment and evaluation protocols finalized
Quarter 3 (April 2017 – June 2017)	• Youth enrollment initiated
Quarter 4 (July 2017 – Sept. 2017)	• Wraparound Training and Implementation Institute established
Year 2	
Quarter 1 (Oct. 2017 – Dec. 2017)	• Wraparound Certification Training started • NYS SOC Pilot and Wraparound Training Institute monthly update started
Quarter 2 (Jan. 2018 – March 2018)	• Monitoring tool for the initial pilot sites released
Quarter 3 (April 2018 – June 2018)	• Service population expanded to Waiver
Quarter 4 (July 2018 – Sept. 2018)	• NYS SOC Summit held • SOC Social Marketing Toolkits delivered • Team structure shifted from triad model to care manager-lead model, with peer support service providers as team members
Year 3	
Quarter 1 (Oct. 2018 – Dec. 2018)	• Collaboration with Project AWARE began • WRAP-NY System website introduced • State-level Cross-systems SOC Subcommittee formed
Quarter 2 (Jan. 2019 – March 2019)	• NYS SOC Implementation Survey conducted • Wraparound Readiness Training for Peers started • SOC 101 and SOC 201 created
Quarter 3 (April 2019 – June 2019)	• Service population expanded to RTFs • Beginning of local SOC technical assistance provision from SOC Project Director
Quarter 4 (July 2019 – Sept. 2019)	• Wrapaganza held • C-SPOA coordinating role in SOC introduced

CHSR DATA COLLECTION AND EVALUATION ACTIVITIES

An organizing framework guides the evaluation activities of the Center for Human Services Research (CHSR) on the NYS SOC project. It is organized around NYS SOC's ultimate aim of identifying resources and strategies that improve the lives of families with complex needs. This framework emerged through an evaluation discussion between CHSR researchers, NKI researchers, and OMH SOC leaders.

The goal of the evaluation is to determine statewide progress toward enhancing SOC and HFW implementation and identify the approaches that work best for different families under different circumstances. The evaluation framework includes four focus areas:

1. **Systems of Care Development:** Identify organizational strategies that lead to the successful adoption of Systems of Care and HFW philosophies and practices.
2. **Training and Workforce Development:** Identify resources and strategies that support the development of an effective workforce.

3. **High Fidelity Wraparound Practice:** Identify the most effective HFW practices that lead to improvement of families' lives.
4. **Family Success:** Identify family/youth characteristics that are associated with attaining particular markers of success.

This report is primarily structured to convey evaluation findings within each focus area, allowing for themes and ideas common across data sources to be identified. Each section will note major changes within the area over the implementation period, current findings, and potential next steps. In addition, current findings from NKI's Cultural and Structural Competence trainings are included as a chapter.

DATA SOURCES

This report incorporates data from many different sources, as listed below. A more detailed description, including number of available datapoints, is available in Appendix A. Data sources include data collected through Year Three of the project, unless otherwise specified.

- **Administrative records:** Administrative records collect some data on every family. They are completed by the wraparound team using records data at baseline, six-month reassessment intervals, and discharge.
- **CANS-NY:** The CANS-NY is an assessment tool completed by the care manager with the family. It identifies needs and strengths of the youth (primarily) and caregiver in various health and functioning domains. This tool is completed at baseline, reassessments, and discharge, so changes over time can be reviewed.
- **Cohesion surveys:** Cohesion surveys are collected from care managers, youth peers, and family peers to understand how they function as a team. These data are collected once at the end of training.
- **Cultural and Structural Competence training surveys:** Same-day evaluation surveys are distributed by NKI to all participants at the end of each training to assess training experience and health habitus-related knowledge. Follow-up surveys are distributed at least three months after training to assess health habitus-related knowledge, attitudes, and practice since training. Qualitative interviews to contextualize information related to the utility and implementation of this training are underway but data are not included in this report.
- **Fidelity assessments - observation and surveys:** Observation (TOM 2.0) and survey (WFI-EZ) fidelity assessments are offered to families from the third through the seventh team meeting. These tools measure the extent to which practice reflects the HFW model.
- **Fidelity assessments - documentation review:** Documentation review is conducted using the documentation available in the WRAP-NY system website. Two review types are currently in use: the 45-Day Review and the 2nd CFTM Review. These tools measure the extent to which practice reflects the HFW model.
- **Infrastructure, Development, Prevention and Mental Health Promotion (IPP) data collection:** Data is collected monthly from project leads to document SOC infrastructure changes, including policy changes, and formal collaborations.
- **Interviews with youth and family:** The opportunity to participate in evaluation interviews is offered to each participating family (youth and caregiver, or young adult) at baseline, six-month reassessment intervals, and discharge. These interviews include assessments of functioning, social support, empowerment, hope, and satisfaction. The SAMHSA-required National Outcome Measures (NOMS) are part of these interviews.
- **Local SOC toolkit use reports:** Reports on use of Social Marketing Toolkits in Year Three were collected by OMH. Responses are from Year Three.
- **Provider interviews & administrator surveys:** Interviews with wraparound providers (care managers and peer support service 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. The administrator 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. Interviews and surveys from Year Three are included.

- **NYS SOC Wraparound Certification training surveys:** Training surveys are collected from attendees following each session. This survey solicits feedback on training style/format, segment specific impression, knowledge acquisition, and overall impression.
- **SOC Implementation Survey:** The SOC Implementation Survey provided a baseline assessment of current SOC implementation at the local level. The survey was completed by individuals identified as important to the local SOC by the SPOA and/or local lead contact. Data from Year Three are included.
- **Wrapaganza survey:** The Wrapaganza survey was administered following the event to collect feedback on the event and current Wraparound implementation. Responses from Year Three are included.
- **Wraparound Peer Readiness and Implementation Training surveys:** Training surveys are collected from attendees following each session. This survey solicits feedback on basic impressions of the training.

Section I: System of Care Development

Although individual communities across the state have received support from SAMHSA to build and expand SOCs for many years, this grant represents the first time this support has been awarded to New York State as a whole. NYS now has a unique opportunity to build up the use of HFW within the infrastructure already created for Health Homes Serving Children (HHSC). In order to expand the use of the SOC philosophy across NYS, the development of extensive infrastructure and ongoing support is necessary to expand and sustain the use of SOC philosophy over the course of the grant and beyond. This coordination requires extra effort but presents the opportunity for the sustainability of HFW far beyond the life of the grant.

As such, the goal of this aspect of the evaluation is to identify organizational strategies that lead to the successful adoption of SOC and HFW philosophies and practices in NYS. Changes in implementation over the past several years are outlined, and current findings on SOC development and implementation are reported, including data from Year Three provider interviews, the statewide SOC implementation survey, 2019 Wrapaganza survey, and Social Marketing Toolkit feedback.

CURRENT IMPLEMENTATION

Medicaid Claiming

Year Three saw significant state-level changes to Medicaid claiming and reimbursement. Peer support services became Medicaid-reimbursable. Waiver was also incorporated into HHSC.

More recent changes have redefined the role of counties' Children's Single Point of Access (C-SPOAs). During Year Three, NYS received approval to amend New York's Medicaid 1915(c) Home and Community Based Services (HCBS) Children's Waivers. As a result of this change, the Children and Youth Evaluation Service (C-YES) was created for child assessment and determination of needed HCBS level of care. This shift means that counties' C-SPOAs are no longer responsible for this evaluation, so cannot claim for these activities. Instead, C-SPOAs are now the coordinating groups for the development and maintenance of the SOC framework, thus bringing together the various child-serving agencies within each county. Implementation of this new division of responsibilities is expected to take shape over Year Four.

Social Marketing Toolkit Implementation

NYS OMH launched several Social Marketing Toolkits at the beginning of Year Three for local communities to use in promotion, peer staff recruitment, and/or education regarding SOC and Health Homes. Entities were also provided the opportunity to apply to have the materials personalized for their own use in planned marketing or outreach campaigns in 2019. Year Three saw a review of the first year of implementation of these materials.

Thirteen entities submitted reports on their marketing activities from January to June 2019 across their campaign foci. Respondents were from Central New York, New York City, Long Island, and the Lower Hudson River regions. Most agencies aimed to reach community providers and stakeholders; most focused on distributing information about Health Home Care Management. Agencies expressed a desire to increase awareness of SOC, educate individuals about the different programs offered, and expand their reach through community partners and client referrals. The materials were used at different types of events (e.g., presentations to stakeholders, school fairs, conferences, client outreach) and electronically through email and agencies' websites. Varying levels of staff (line staff, middle management, executives) all reported using the tools.

Entities typically used two different marketing tools. All tools were used by at least one agency; the most frequently used were palm cards (see **Table 1**). Entities reported that the toolkits were simple, engaging, and easy to distribute, and that they gave a great overview of the different campaign foci. Barriers to use included hesitant families (e.g.,

undocumented families), scheduling, difficulties with comprehension of the tools, late access to the kits, and lack of workforce to implement the tools. Interestingly, these products were developed to be used by local communities; however, they may not be as helpful in actuality if there are not staff available to present them.

Generally, though, the agencies who reported on their use of these toolkits were able to reach some of their goals and achieve the behavioral changes they wished to see. They reported increases in referral rates, SOC awareness, community partnerships, and connection to existing clients as a result of using these materials. The toolkits were actually so successful that agencies asked for additional technical assistance in producing more marketing tools.

Table 1. SOC Social Marketing Toolkit materials use, in descending order of frequency.

Marketing Tool	N Entities Using
Palm cards	8
Short video	6
FAQ sheet	6
Poster	4
Long video	3
Display ad	1
Infographic	1

CURRENT FINDINGS

SOC Implementation Survey: Key Results

In the winter of 2019, CHSR surveyed individuals across NYS who were involved in at least one county's SOC. The Rating Tool for Implementation of the System of Care Approach for Children, Youth, and Young Adults with Behavioral Health Challenges and Their Families (revised 2015) was implemented. This instrument is widely used in SOC implementation evaluation, and is designed to "…assess progress in a community or region implementing the system of care approach for children, youth, and young adults with behavioral health challenges and their families." As such, it represents a direct tool for measuring progress in specific components of SOC implementation. Several key findings are presented here; full analyses and results can be found in the 2019 "*System of Care Implementation in New York State*" report.

Nine hundred thirty individuals, representing in 51 Upstate New York communities, responded to the survey. Most worked in the mental health, social service, school, or care management agencies.

While many respondents reported understanding the SOC and HFW approaches, many did not know if their county was prioritizing or implementing either approach. Also, most did not know if their community had a strategic plan for SOC implementation. Further, only about one-third of respondents reported that the SOC approach was currently being implemented "substantially" or "extensively" in their community. As such, strengthening of SOC implementation efforts, or at least improvements to the marketing and communication of ongoing work, may be needed. Mental health and direct service providers (e.g., care managers, youth and family leaders) were perceived to have the highest commitment to the SOC philosophy, as compared to other child-serving systems, indicating strong provider agency commitment to SOC efforts.

Respondents were also asked to evaluate the extent to which service delivery was guided by SOC values and principles in nine domains. On average, the greatest strengths were found for implementation of family-driven and least restrictive approaches; the greatest challenges were seen in implementing youth-guided approaches, cultural and linguistic competence, and access to the necessary array of services. The availability of home- and community-based and out-of-home (residential) support services, and/or their appropriate use, was also reported to be a challenge, with half of respondents noting almost all services to be less than moderately or mostly available and appropriately used. Therefore, service availability, or knowledge of available services, may be a barrier for SOC implementation. And exempting defined entry points, less than one-quarter of respondents indicated that the various components of SOC infrastructure were at least substantially implemented. The best candidates for additional technical assistance included processes for strategic communications or social marketing, financing, and management of care and costs for high-need populations.

However, there was also high variability in responses by region (or county), and by respondents' service system. Long Island and counties with SOC pilot sites had higher scores in nearly all domains, consistent with more developed SOC implementation in these areas. And care coordination-related service systems (e.g., health homes, care management

agencies, family peer groups, SPOAs) had notably high ratings in many domains, potentially because of the common values between the systems; less-connected child-serving systems (e.g., probation, schools, physical health agencies) generally had lower scores.

There was an especially high rate of "don't know" responses through the survey; this pattern could reflect either entries from respondents who were less knowledgeable about their county's child-serving systems, or a need for improved statewide communication around SOC for improved awareness of current activities.

CHSR will repeat this survey in the winter of 2020 to examine any changes in responses over the year interval. Implementation is hoped to have advanced over the period, both from additional growth within counties and in response to the additional efforts implemented by the State team over the past year. As such, scores are expected to improve, with higher ratings of knowledge of SOC implementation work, service delivery being guided by SOC principles, availability and appropriate use of services, and SOC infrastructure implementation.

Wrapaganza Survey Results

The 2019 Wrapaganza Celebration survey included several questions on attendee's satisfaction with current SOC implementation support, benefits and challenges of the SOC/HFW model, and any ongoing needs. Key findings are summarized here; full analyses and results can be found in the 2019 "*Wrapaganza Celebration Survey Results*" report.

Overall, about two-thirds of respondents reported being satisfied with the implementation support they were receiving from the State Team. A total of 46 HFW providers and county administrators noted at least one benefit of SOC/HFW; most (over three-quarters) felt that the emphasis on family voice and choice, and the inclusion of peers, were particular benefits. These results are consistent with the broader SOC implementation survey finding that respondents felt that service delivery was family-driven, and that direct service providers (particularly peers) were highly committed to SOC. Further, over half felt that SOC/HFW had increased cross-agency communication or improved child outcomes. Frequently noted challenges included documentation issues (particularly as related to dual-documentation requirements), family confusion about models, inclusion of natural and community supports, identification of appropriate families, and pressures from national timeframe expectations or standards. These topics are strong candidates for state technical assistance.

Interview Data

Interviewed providers also spoke about some of the organizational contributions to HFW implementation across the past few years. Part of the Year Three interviews with HFW providers focused on whether and how their organizations and agencies were supportive of the HFW process. Most providers felt supported by their organizations in providing HFW; these interviewees valued the trust, communication, and team support that their local administrators provided. As two care managers explained:

> *"Yes, 100%... we are very fortunate that we can bounce ideas off each other; not only care managers, [county administrators/leaders] are there… we are free to talk with her about any concerns we have… we are in constant communication. I know a lot of other agencies do not have these things."* – Care Manager

> *"I feel like they trust me to do what I was taught to do. They sent me as a rep of the agency to do what I need to do."* – Care Manager

Providers mentioned several ways that organizational support for their HFW work could be improved. First, many interviewees noted that HHSC and HFW are not always integrated in a way that supports their work, both due to the burden of working across multiple systems and the different mindsets and requirements of the two approaches. Many providers appreciated the individualized and strength-based approach of HFW, and perceived HHSC to be more "deficit-based" and less consistent with these values. However, they also felt that it was a challenge to meet the requirements for both systems at the same time. Multiple care managers noted that they often have to complete multiple versions of the same document to satisfy each system: as one stated, "*I have to do three different crisis plans.*" The two systems were also often reported to use different data keeping systems, and care managers found it frustrating to "go back and forth" between the two, particularly when the same (or similar) information needed to be entered into both. Several noted that they often ended up prioritizing HHSC documentation because of the deadlines

for that paperwork and other requirements. While HFW does have internal deadlines and timeframe expectations, especially for completion of the Engagement and pre-Implementation Phase activities, these windows were not taken to be as "hard," and so were less likely to be prioritized. However, providers did find the HHSC-required CANS-NY assessment to be helpful in their HFW work, as they could use it to create an HFW Plan of Care and identify strengths, making it useful for both processes.

Some providers described a lack of support due to poor understanding of HFW or what was needed to implement HFW by organization and agency leaders. HFW information dissemination may be beneficial for some agency and organization leaders to increase support for HFW. Another area that could use additional support is funding; providers felt that their work could be improved through greater access to flexible funding. (While most care managers supported through the SAMHSA grant have access to flexible funding, not all may be aware of the process through which they obtain these funds.) Providers appreciated the HFW resources they have received, such as pamphlets, a manual, etc., and felt they would benefit from even more materials, such as video versions of the training, project materials in additional languages, and additional pamphlets geared towards providers to increase the appropriateness of referrals.

Those who have been in the project for several years also noted the challenges of changing expectations across the implementation period, a common characteristic of pilot projects. One specific change was the move from the "triad" model to the current "facilitation team" approach, which changed the role of peers. In particular, peers did not feel that their role was as valued by State leadership. As one peer support service provider explained, "*They seem to be very CM-oriented in discussions on the phone… The PA role does not seem to be a valued part of training.*" Another felt that because of the current extensive requirements on them, peer support service providers were not currently able to meet with families at the required frequency.

Other implementation challenges reported included difficulties navigating the changing Medicaid landscape meeting service requirements, particularly while respecting family choice. While HFW agencies are paid in full if they provide two Health Homes services in a month, one of which is face-to-face, some care managers remained confused about perceived billable service requirements in HFW. In addition, care managers noted that families frequently canceled scheduled meetings, resulting in challenges meeting the monthly face-to-face requirement: as one care manager stated, "*Families have very busy lives so being able to do face-to-face with them is not as easy as people thought it was going to be, a lot of cancellations.*"

Other challenges included limited service availability, particularly for transition-age youth. Care managers felt that having services either co-located with their agency, or at least close by, was particularly helpful in connecting families to needed services, but those who did not have such close proximity to other service providers struggled to make these connections. This point supports the importance of a functioning SOC on which care mangers can rely.

POTENTIAL NEXT STEPS

Together, these data sources identify several current strengths of the SOC implementation, as well as some areas for additional assistance over the next year.

First, the data consistently identified the emphasis on family voice and choice in HFW and SOC; the care team appreciated the individualized, family-driven approach emphasized in this practice, and reported it to be one of the major strengths of service delivery. The inclusion of peer support service providers was also noted as a strength by both peers themselves and care managers, though Peers also reported needing some additional support around their role in the care team.

Additionally, the creation and distribution of the Social Marketing Toolkits and the SOC 101 presentations may have helped address the outstanding need, identified in the SOC Implementation Survey, for strengthened communication around SOC implementation across the state. While these materials were distributed before the administration of the survey, they may not have been put to use until later, so the survey results likely reflect a pre-Toolkit and pre-presentation state. The Winter 2020 administration of this survey will help determine the impact of these components, particularly whether more individuals are now aware of their county's implementation of SOC.

Lack of integrated documentation was consistently reported as a burden. The demands of documentation for both HHSC and HFW were reported to be substantial, and sometimes conflicting or frustrating, for both the care team and for families themselves. Any methods of creating greater consistency between the paperwork required for each system or determining ways of better aligning required forms or steps (e.g., crisis plans, Plans of Care) would alleviate a significant barrier for service providers and hopefully reduce family confusion about the process. Additionally, some providers reported feeling well-supported by their organizations to implement HFW and SOC, though they still noted further resources needed.

Service availability was also consistently noted as a challenge. As SOC expands to more areas, connections with new local service providers are needed. The IPP reporting has demonstrated the implementation of new policies meant to help cross-system collaboration, which may result in greater awareness of available services in each locality, but these connections may need additional support from SPOAs, particularly in their new role as local engagement leaders. Implementation of the new Policy Research Associates workshops aimed at improving local SOC development and cross-system conversations may help increase knowledge of local services and improve collaboration between partners. Further, some needed services may simply not be available within a community, requiring additional development.

Year Three saw significant changes in Medicaid benefits and access procedures; many of these shifts have only recently been implemented, and thus continue to need significant Department of Health support as agencies determine their new roles under the new rules. Given the confusion evidenced by care manager feedback, reiterating that their reimbursement is based on completing two monthly contacts with families (one in-person) may be warranted.

As noted, CHSR will repeat the administration of the SOC Implementation Survey in early 2020 and will compare the Year Four responses to those of Year Three to evaluate system-wide progress in implementation. Further, a major continued component of NYS OMH's Year Four activities will be planning for project sustainability even after the end of the current SAMHSA grant. These findings may help direct attention to areas requiring additional support to promote continued implementation and smooth the path to sustainable practice in Year Four and beyond.

Section II: Training and Workforce Development

NYS SOC established the Wraparound Training and Implementation Institute (WTII) in 2017 to create a statewide infrastructure for HFW training and workforce development. WTII includes a training team who have established an HFW certification process, developed training curriculum and materials, and delivered trainings, coaching, and webinars to multiple providers across the state. Building an effective workforce through high quality training, coaching, and supervision, will help ensure HFW is being implemented according to the NYS SOC model.

The goal of this aspect of the evaluation is to identify resources and strategies that support the development of an effective workforce. Current findings on training and workforce development are reported here, including data from care manager and peer readiness training briefs and the Training and Workforce Development Research Brief. Information from Year Three provider interviews and administrator surveys were included in the research brief.

CURRENT IMPLEMENTATION

As the project has evolved, so have the specific components of the HFW certification process. The training team refined their processes and practices over the course of the grant period in an effort to respond to the expansion of HFW implementation, the needs of sites, and the need to plan for long-term sustainability. Changes in implementation since the beginning of the project are outlined below.

Certification process

Early on, the training team established multiple components of the Wraparound Certification process. Trainees were initially required to attend classroom trainings, TA sessions, webinars, and team coaching; present a team case study; and submit Child and Family Team Meeting (CFTM) audio recordings and documentation. As of the start of Year Three, trainees are now required to attend all 12 classroom trainings, at least six webinars, and at least eight implementation support meetings over the course of a year. Supervisors are required to attend eight coaching sessions from WTII staff; care managers are required to attend 32 coaching sessions with their supervisors. Specific changes with the training and coaching processes are detailed below.

Training

Changes were made to the training format, content, and target audience. Classroom training was originally scheduled to take 16 days over a six-month period. These sessions originally included Cultural and Structural Competence and Health Habitus; this content was then moved to a separate, stand-alone CSC training. This shift, and otherwise shortening one other session, reduced the training to 12 days, which made attendance more feasible for those who found it challenging to attend all of the sessions.

Originally, providers attended trainings as a “triad” team, consisting of a care manager, family peer support service provider, and youth peer support service provider. While this format helped with team building, there was confusion across teams on job roles and responsibilities within this model. As the model moved away from the concept of the “triad,” a separate peer-only Wraparound Peer Readiness and Implementation Training was created, allowing peers and trainers to focus more specifically on their unique roles and billable peer services. In Year Four, Regional Parent Advisors and Regional Youth Partners will be trained to deliver the training and will be responsible for leading those going forward.

Further, care manager supervisors became included on all trainings: while originally they had only attended the first session (which focused on ways to support staff generally), they are now invited to attend all trainings, with the goal of improving staff support in this model through supervision and coaching. Waiver and RTF providers were also added to the trainings as the project expanded.

Coaching

Changes were made to the coaching format and frequency. Originally, a designated WTII coach provided weekly one-on-one coaching to both care managers and peers for six months; group coaching was also offered for some sites. As the project grew, WTII switched to a "coach the supervisor to coach" model, wherein the WTII trainer coaches supervisors to coach the providers directly. Supervisors are expected to provide on-going coaching to their staff weekly, and are offered individual coaching monthly by WTII for one year. One cohort of providers, whose supervisors did not attend trainings, were coached by WTII directly. This change promotes adherence to the model on a local level and is a more sustainable option for long-term coaching.

CURRENT FINDINGS

Summary Information from Training Briefs

Between November 2017 and September 2019, the State team conducted 33 Wraparound Certification trainings with six cohorts (five of whom have completed all trainings by the end of Year Three, and one of whom will complete their training in Year Four), for a total of 163 trainees. Trainings were held statewide, covering regions in Central New York (Herkimer), the Capital Region (Albany), and Downstate (Westchester, NYC). Trainings will continue in Year Four in the Capital Region and NYC, and expand to the Long Island area.

One week following each training session, attendees were emailed a link to an online training survey. Respondents included care managers, youth and family peer support service providers, administrators, supervisors, and RTF providers. The evaluation team compiled and analyzed data from each survey and completed 37 training briefs by the end of Year Three, including individual reports for each of the 32 sessions and one combined report for each of the five cohorts once all sessions were completed. Findings from the combined briefs are summarized below.

The average response rate across all individual surveys across all cohorts was 59%; response rates tended to decrease over the period (see **Table 2**). Response rates varied between sessions within each cohort: Central NY and Albany 1 showed some decrease over the sessions; the Downstate cohorts and Albany 2 showed overall decreases but also broader fluctuations between sessions. When response rates were low, attempts were made to address this issue by sending out multiple reminders from both the evaluation team and WTII, and by extending the survey completion deadline. Those efforts will continue in Year Four.

Table 2. Average Wraparound Certification training survey response rates by cohort (N=21-43)

	Central NY (N=21)	Downstate 1 (N=32)	Albany 1 (N=43)	Downstate 2 (N=35)	Albany 2 (N=22)	Overall average
Average	71%	67%	60%	59%	42%	59%

Overall, attendees reported that all of the training styles helped them understand the training material (average scores for each training style reached at least 75 out of 100; see **Figure 1**), though there was a slight preference for case study, group activities, and videos. As such, attendees preferred interactive activities and formats that highlighted more practical, concrete examples of HFW practice.

Figure 1. Average survey ratings of training styles across all cohorts

How much did each training style help you understand the material?

Attendees were also asked direct questions about specific concepts presented in the training. While it is difficult to directly evaluate any changes over the period due to changes in the training and the survey itself, some general themes emerged. In the earlier cohorts, attendees struggled most with questions related to Health Habitus and Cultural Competence, CFTM skills, and the transition phase. Moving Health Habitus and Cultural Competence to a separate training may have addressed this issue, as it allows for more specific focus on these topics. In later cohorts, attendees scored higher on questions related to CFTM skills, indicating a better understanding of those concepts. This improvement between cohorts suggests a change in the curriculum or in the delivery of this topic. Documentation was also reported to be challenging for attendees across the majority of the cohorts.

Attendees were also asked to provide general feedback on the training. Overall, attendees enjoyed the trainings and appreciated how knowledgeable, helpful, engaging, and prepared the training team was. They liked the interactive nature of the training (e.g., group, hands-on, and role-playing activities), but wanted more realistic cases and examples to work through. They also wanted additional - or earlier - training on specific topics, such as documentation, Health Habitus, and identification of certain Plan of Care elements (e.g., underlying needs). Feedback was given regarding the length and location of the training: some thought it was long and felt overwhelmed by the amount of information presented, and some preferred a training more centrally located or closer for all attendees. Generally, most appreciated the comprehensiveness of the trainings and felt that the information presented was useful in developing and improving skills for wraparound practice.

Peer Readiness Trainings

Between February 2019 and September 2019, WTII conducted 11 Wraparound Peer Readiness and Implementation Training (Peer Readiness trainings) to four cohorts (three have completed all trainings by the end of Year Three, and one will complete their training in Year Four), for a total of 105 trainees. Trainings were held statewide, covering regions in Central New York (Utica), the Capital Region (Rensselaer), and Downstate (Westchester, NYC).

Training attendees completed paper surveys immediately following each training session. Respondents included youth and family peer support service providers, administrators, and supervisors. The evaluation team compiled and analyzed data from each survey and completed ten training briefs by the end of Year Three. Findings from the individual briefs are summarized here.

Response rates were high across all cohorts with an overall average of 90% (see **Figure 2**), potentially because these surveys were completed in-person immediately following the session, as opposed to online a week later.

Figure 2. Peer Readiness training survey response rates for each cohort (N=15-36)

Overall, attendees across all cohorts felt that the training content helped them understand and perform their role in wraparound, specifying various takeaways and concepts from each training that they felt were valuable. They also felt the trainers were knowledgeable, prepared, and well-organized. They indicated some areas for improvement, including a desire for a greater diversity of activities (e.g. role-playing, group, and hands-on), more practical examples and scenarios to work through, and materials and resources to take back with them. Feedback varied on the length of training: some said it could be shorter, while others felt it could be expanded. Attendees also would have appreciated if refreshments were provided during the training sessions.

Attendees were also asked to provide a list of topics they would like to see in a webinar following the training. Most were interested in learning more about some of the topics already covered in the peer trainings (e.g., wraparound phases and principles, Plan of Care components), indicating a need for training reinforcement, as well as some new topics (e.g., working with different types of youths, practicing wraparound in various contexts and systems, and infrastructure issues).

Potential Enhancements to Training, Coaching, and Supervision: Research Brief Summary

The aims of this research brief were to summarize care managers' and supervisors' current feedback on HFW training, coaching, and supervision, and propose recommendations for training and coaching revision to better support HFW practice. Key findings are summarized here; full analyses and results can be found in the 2020 Research Brief "*Identifying Enhancements to Training, Coaching, and Supervision.*"

Information was collected through the Year Three provider interviews with care managers and online administrator surveys with care manager supervisors. Care managers were asked about training, coaching (both direct coaching of care managers by WTII staff, and coaching care manager supervisors to coach), and supervision, focusing in particular on the aspects of each that have gone well and that could be improved. Supervisors were asked qualitative and quantitative items on classroom training, instruction on how to coach care managers, supervision of care managers, access to resources to support HFW, organizational support, and ways supervisors benefited from training.

Common themes were found across multiple domains. Care managers appreciated the collegial support they received across all aspects of training and coaching, describing the interactions with others as an opportunity to learn from each other and share experiences. One care manager noted that the most helpful aspect of training was, "*…getting to see other people from other agencies and talking about how their office works and what the differences are and trying to help one another with planning and using the model.*" Care managers also found the WTII trainers to be helpful, knowledgeable, and responsive to their needs.

Both care managers and supervisors desired more concrete, HFW-specific instruction on topics such as breaking down Plan of Care components and determining CFTM facilitation tasks. As one care manager reported, "*I say […] specifically about how to break down needs and goals. Everyone had a lot of questions on that section.*" Specific HFW skills were identified as areas of practice that remained difficult after training, suggesting more support in this area is needed. Multiple care managers also stated their supervisors did not provide enough HFW-focused support, and many

supervisors noted a need for quality assurance mechanisms to further support effective practice of the model. As one supervisor said, "*[I need more help with] coaching […] individually and as a team.*"

Themes unique to training, coaching, or supervision were also identified. Care managers thought that the training provided a comprehensive background of HFW, but found content not specific to HFW (e.g., cultural competence) to be irrelevant. They also reported some challenges with the webinars offered, and wanted more training on how to document HFW practice in the WRAP-NY system website. Care managers noted that group WTII coaching was helpful, but found communication in the group phone call setting to be challenging. Finally, care managers said supervision was most helpful when their supervisor reviewed each case and provided specific feedback.

Overall, care managers expressed many positive experiences with HFW training, coaching, and supervision, including the knowledge they gained from the training itself, opportunities for peer support from other care managers, and appreciation for WTII trainers. Both care managers and supervisors recognized the need for continued support to carry out the HFW practices that they learned about in training. These findings will help inform WTII as to which aspects of the process should be maintained, and which areas could be enhanced to improve HFW practice.

POTENTIAL NEXT STEPS

Across these data sources, common strengths and areas for improvement were identified. Overall, providers enjoyed the trainings, felt the trainers were knowledgeable and helpful, and valued the interactive elements of the process, which is encouraging. While providers felt that the information discussed during training and coaching was comprehensive, they also wanted more HFW-specific instruction with concrete, realistic case scenarios or examples, and additional resources and trainings to better implement and support HFW. WTII has already taken steps to address some of these challenges: they plan to strengthen coaching for supervisors and will introduce the Practice Review Tool in training during Year Four. This tool will aid supervisors in supporting HFW practice locally by guiding supervisors through document review of care managers' cases. They will also consider creating a supervisor-specific training. Revisions such as these can help enhance the training and coaching processes for current and future cohorts.

CHSR will continue to collect data on care manager certification and Peer Readiness trainings to help inform the training team over the next year.

Section III: Fidelity to High Fidelity Wraparound Model

Practitioner fidelity to the HFW model is critical for ensuring high-quality implementation and positive family outcomes. The NWI's Wraparound Fidelity Assessment System (WFAS) is a set of instruments designed to examine unique aspects and perspectives of each family's HFW experience. These tools have been used since the beginning of the grant to assess the extent to which NYS SOC practitioners have fulfilled each of the HFW model's practice standards. While strategies for fulfilling these practice standards have shifted over the grant period, the standards themselves have remained constant.

This aspect of the evaluation aims to identify the HFW practices implemented with greatest fidelity to the model. Of course, if fidelity to expected model practice is lacking, families cannot be said to have received HFW, and the expected changes in families' lives may not be evidenced: HFW has demonstrated promising evidence of effectiveness, but only where model fidelity was high (Bruns, Suter, Force, & Burchard, 2005). Data from fidelity assessment can also facilitate eventual identification of specific aspects of the model associated with family improvement, highlighting critical practices worth sustaining.

Thus, fidelity assessment remains the gold standard for the dual goals of the HFW practice focus area: identifying the status of fidelity to model standards and identifying the most effective HFW practices that lead to improvement in families' lives. In this report, we focus on the first aspect; future work may address the second. The fidelity assessment instruments include two WFAS instruments: the Wraparound Fidelity Index EZ (WFI-EZ) and the Team Observation Measure 2.0 (TOM 2.0). Document review analyses used information from the 45-Day Review and the 2nd CFTM Review, two CHSR-created tools meant to compensate for identified issues in the DART (the Document Assessment and Review Tool provided by NWI) and allow for greater practice improvement utility. Fidelity assessment was supplemented by reports available in the WRAP-NY system website, the Transition Plan Creation report, data from Year Three interviews with care managers, and other information pulled from care manager records.

CURRENT FINDINGS

Status of Fidelity to Model Standards: WFAS Instruments

The WFI-EZ and TOM 2.0 focus on the implementation of key practice elements, or sets of practices NWI considers to be especially critical in the HFW process and observable throughout the phases of participation. Percentages are used to reflect the level of fidelity achieved.

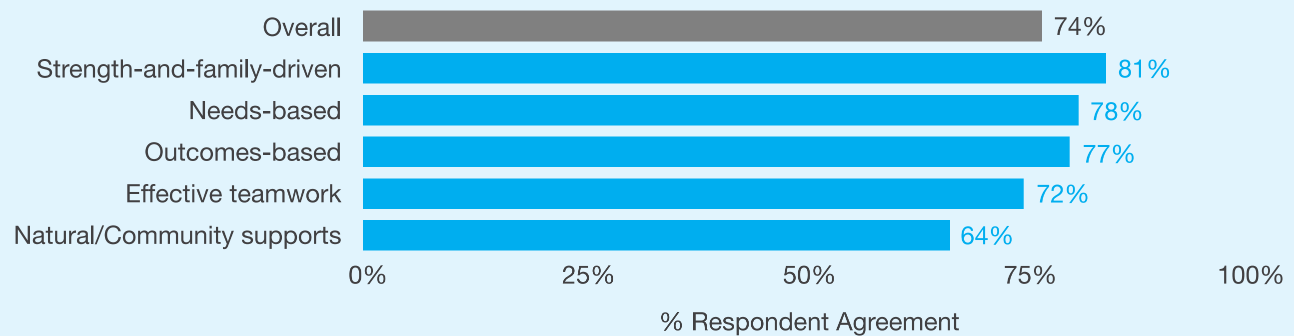
WFI-EZ.

The WFI-EZ tool is a survey that asks all HFW participants to rate the extent to which they agree that HFW was implemented faithfully, on a scale of Strongly Disagree (1) to Strongly Agree (5) in five domains; average responses for each domain were then translated into percentages (e.g., an average agreement score of 4/5 would be an 80%). Respondents included the youth, caregiver(s), care manager, youth and family peer support service providers, and any other team members. As team members' perceptions of the extent to which key features of the model were present can be highly variable, surveying all participants is crucial to obtain a full picture of whether HFW was implemented as expected. For example, while a care manager could conclude that they actively empowered families to take ownership of the HFW process, the family may report not feeling empowered; in such a case, it would be reasonable to suggest that the model was not fully implemented. The current results include responses from all participants (N=103), or 21 teams, for whom data were available, by individual and role, at the level of overall fidelity and of key practice elements.

Overall perceptions. The average percent agreement across all participants and domains was 74% (see **Figure 3**). HFW participants thus tended to agree that the practice features captured by the WFI-EZ were generally implemented to fidelity. Domain-specific results showed that a greater proportion of participants agreed that the Strength-and-

Family-Driven, Needs-Based, Outcomes-Based, and Effective Teamwork elements were implemented; agreement was lowest for the implementation of Natural/Community Supports. Examination of specific WFI-EZ items in the Natural/ Community domain showed that, in addition to being the lowest-rated domain, it also included the lowest-rated item: *Our Wraparound team does not include any friends, neighbors, or extended family members*. A majority of respondents indicated that natural supports were not included on their care teams. In summary, most participants who completed WFI-EZ surveys felt that the HFW process focused on strengths and needs and encouraged family voice and choice, but were less likely to agree that natural and community-based supports were integrated into teams and plans.

Figure 3. WFI-EZ respondent percent agreement overall, and by Key Practice Element.



Perceptions by respondent. When broken out by role, respondents' ratings were similar to the overall ratings (see **Table 3**). Strength-and-family-driven, Needs-based, and Outcomes-based were all rated similarly and showed the highest ratings, while Natural/Community Supports was unanimously the lowest. Ratings also tended to follow the national average for respondents, though there were a few noteworthy differences. First, youth (N=15) and caregivers (N=27) in the NYS pilot tended to provide slightly *higher* ratings than national averages for these roles, indicating greater perceived fidelity. However, NYS youth, caregivers, and facilitators (N=18) rated Natural/Community Supports even *lower* than the national average. Thus, NYS pilot participants reported that their HFW experience was closer to model fidelity than the national sample, exempting the domain of natural and community supports.

Table 3. WFI-EZ mean percent agreement by domain and respondent type in NYS SOC vs. National Average.

	Youth N=15		Caregiver N=27		Facilitator N=18		Peer Support Service Provider N=27†	
Domain	**NYS**	**National**	**NYS**	**National**	**NYS**	**National**	**NYS**	**National**
Overall	74%	69%	75%	72%	73%	74%	71%	73%
Strength-and-family-driven	79%	72%	83%	78%	81%	83%	76%	82%
Needs-Based	79%	72%	79%	74%	81%	75%	71%	75%
Outcomes-Based	76%	73%	78%	75%	73%	76%	75%	76%
Effective Teamwork	71%	64%	72%	68%	72%	68%	67%	66%
Natural/Community Supports	62%	66%	61%	66%	57%	66%	67%	66%

†Family peer support service provider=13; Youth peer support service provider=14.

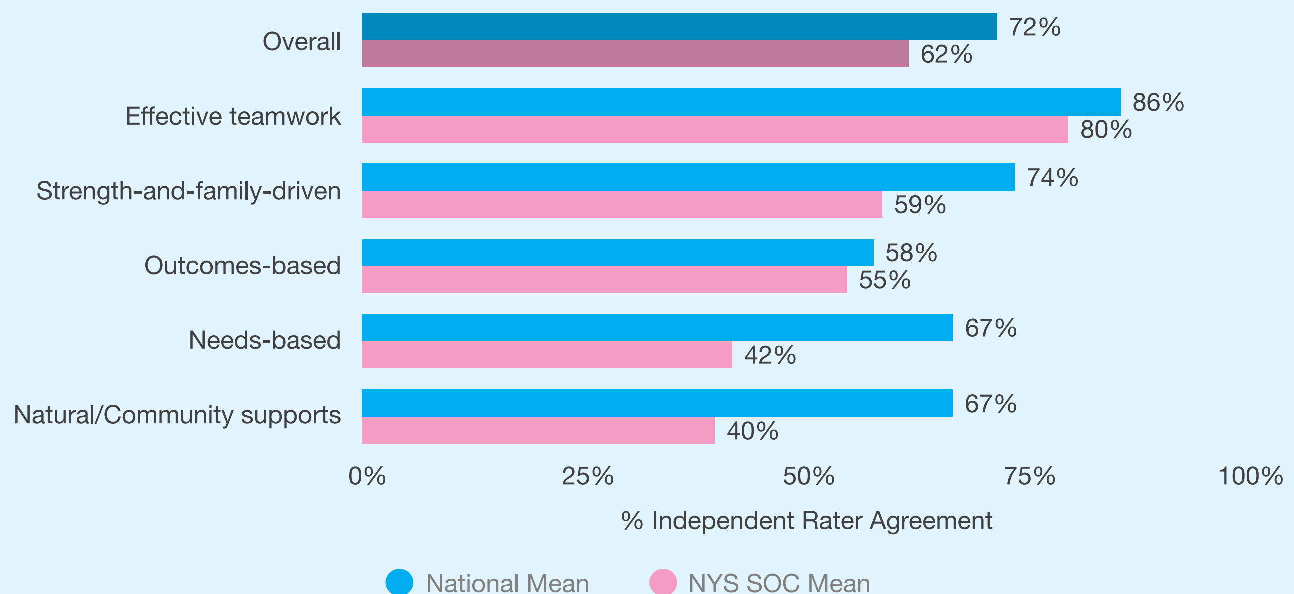
TOM 2.0

The TOM 2.0 is another important fidelity tool used to identify whether each of the HFW practice standards potentially observable within a CFTM are present. The TOM 2.0 includes the same five domains as the WFI-EZ plus two additional domains specific to meetings: Meeting Attendance (whether family members and individuals key to the Plan of Care attended the meeting), and Skilled Facilitation (the facilitator's ability to conduct a high-quality meeting). While it is

important for HFW participants to feel they have received key aspects of the HFW model, as assessed by the WFI-EZ, it is also critical to objectively identify practice standards in place. The instrument is completed by an external data collector after observing a CFTM, allowing this more impartial view. Observers score each item based on whether a standard was present (or absent); a perfect fidelity score for a meeting would include "present" on every item. The TOM 2.0 can thus facilitate identification of gaps in replication of the model across families and sites. Such replicability is needed to ensure that *all* current pilot families and future families receive model-standard HFW. The current results describe the extent to which observed CFTMs (N=25) followed HFW practice standards. Additionally, team cohesion scores are reported; these items reflect the extent to which the facilitation team members worked together and created warmth in the CFTM. These items were added to the TOM 2.0 by CHSR. Comparison to WFI-EZ ratings are made to identify differences in these two perspectives.

Overall and by Key Practice Element. Overall fidelity scores reflect the average percent fidelity of each observed meeting. NYS demonstrated overall TOM 2.0 fidelity of about 62%, indicating that observers viewed fidelity at any individual CFTM to be lower than team meeting participants did across all their CFTMs and other HFW activities (see **Figure 4**). Further, exempting the Effective Teamwork element, observers' scores within each domain were typically lower than the corresponding WFI-EZ ratings. Interestingly, NYS pilot ratings on the TOM 2.0 were also lower than national TOM averages.

Figure 4. TOM 2.0 Percent Fidelity Overall and by Key Practice Element, in NYS pilot sites versus National Averages.



These findings suggest that HFW practice standards are less consistently observed in NYS pilot CFTMs than in CFTMs across the country. However, as these current NYS sites have only been practicing HFW for at most two years, some lag may be understandable. HFW participants in pilot sites generally report experiences in CFTMs that are consistent with key HFW practice elements to a greater extent than observed by the external data collector, except for the extent to which the team works together. Participants tend to report that the HFW process focuses on their needs more than the external observer sees. But all reporters agree that the practice element least likely to be fulfilled is the involvement of Natural and Community Supports.

Skilled facilitation. Skilled facilitation focuses on care managers' skill in facilitating a meeting. Observers indicated that two-thirds (66%) of key practice features reflecting skilled facilitation were implemented. Care managers appeared to excel in managing disagreement (met in 14 of 15 applicable meetings) and keeping team members engaged throughout the meeting (met in 21 of 25 meetings), but were less consistent on preparing needed documents and following a clear agenda (each observed in 13 of 25 meetings).

Team Cohesion. CHSR added three items to the TOM 2.0 scale to examine the degree of group cohesion among facilitation team members in a team meeting. Items focused on: (1) whether every facilitation team member makes a substantive contribution to the discussion; (2) whether team members respond encouragingly to one another; and (3) the degree of collective warmth, or a general joviality conveyed verbally and nonverbally during the meeting. Cohesion in team meetings as measured on these three items was high. Observers indicated that, in every observed meeting, all team members made substantive contributions (15/15 meetings) and responded encouragingly to one another (15/15 meetings). Further, the average level of level of warmth was 4.27 out of 5, with no meeting rated below the midpoint on the scale, suggesting team members consistently created warmth in meetings. These findings are consistent with observers' high ratings of effective teamwork on the TOM 2.0, suggesting the facilitation team members work well together and as a broader team with youth, caregivers, and other team members.

Training Cohesion Scale

Another measure of facilitation team cohesion was captured at the end of training. The Current Status of Group Cohesion Scale was administered to each cohort of HFW training participants at the end of their classroom training period to examine the extent to which care managers and peer support service providers worked together well.[1] Among facilitation team members who completed the survey and indicated that they worked with other facilitation team members (N=21), the average cohesion score was 3.12 (out of 5). This score suggests the teams are generally cohesive, but that there is room to improve, a finding similar to that found from the TOM 2.0 cohesion items. As such, team members generally reported good cohesion, and external observers also saw positive, warm, cohesive team meetings and effective teamwork. Group differences in cohesion (e.g., cohort membership, facilitation team role, original pilot vs. expansion county, etc.) were examined, but none showed significance, likely due to the small number of respondents.

In addition to the Cohesion Scale, the survey included three open-ended items asking participants to describe what it looks like when their team is at their best, what it looks like when they are not working well together, and what the team could do to work at their best more often. Open-ended responses included similar themes as described in the Year Two annual report: team members are working best when they are in regular communication and open to feedback, but struggle when they do not follow through on responsibilities or avoid interpersonal difficulties with other team members. A unique theme from new Year Three respondents was a focus on families, rather than the team, in describing good teamwork. For example, one supervisor said the team works at its best when *"families are successful!"*

DOCUMENT REVIEW

Document fidelity review was performed using two tools. The 45-Day Review is completed for every youth after their forty-fifth day since referral into HFW. It examines whether the elements expected to be completed and entered into the WRAP-NY system at this point (i.e., the Crisis Plan and Plan of Care) are present and written in ways that reflect adherence to HFW practice standards.

The 2nd CFTM Review is completed for every youth whose WRAP-NY system records indicate that they have had two team meetings. It includes a reassessment of the presence and model fidelity of the same POC elements examined in the 45-Day Review, to identify possible areas of improvement or persistent gaps, and review of forms expected to be completed each time a youth has had a CFTM.

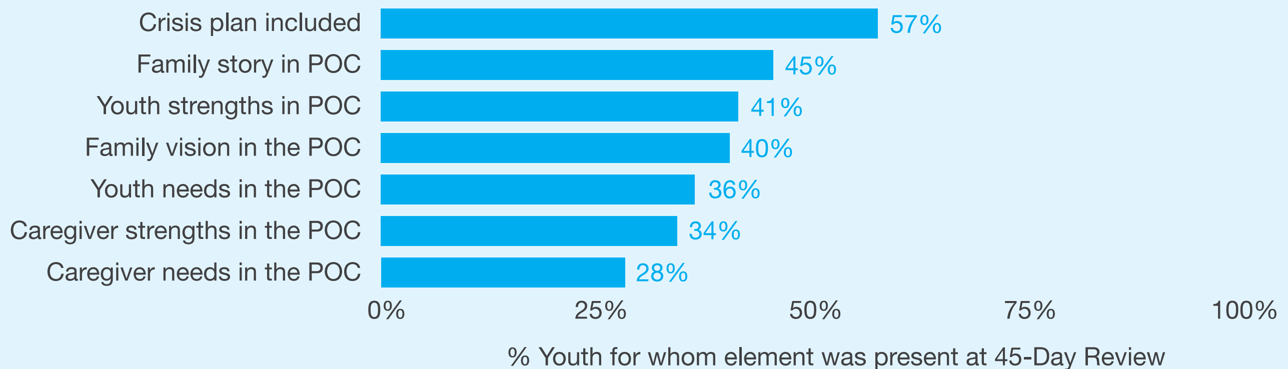
45-Day Review (N=141)

Completeness of 45-Day Review documentation. The prevalence and pattern of missing records is crucial for examination in order to establish that sufficient data is available for analysis, and to avoid nonresponse bias. Examining completeness of documentation can also identify areas of difficulty for care managers and thus highlight areas needing increased support. Across all 45-Day Reviews completed by the end of Year Three (N=141), only 57% had a Crisis Plan available, and none of the six key components of the POC were completed for more than half of the sample (see **Figure 5**). This gap suggests that much of the major POC documentation was not entered into the WRAP-NY system

[1] Originally, the Cohesion Scale was administered to training participants twice: once halfway through the classroom training period, and once after training was completed. However, within these first two cohorts, only 4 trainees had sufficient data for analysis at both time points, prompting a shift to a one-time administration for subsequent cohorts.

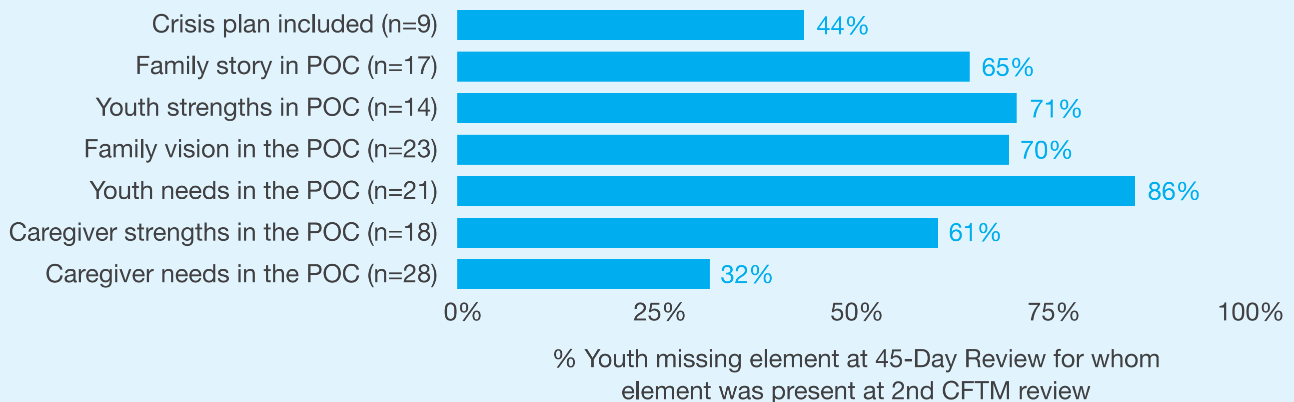
website, that it took care managers longer to create and enter those elements into WRAP-NY by the 45-day mark, or both. Entries for caregiver strengths and needs were particularly sparse. Additionally, although the most prevalent record (i.e., the least likely to be missing) was the Crisis Plan, it was still only available for about half of cases. This document is expected to be created at the family's first meeting with care managers and represents a critical piece of the family's health and safety; as such, prevalence of Crisis Plans is expected to be much higher, even where difficulties with documentation are pronounced.

Figure 5. Completeness of Crisis Plan and POC components for eligible youth (N=141) at time of 45-Day Review.



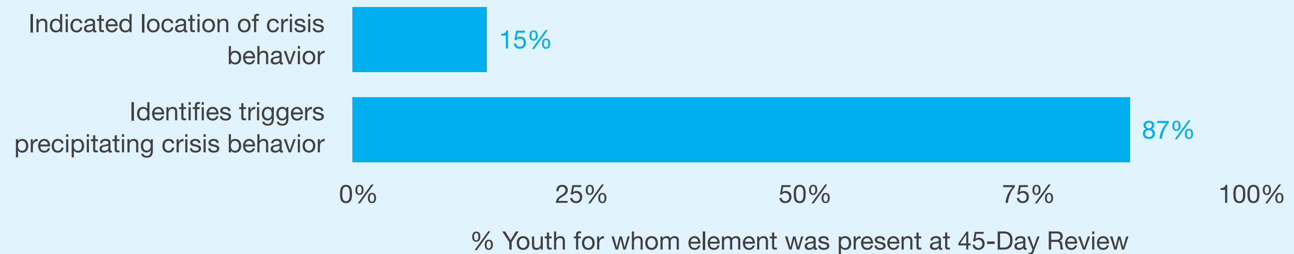
However, many youth who were missing POC elements as of the 45-Day Review had these elements at the time of their 2nd CFTM (**Figure 6**), suggesting care managers largely needed more time to produce these elements or enter them into the system.

Figure 6. Completeness of records at 2nd CFTM Review for youth missing elements at 45-Day Review.



Crisis Plans. Only 81 families had Crisis Plans entered as of the 45-Day Review. The 45-Day Review was used to examine whether these 81 Crisis Plans reflected two critical practice standards: identification of triggers that precipitate crisis behaviors, and the location where crisis behavior(s) occur. Available Crisis Plans showed high fidelity on the former, but low fidelity on the latter (see **Figure 7**). Further, only 13% of youth whose plans lacked identification of location of crisis behavior at the time of 45-Day Review had locations identified at the time of the subsequent 2nd CFTM Review, suggesting this as area in need of further support.

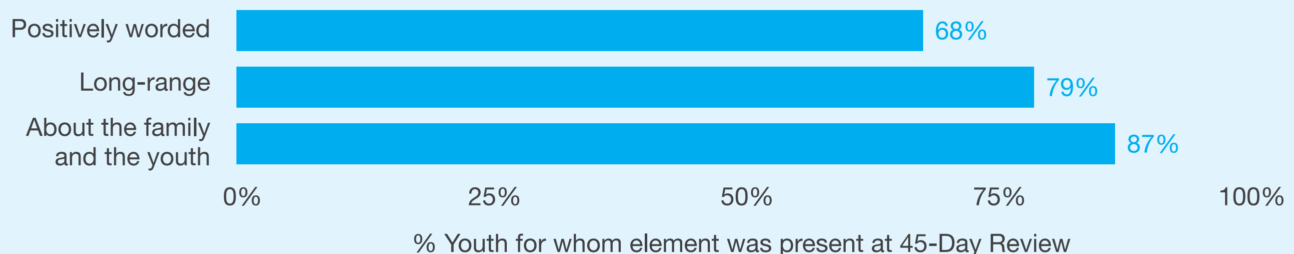
Figure 7. Percentage of youth with Crisis Plans entered into WRAP-NY system (N=81) with Crisis Plan elements present at time of 45-Day Review



Crisis events. In addition to Crisis Plans, the 45-Day Review includes an assessment of whether crisis events were addressed in ways consistent with the NWI standards. Only 3% of youth (N=5 of 141) had crisis events recorded in the WRAP-NY system website. Of these, none had records indicating that their crisis plan was updated within 24 hours, or that a CFTM was held within 72 hours, both NWI practice standards. Among those lacking records of crisis events (N=136), 11% had progress notes that appeared to indicate the need for a crisis event record. But these rates seem low in comparison with providers' reports about difficulties in conducting HFW due to high rates of crises. Thus, crises may be underreported and, where they occur, may not be addressed in ways consistent with the NWI standards.

Family story and vision. Family stories and visions are critical elements of Plans of Care. The story captures the family's history and areas of past difficulties as well as current resources and important people who may be part of their HFW process. The vision focuses on the family's future, identifying the family's ultimate goal. Each element has fidelity standards: stories should incorporate families' cultures, and visions need to integrate a future for both the family and the youth, be sufficiently long-range in scope, and be positively worded. Where stories were available (N=63 of 141), only 21% appeared to incorporate the family's culture. However, family visions (N=56 of 141) tended to more consistently incorporate NWI standards, as shown in **Figure 8**: each family vision element appeared in at least two-thirds of family visions, and visions were especially likely to describe a future that included both the youth and the family.

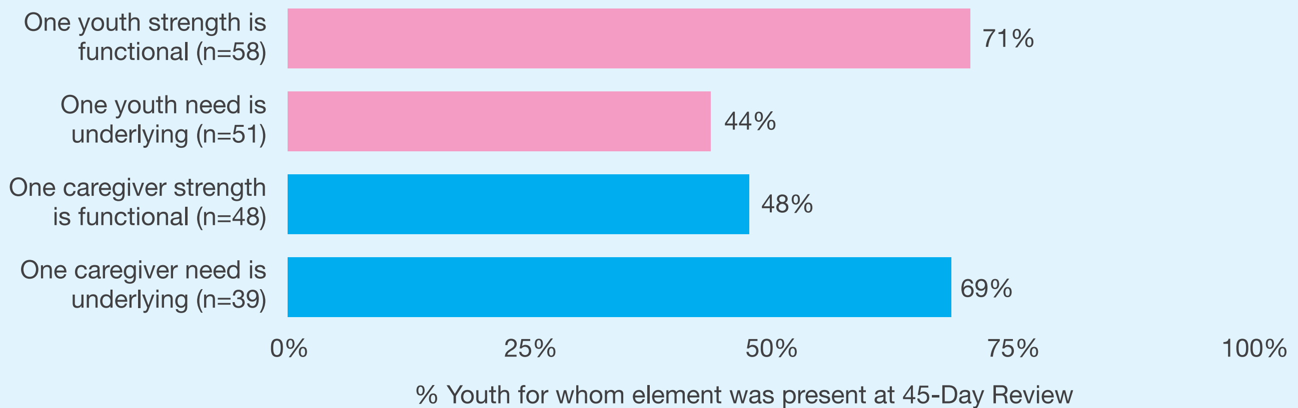
Figure 8. Percentage of youth with available Family Visions (N=56) with critical element present in WRAP-NY system website at time of 45-day review.



Strengths and needs. Strengths are a key component of HFW. Care managers are tasked with identifying "functional strengths," or things youth and caregivers are *good at* or *interested in*, so they can create strategies based on these strengths. Strengths that reflect personal attributes or personality traits (e.g., compassionate) are not considered to be functional strengths because they are difficult to build into strategies, or methods by which the care team can address needs. Needs are also required to focus on youth and caregivers' *underlying* needs, rather than surface-level problem behavior or services. Nearly three-quarters of youth with one or more strengths entered into WRAP-NY (N=58) had at least one strength that was functional, while less than half of caregivers with one or more strengths (N=48) had at

least one that was functional. But in contrast, among caregivers and youth with need statements in WRAP-NY (N=39 and N=51, respectively) higher percentages of caregivers had at least one need expressed as an underlying need (see **Figure 9**).

Figure 9. Percentages of family records with entered youth and caregiver needs and strengths reflecting critical features of each.

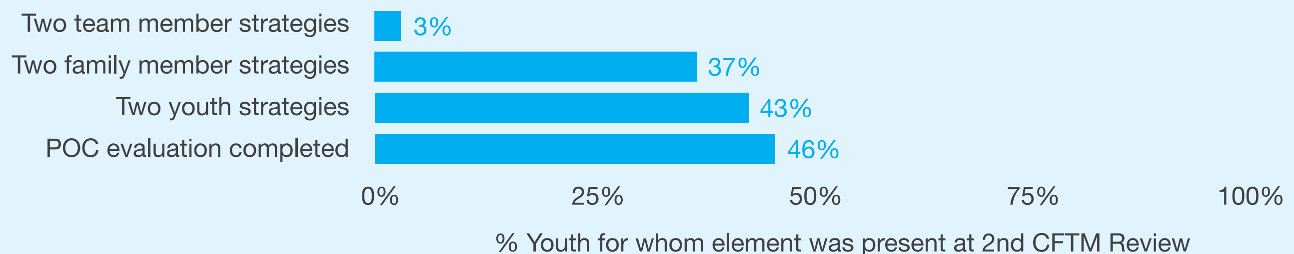


2nd CFTM Review (N=35)

Completeness of 2nd CFTM Review documentation. Thirty-five families were eligible for the 2nd CFTM Review. However, critical elements were scant (see **Figure 10**). This limited data availability makes it difficult to assess whether key features of the model specific to team meetings are implemented with fidelity.

For example, by NWI standards, progress on addressing needs should be evaluated after every CFTM, evidenced by completion of the POC evaluation form. Additionally, youth and caregivers should each have two strategies, and two strategies should be assigned to any other team member(s). However, less than half of families with two CFTMs in the WRAP-NY system website had even a single POC evaluation (when at least two would be expected) and less than half had POCs showing two strategies assigned to youth, caregivers, and team members. Such progress evaluations may thus not be occurring consistently and key documentation not completed, or may not be consistently entered into the WRAP-NY system.

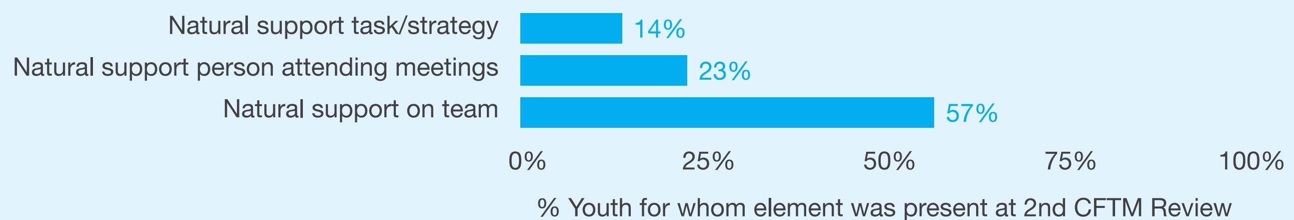
Figure 10. Percentage of eligible youth with a 2nd CFTM Review (N=35) with POC evaluations and two strategies for youth, family members, and team members.



Caregiver and youth attendance. The NWI practice standard for caregiver and youth attendance is attendance at every meeting. Only two out of the 35 families were missing one of these members at these first two meetings; thus, 94% of caregivers and youth met this standard for their first two meetings, suggesting that attendance among the focal members of the HFW process is very close to meeting the standard.

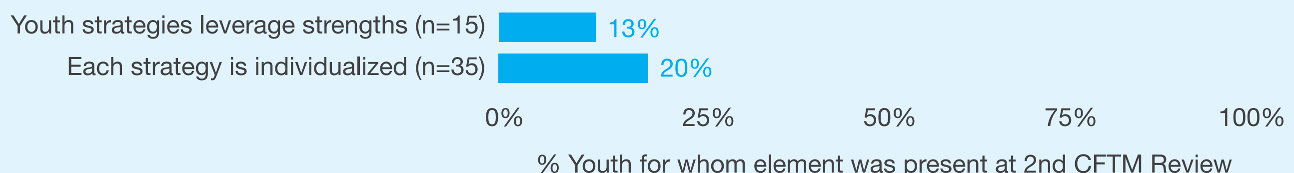
Natural and Community Based Supports. NWI expects each family to have at least one support person on their team. However, only about half of youth (N=20 of 35) had such a person on their team. Further, taking the next step toward inviting natural support people to team meetings or writing them into a task/strategy in the POC appears to continue to be challenging even for these families. Only about a quarter (23%) of youth records indicated that a natural support person attended meetings; fewer youth (14%) had records that showed community activities built into tasks or strategies, indicating additional areas needing support (see **Figure 11**).

Figure 11. Percentage of youth records eligible for a 2nd CFTM Review (N=35) with POCs reflecting natural and community based support standards



Strength-and-family-driven. Creating individualized strategies based on strengths is an important part of personalizing the HFW process to each individual youth, caregiver, and team members. However, only 20% of youth (N=7 of 35) had a full set of individualized strategies, and even fewer youth who had at least two strategies had strategies that incorporated their strengths (N=2 of 15; see **Figure 12**). These issues were even more apparent in caregiver and team member strategies: none appeared to incorporate strengths.

Figure 12. Percentage of youth eligible for a 2nd CFTM Review with strategies reflecting NWI strengths-based and individualization standards



Outcomes-based Process. Having an outcomes-based process means that the team is monitoring progress toward their goals and making needed updates to their plan as their HFW process and their needs evolve. One way the presence of an outcomes-based process is assessed in the 2nd CFTM Review is the prevalence of POC evaluations, as described above. Another way is to examine whether meaningful updates have been made to the POC following CFTMs and to examine goals to see if they are written in such a way as to be amenable to evaluation (i.e., objective, measurable, and/or concrete). Again, this domain was an area of difficulty: only 37% of youths' POCs had a meaningful update following each CFTM, and only 11% of youth had plans in which all goals were specified in measurable terms.

Transition Plan Creation Report (N=62)

Just under a quarter (23%; N=14) of the 62 youth identified as inactive in the WRAP-NY system had transition plans. These 14 transition plans appeared in only four of the 16 agencies with at least one youth in the WRAP-NY system; three of these four were among the original pilot sites and all four participated in the first training wave, but still had records of inactive youth without transition plans. Of these, only seven had transition plans created before they exited HFW. Ideally, all youth across all sites would have transition plans created before their HFW exit, as HFW intends to prepare youth and their team for life after HFW. Understandably, some youth exit HFW abruptly due to adverse events, making it difficult to create and implement a transition plan. Still, that so few youth had transition plans suggests that transition planning remains an area of difficulty for NYS SOC providers, particularly among expansion sites.

Factors Impacting Engagement Timeframes: Research Brief summary

HFW expects rapid family engagement and plan development; this process is assumed to promote stabilization, instill ownership, and promote team cohesion. But NYS's HFW pilot has seen significant variability in the time families take to complete their first CFTM and develop a first Plan of Care: about a quarter achieve this milestone in the 40 days expected by NWI, but over half take several months or more to reach this point. CHSR undertook a quantitative and qualitative examination of factors impacting the early engagement timelines of HFW participants to better understand potential circumstances leading to extended timeframes and identify possible proactive solutions and shifts to address these issues. Key findings are summarized here; full analyses and results can be found in the 2019 *"Quantitative and Qualitative Exploration of Factors Associated with Time to First Child and Family Team Meeting"* Research Brief.

As of the point of analysis, 126 families across New York State had achieved their first CFTM. Individual-level characteristics at enrollment in HFW were considered, as were care manager notes on "Reasons for Delays" in milestone timings. Several variables were identified as significantly impacting the time to first CFTM, and some contextual explanations were garnered; these two points were frequently in alignment, indicating consistency in analyses and findings.

Quantitatively, early care manager turnover and involvement in the Child Welfare or Juvenile Justice systems were associated with longer times to first CFTM. In contrast, involvement with a Physical Health agency, not scoring as High Acuity on the CANS-NY assessment tool, and not being eligible for or enrolled in Medicaid were associated with faster first CFTMs. Qualitatively, care manager's reasons tended to center around schedule misalignments (either between the family and the care team, or within the care team), challenges with participating in the process (e.g., families reporting that the process was too fast, family members declining to participate, difficulties with HFW activities, or unsuccessful care manager outreach), adverse family circumstances (e.g., hospitalizations, loss of housing), HFW team administrative difficulties, and weather (i.e., meetings being canceled due to snowstorms).

These findings may be helpful for proactive identification of families likely to have extended early timeframes, thus allowing agencies to implement new strategies for this group (or for all families) to help move them through the early steps of HFW. For example, initial meetings could be used to comprehensively describe the HFW process, including noting the intensity of these early steps, and coordinate calendars to schedule the next meetings. Agencies may also develop strategies for family contact and engagement, particularly for families involved in certain systems or situations as of enrollment. They may also provide useful context for consideration of broader state system-level policy or procedure shifts, particularly for cases of staff turnover, family crises or adversities, and weather; for example, expected timeframes may be extended in cases of family adversity or staff turnover, and teleconferencing could be considered to allow for meetings to be held even during snowstorms.

HFW Practices Leading to Family Improvement

One item on the annual provider interviews item asked respondents what parts of High Fidelity Wraparound help families the most; responses to this item were explored in a recent data tidbit (see December 2019). Many responses reflected one or many of the Ten Principles of High Fidelity Wraparound (Bruns, Walker, Adams, Miles, Osher, Rast, & VanDenBerg, 2004). In particular, interviewees reflected that family voice and choice, being strengths-based, and having a team-based approach were especially critical. As one youth peer support service provider noted, *"[Families] are doing what they want to do, not what someone is telling them they should be doing… that choice makes the family more motivated to do it."* A care manager reported that focusing on the positives *"…really does turn a lot of the situation around so you can focus on what they're good at and how to work on something they're not as good at."*

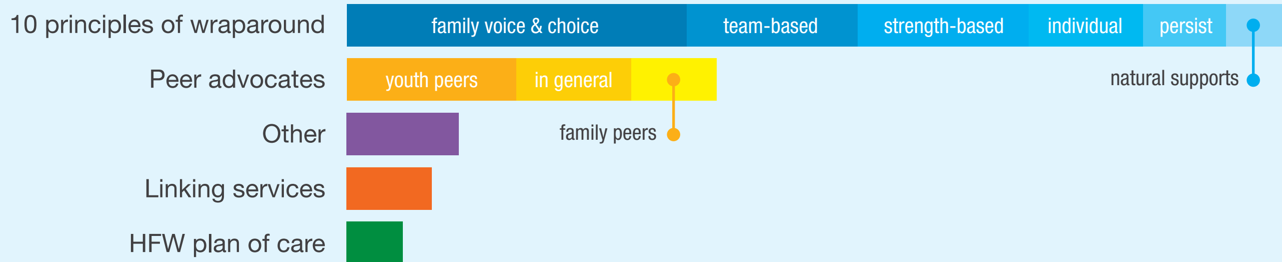
Further, interviewees often noted the importance of peer participation in HFW on family progress:

> *"The families have told me it's helpful for them to have someone who has gone through it that understands."*
> – Family peer support service provider

> *"Some youth have not made any progress and are now able to talk about things… and can share things with providers… that's a huge plus to wraparound."* – Care Manager

Other responses included the importance of linking families to other services; the helpfulness of the individualized Plans of Care; the focus on underlying needs; and several other unique ideas (see **Figure 13**).

Figure 13. Proportion of responses about most helpful part of HFW, grouped by major theme; bar length reflects relative frequency (N=33 respondents).



That the feature of HFW most frequently identified as helpful in NYS was family voice and choice indicates the critical nature of this component and what distinguishes HFW from other models. Care managers' views are also consistent with fidelity data: *strength-and family-driven* was consistently the highest or nearly highest practice element across each instrument assessing fidelity and among HFW participants. Facilitating family ownership of the HFW process is clearly an indispensable model feature.

POTENTIAL NEXT STEPS

NYS has made great progress in HFW implementation over the past 30 months and is thus able to identify challenge areas in need of additional support in Year Four.

First, while providers have excelled in championing family voice and choice, celebrating their success (e.g., at future SOC summits, through monthly updates, or during team implementation meetings) may boost capacity to facilitate family voice and choice even further.

Second, facilitation teams need more help in how best to integrate natural and community-based supports into family HFW processes. This is an area of difficulty not just in NYS but also nationally, so progress may be difficult to achieve; nonetheless, exploring strategies among sites that have done this well and sharing their strategies more broadly could facilitate progress in this area.

Thirdly, providers also appear to need further assistance on HFW documentation in the WRAP-NY system website. HFW events and activities appear underreported in the WRAP-NY system, suggesting work is happening, but not being reflected through documentation. It is understandable that documentation in the WRAP-NY system is limited, as care managers are likely more motivated to enter records in HHSC electronic health records, which is necessary for reimbursement. Still, monitoring model fidelity may be most sustainable through documentation, and documents are needed to conduct this form of fidelity assessment. While some forms or fields within the WRAP-NY system are less consistently completed (e.g., location of crisis behaviors, transition plans), WRAP-NY documentation is inconsistent in almost every area, so general assistance is likely needed as a first step. Future webinars or workshops that focus on how to use the website within implementation support meetings may be opportunities to provide this support. CHSR could also provide support in this area if desired.

Finally, NYS should consider introducing strategies to help HFW teams meeting timely engagement milestones. Possible strategies include scheduling out activities and meetings in advance using common calendars and, when meeting in person is not possible, teleconferencing. Creating different timelines for families who have experience significant adversity may also be an option.

Section IV: Family Success

The primary goal of SOC and HFW activities is to achieve positive outcomes for involved families and children. In particular, the HFW process should lead to improvements in family and youth health and functioning. Due to these expected improvements, one would expect a reduction in the need scores and an increase in the strength scores on CANS-NY assessments for youth and caregivers in HFW.

Year Three has seen the collection of substantial data towards answering questions in this focus area and the laying of specific groundwork for next analyses and steps over Year Four. Current findings using family interview and administrative data are presented, as well as some information gleaned from the Year Three provider interviews. While many questions regarding family success cannot yet be directly answered, plans are now more concretely in place to address this topic in the final grant year, including the capstone Medicaid analyses, outlined below.

CURRENT FINDINGS

Family Interview and Administrative Record Data

As of October 2019, 192 families had been enrolled in HFW; project enrollment goals were thus achieved one year ahead of target. About half (51%) have been discharged. At least one member (caregiver or youth, or young adult) of each of 110 families completed a baseline interview, 45 completed at least one reassessment interview, and 52 completed a discharge interview (see **Table 4**). 56 caregivers, 34 youth, and two young adults (59 total families) had data for both a baseline interview and at least one post-baseline interview (whether reassessment or discharge).

Table 4. Family Interview and Administrative Record Data availability.

Timepoint	N Eligible Families	N Interviews Obtained (/of N eligible)				N Administrative Record Only
		Total Families	*Caregivers*	*Youth*	*Young Adults*	***Total Families***
Baseline	192	110	105/185	73/185	2/7	82
6-month Reassessment	68	41	39/66	26/66	2/4	27
12-month Reassessment	20	14	12/18	7/18	1/2	6
18-month Reassessment	4	2	2/4	1/4	0/0	2
Discharge	97	52	52/94	27/94	0/3	45

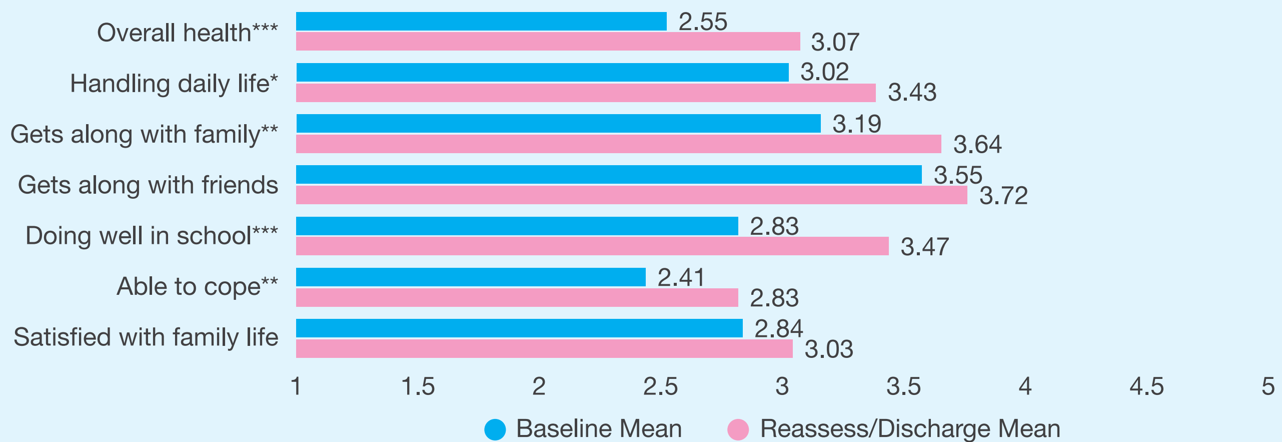
In some areas, the sample has sufficient data to compare interview responses at intake and a later timepoint and thus determine changes potentially due to HFW participation (see Appendix for more information on interview scales). Notably, of the discharged families, 72 were discharged prior to the transition stage (i.e., prior to the completion of wraparound); 25 were discharged during the transition stage (i.e., families “graduated” from HFW). Most families discharged during the transition stage were from Erie County (N=18), an early implementing county that withdrew from the pilot at the end of Year One. Given more “successful” discharges, future analyses may be able to compare responses from families who graduated versus those who were discharged before completing the process to determine the impact of full participation versus partial.

Youth and caregiver growth during HFW, as reflected by changes in scores on standardized scales collected during these interviews, have been explored in several recent Data Tidbits. These short analyses are included in the monthly SOC newsletter, shared with the NYS SOC community. This work has demonstrated that, after some period of participation in HFW, families tend to feel more empowered (average scores on the Family Empowerment Scale improved by 0.2 points, out of 5; see July 2019); report increased social connectedness (Social Connectedness scores improved by about 0.2 points, out of 5; see August 2019); and show decreased caregiver strain (Caregiver Strain

Questionnaire scores decreased by about 0.4 points, out of 4; see November 2019). Available reassessment and discharge data also demonstrate positive participant experiences in HFW and care coordination that is reflective of HFW principles (average Participants' Perception of Care scores were 4.3, out of 5; see April 2019).

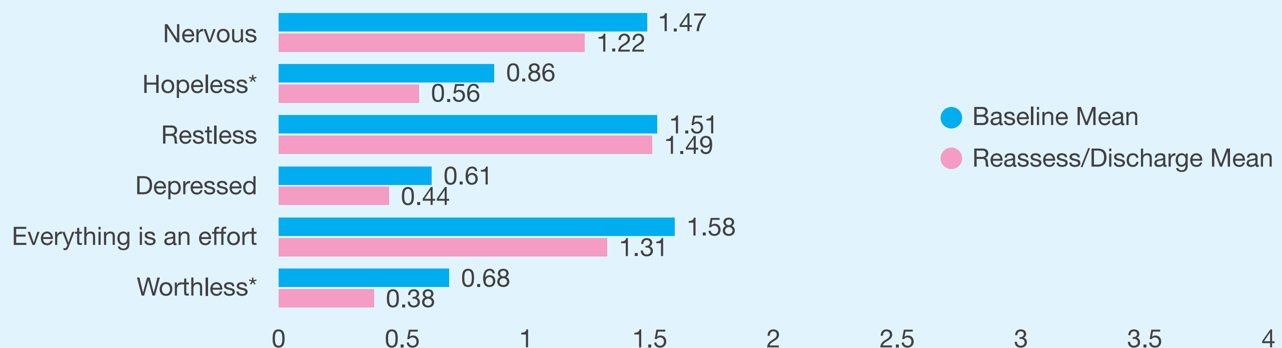
Further analyses have explored changes in the NOMS data, particularly those related to youth functioning. Interviewees are asked to rate their, or their child's, overall health, on a scale of 1 (Poor) to 5 (Excellent), and to rate their ability to function in various aspects of their life, on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree). As compared to baseline responses, families reported significant improvements in overall health, and were more likely to agree that they, or their youth, were able to handle daily life, get along with family, do well in school, and cope, as of their last interview (reassessment or discharge; see **Figure 14**). As such, participation in HFW appears to improve children's functioning in general and improve their overall health.

Figure 14. Reported improvements in child health and functioning for N=58 families with both baseline and reassessment or discharge data (*=*p*<0.05, **=*p*<0.01, ***=*p*<0.001).



With respect to changes in child mental health and functioning, youth reported that they felt hopeless or worthless less frequently (on a scale of 0=None of the Time to 4=All of the Time), demonstrating improvements in mental health functioning due to HFW participation (see **Figure 15**). While there were not significant changes in response to the other items on the scale, they may become significant as more youth complete a reassessment or discharge interview and the sample size increases, or may require more time for changes to be evidenced, thus only becoming significant when examined after longer intervals.

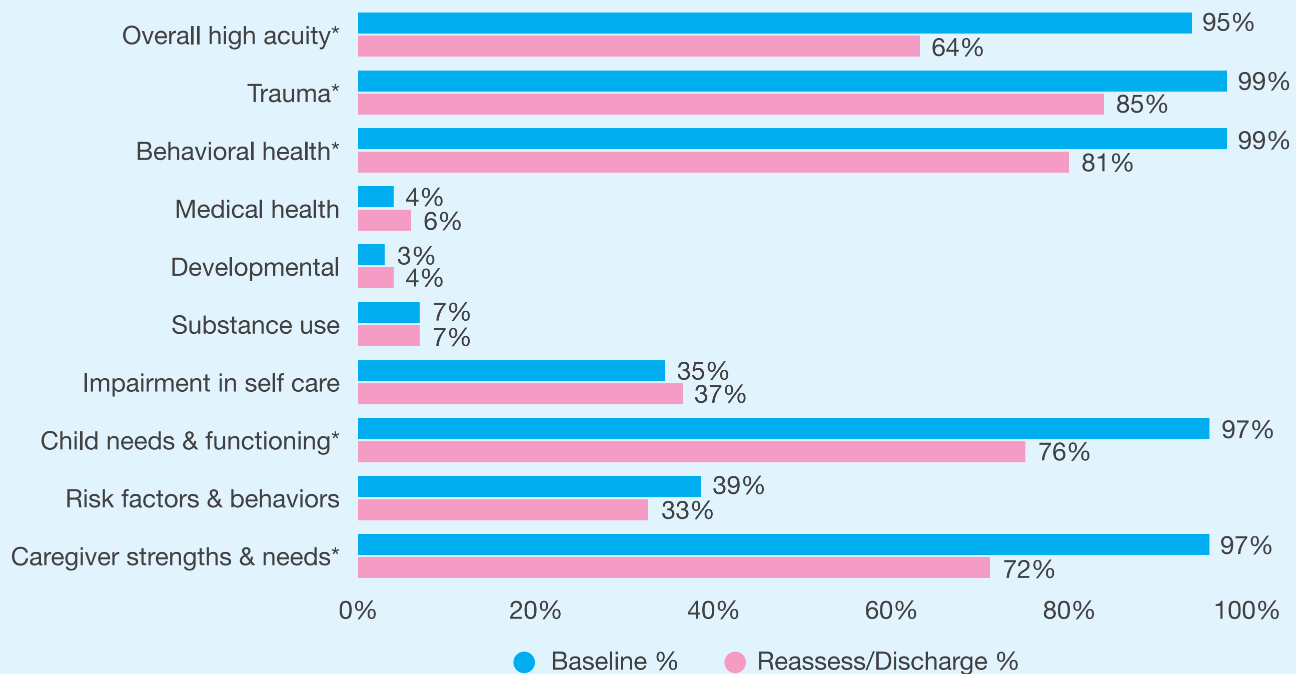
Figure 15. Reported improvements in child mental health and functioning, for N=37 youth with both baseline and reassessment or discharge data (*=*p*<0.05).



Another way to explore youth and caregiver changes over the course of HFW is to examine whether strengths and needs have changed. The CANS-NY tool is designed to assess youth and caregiver strengths and needs in various domains. Items are scored from 0 (no evidence of the need/a powerful strength) to 3 (immediate action is needed/no strength). This tool is completed by care managers (and SPOAs for eligibility determination) and is designed to help guide the care coordination process.

There were some positive findings when looking at changes in CANS-NY scores corresponding with participation in HFW in 74 families with both a baseline assessment and at least one later assessment (last available assessment: 6-month reassessment, N=20; 12-month reassessment, N=8; 18-month reassessment, N=5; and discharge, N=41). First, while 95% of families (71/74) scored as High Acuity at baseline, only 64% (47/74) met the criteria at follow-up ($t(73)=5.407$, $p<0.001$; see **Figure 16**). Families also showed reductions in needs across some critical CANS-NY subscales. Families were less likely to meet the High Acuity criteria for Trauma ($p=0.001$),[2] Behavioral Health ($p<0.001$), Child Needs & Functioning ($p<0.001$), and Caregiver Strengths & Needs ($p<0.001$). No changes were found for Medical Health, Developmental Needs, or Substance Use, but unlike the other subscales, these items were not completed universally.[3]

Figure 16. Percent of families meeting High Acuity on overall CANS-NY assessment and in each domain, for N=74 families with both baseline and reassessment or discharge data (*=$p<0.05$).



Further, youth were reported to exhibit greater strengths after involvement in HFW. While the Child Strengths subscale is not part of the High Acuity scoring requirements, and so was not completed for all families, scores also tended to improve over participation for the 65 families with such data. Overall scores decreased (baseline mean = 21 out of a possible 39, reassessment/discharge mean = 17.3, $t(64)=4.526$, $p<0.001$), and the number of items rated at least a 2 (identified but not currently useful strengths) or rated as a 3 (no strength identified in area) decreased (8.1 to 5.9, $t(64)=4.737$, $p<0.001$; 2.5 to 1.2, $t(64)=4.877$, $p<0.001$, respectively). Youth presented more, and more powerful, strengths after participation in HFW.

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[2] Note that the scoring for the Trauma subscale includes Behavioral Health, so families who meet the criteria for Behavioral Health will necessarily also meet the criteria for Trauma.

[3] Medical Health recorded for N=17 of 74 families; Developmental Needs N=25; Substance Use N=23.

As such, broad family improvements across multiple domains are evident after participation in HFW, whether after six months or discharge from the process. Based on interview and administrative data, families report feeling more empowered, more socially connected, less strained, and healthier and more able to function, and have less severe symptoms.

Provider Interview Data

Service providers also noted some of these positive family changes during the Year Three interviews. While no questions specifically focused on this topic, some providers spoke to perceptions of youth and family improvements. As one care manager explained, due to HFW, families are more able to

> *"…focus on the strengths and positives. In the team meetings, [they] can say, 'hey, you wouldn't have been able to do this a year ago.' They can see and track their progress. It's more rewarding to see that."*

As such, families may be able to both achieve more, and recognize their own successes, after taking part in HFW. Another care manager noted that families *"…are in charge of what's happening and what is worked on,"* demonstrating family's empowerment to lead the management of their own care in the HFW process.

Several providers did note that some families may be better matches for HFW than others (e.g., some families are not yet ready to take part in such an extensive process, others have insufficient family buy-in, others may have goals that are not the right fit for the program, etc.), but still felt that most enrolled families were a "good fit" for HFW, and thus had the potential for positive changes with participation.

POTENTIAL NEXT STEPS

As such, Year Four activities will focus on the continued collection of family interview data and administrative records at each timepoint. Additional reassessment and discharge interviews are especially expected, as more families stay enrolled for long enough to reach these timepoints or leave wraparound; as noted earlier, analyses may be able to compare responses from families who "graduate" to those who discharge before graduation. This information will help establish the impact of HFW on family successes through changes in responses to administrative and interview scaled items and evaluations of the HFW process.

Medicaid Analyses

Importantly, a set of analyses based on Medicaid data are planned for Year Four. This work will allow determination of changes in Medicaid utilization due to participation in HFW, particularly in categories of service strongly related to HFW efforts and client needs. These analyses will thus provide more direct causal information about the impact of HFW on youth outcomes, and hopefully youth successes, in comparison to care coordination alone; these results can help plan for project sustainability even after the end of the current grant. The evaluation team finalized a Medicaid analysis plan during the Year Three contract; the plan is summarized here. The data itself is expected to be pulled by OMH analysts in July 2020, and will be analyzed by the evaluation team for the Year Four final report.

These analyses will examine changes in utilization for 115 HFW youth six months before versus after HFW enrollment. These differences will be held in comparison to a control group of youth who did not receive HFW but were continuously enrolled in HHSC care management in a similar time period, drawn from Medicaid data and matched to HFW clients using Propensity Score Matching to ensure similar backgrounds and histories, symptomatologies and clinical profiles, and pre-period Medicaid utilization.

By addressing client needs through care coordination, connecting them with needed services, and creating a support system, HFW is expected to reduce high-intensity behavioral health service utilization (e.g., inpatient hospitalizations, crisis response, out-of-home placements, intensive outpatient services) beyond the impact of regular HHSC care coordination. Further, if HFW is more effectively connecting participants to behavioral health services, HFW client's clinic-outpatient service utilization (e.g., clinic, therapy, pharmacy) may increase in their post-period, and may be higher than that of Comparison clients during and after enrollment. These changes may be seen in either total spending within these categories, or in amount of service utilization (i.e., number of visits or days of service). Contrasting pre-post utilization in Comparison clients to that in HFW clients will thus allow determination of outcomes specific to, and hopefully caused by, HFW, providing direct evaluation of the impact of HFW on Medicaid service utilization.

Section V: Health Habitus Integration Training for High Fidelity Wraparound Teams

Under the auspices of the current grant, the Center for Research on Cultural and Structural Equity in Behavioral Health (C-CASE) at the Nathan Kline Institute for Psychiatric Research developed and implemented the Cultural and Structural Competence (CSC) training for providers working with families with youth with serious emotional disturbances. Health Habitus Integration is the primary component of the CSC training; it is designed to enhance understanding of the structural and cultural determinants of health and integration of this understanding into practice. The final form of this training aims to equip peer support service providers with salient skills and tools to integrate their social and cultural determinants insights into their HFW skill set as they worked with families and youth, and with colleagues in their care teams. Below, we briefly (1) discuss the Theory of Health Lifestyle, revised by C-CASE, (2) describe the CSC training components, (3) suggest the theory's suitability for providers trained in HFW, and (4) conclude with preliminary evaluation findings of the CSC training.

THE SOCIAL DETERMINANTS OF HEALTH FRAMEWORK AND THE HEALTH LIFESTYLE THEORY

For more than two decades, public health practitioners and researchers have recognized the influence of social determinants on mental and physical health. Social factors, such as race/ethnicity, social class, gender, age, and stigma or discrimination, are the building blocks of social structure and determine individuals' place in this structure. These social factors have been identified as distal fundamental causes of health and health disparities (Compton and Shim, 2015; Link and Phelan, 1995; Phelan, Link and Tehranifar, 2010; Hatzenbuehler, Phelan and Link, 2013), which are conceptualized as affecting more proximal causes (e.g., access to medical care, adherence to treatment, adoption of certain health beliefs), and protecting or increasing health risk. Consequently, when interventions address only one causal pathway (e.g., locating a public mental health clinic in one's community), other pathways (e.g., race-related and/or substance use-related stigma deterring access to services in the community) continue to operate and produce disparities (Link and Phelan, 1995).

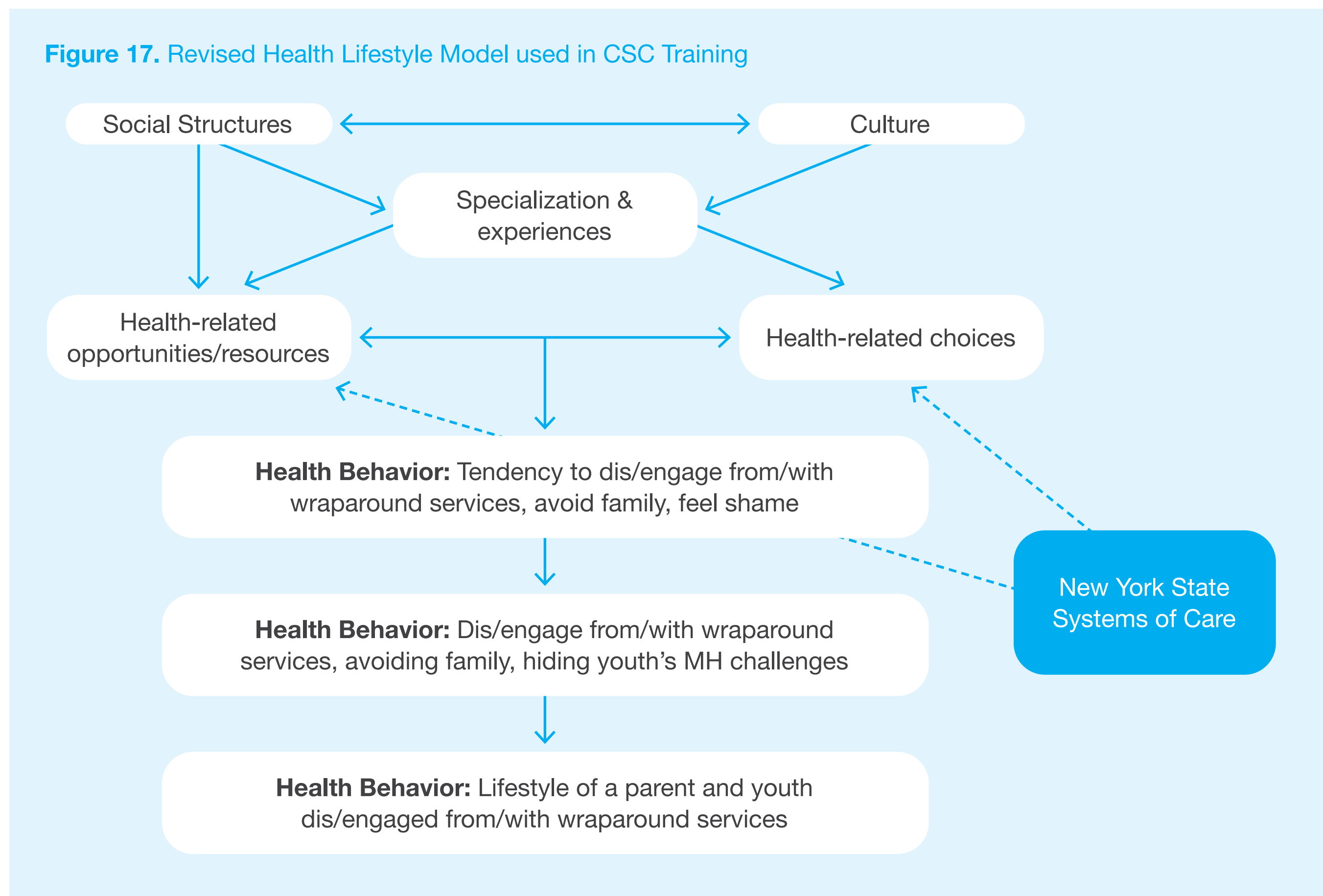
The framework of social determinants of health has been invaluable in revealing the social and structural patterns of health outcomes and disparities. However, in its application, social determinants have been conceptualized and measured as individuals' access to and use of resources (e.g., income, education, transportation). This approach prioritizes individual behavior and confines the social determinants to the individual level, thus losing sight of the social context (e.g., policy, community, healthcare institution; Freese and Lutfey, 2011). The concept of health habitus refers to the structurally determined tendencies of individuals when caring for their health (Bourdieu, 1977, 1990). This concept has been suggested as one way to bridge the social level with the individual level which, in turn, addresses the aforementioned limitation of the social determinants framework (Freese and Lutfey, 2011). Health habitus, and how it sponsors and reproduces health behavior that, over time and with repetition, becomes a health lifestyle, constitutes the core of the Theory of Health Lifestyle (Cockerham, 2005, 2013). C-CASE revised this theory to emphasize the role of culture, stigma, and intersectionality.

The Revised Health Lifestyle Model anchors health habitus in the social structure *and* in culture. Health habitus, as indicated above, motivates health *behavior* that, over time and with repetition, becomes a health *lifestyle*. A key revision to the model was the integration of stigma and how it is generated through culture and becomes a feature of health habitus through socialization and experiences. First, social determinants, such as race/ethnicity, class, gender, age, and geographic location (rural vs. urban) are defined as the building blocks of social structure. Second, these social determinants intersect and shape a variety of types of socialization and of experiences. The intersection of these determinants directly influences one's life opportunities/constraints. Third, culture (i.e., shared beliefs, values

and norms) is assigned a primary role, and an interplay between culture and social structure is posited. This interplay, through socialization and experiences, also influences life opportunities/constraints, which in turn, inform a range of life choices. Health habitus is generated at the interplay between life choices and life opportunities/constraints.

Finally, the provision of the wraparound services under the NYS SOC expansion grant was included in the model. These enhanced services, guided by the ten principles of wraparound, are suggested to have the potential to expand the life opportunities and life choices for families and youth. For example, HFW increases the availability of formal and informal supports for the family, and strengthens families' feelings of competence in making their own health decisions and working on the goals they identify as important. These supports and activities can thus transform a family and youth's health habitus, behavior, and lifestyle (see **Figure 17** for the complete Revised Health Lifestyle Model).

Figure 17. Revised Health Lifestyle Model used in CSC Training



ELEMENTS OF THE CULTURAL AND STRUCTURAL COMPETENCE (CSC) TRAINING

The Cultural and Structural Competence (CSC) training consists of two main components and is provided by expert facilitators with advanced degrees in the social sciences and/or public health. The 6.5-hour training session is conducted in-person and is followed by a one-hour webinar "booster" at four weeks to enhance trainees' skills.

The first part of the CSC training reviews Culturally and Linguistically Appropriate Services (CLAS) standards with a focus on the domains of culture, health equity, and structure. This component is lecture-based and is designed to provide trainees with a shared language for discussing cultural and structural differences and health disparities. It also includes a discussion on using the term "cultural humility" instead of "cultural competence," and highlights the differences between implicit and explicit bias. This component also lays the foundation for the Health Habitus Integration training.

The second part of the CSC training, the Health Habitus Integration component, is theoretically driven and aims to provide family and youth peer support service providers with the skills and tools to integrate their insights regarding social and cultural determinants of health into their HFW skill set as they work with families and with colleagues such as care managers and supervisors. As such, it consists of both didactic lecture sections that pertain to the theoretical and methodological components of the training, and practice sections that include hands-on activities for experiential learning.

The Health Habitus Integration training includes a didactic phase to refresh trainees' knowledge on the role of culture in services; an introduction to the Health Lifestyle Model and how health habitus can interfere with engagement in services; writing of one's own health habitus; a didactic phase on conducting an in-depth interview designed to elicit the family and the youth's health habitus, using the interview guide as a tool; a practice phase where trainees engage in health habitus interviewing and composing a health habitus note in small groups; and a discussion on potential strategies for integrating the health habitus information into the peer support service providers' one-on-one meetings with the family and youth, as well as into the care manager's meetings with peer support service providers. The follow-up webinar focuses on discussing an example of a family's health habitus note and strategies for integrating the information in the note into the peer support providers' work.

From August 2018 through the end of Year Three, seven CSC trainings were held in six NYS counties: one training each in Kings, Oneida, Onondaga, Rensselaer, and Westchester counties, and two trainings in Albany county; a total of 146 individuals have been trained.

MIXED METHODS EVALUATION OF CSC TRAINING

To evaluate CSC implementation and inform training refinement and follow-up activities, we used a mixed-methods approach, incorporating same-day and follow-up quantitative surveys and in-depth qualitative interviews. Data collection activities are ongoing, with the goal of collecting 200 same-day surveys, 75 follow-up surveys, and 40 qualitative interviews.

Data Collection Tools: Survey & In-Depth Interviews

Self-administered same-day evaluation surveys are given to all participants at the end of the in-person CSC training. The survey takes approximately 10 minutes to complete. It assesses health habitus-related knowledge and CSC training experience, including the perceived utility of health habitus, trainee self-efficacy, and opinions on how health habitus training concepts and tools can be incorporated into practice, as well as trainee demographic characteristics. To date, a total of 138 trainees have completed same-day surveys, for a response rate of 94.5%.

To assess CSC training efficacy and impact on practice, C-CASE also conducts a follow-up assessment at least three months after training. This second assessment includes a survey to ascertain health habitus-related knowledge, attitudes, and practice since the CSC training, including intentions to maintain or begin using CSC training principles post-training (survey duration 10-15 minutes). The survey is administered either in-person on a laptop using the Audio Computer Assisted Self Interview program or online via an emailed link. To date, 49 trainees have completed the follow-up survey.

Follow-up qualitative interviews (duration 35-50 minutes) are also conducted at least three months after training, to contextualize the training assessment and begin identifying implementation experiences. These interviews collect information about trainees' experience during the training as well as their understanding of health habitus, its relevance to their work, and any personal or professional insights they might have gained through the training. The interview asks about trainees' experiences in applying the specific tools and resources provided in the CSC training, including identifying barriers and facilitating factors, and addresses whether and how the CSC training has been incorporated in practice, including reasons for not implementing the CSC training. The interviews are conducted in-person and audio-recorded for verbatim content analysis. To date, 27 trainees have participated in an interview at one of three conferences. Data analysis is underway and findings will be available in Year Four.

Analytic Plan

For the preliminary reporting included in this report, descriptive statistics were used to characterize the sample from the same-day assessment. We also provide descriptive statistics of trainee's same-day knowledge, attitudes, and perceptions to the CSC training. To quantify health habitus knowledge immediately after training, the percent correct

of the seven knowledge questions from the same-day survey was computed. The perceived utility of CSC training components was measured by asking trainees how useful they found each of the four elements (writing their own health habitus, practicing health habitus interviewing, using the interview guide, writing a health habitus note as a group) to be, on a scale of not useful (0) to very useful (2). A total utility score was computed for each trainee by summing these responses; scores thus ranged from 0 to 8, with higher values indicating greater perceived utility.

For the follow-up surveys, descriptive statistics describing the sample and their self-reported implementation of health habitus principles in HFW practice are provided.

Preliminary Findings

Demographics. Table 5 provides the distribution of trainee characteristics from same-day and follow-up evaluations. A total of 138 individuals completed same-day evaluations. Over half (62%) of the trainees were either family (n=65, 48%) or youth (n=19, 14%) peer support service providers; the remaining trainees were care managers (n=27, 20%) and supervisors (n=25, 18%).

Most trainees were White non-Hispanic (75%) and Female (91%). Trainees ranged in age between 19 and 72 years; categorized, those aged 19-29 years and 50 years and older represented the modal age groups.

Table 5. Same-Day and Follow-Up Survey Respondent Demographics.

Measures	Same-Day	Follow-Up
All Respondents	138 (100%)	49 (100%)
Role		
Youth peer support service providers	19 (14%)	15 (31%)
Family peer support service providers	65 (48%)	24 (50%)
Care Manager	27 (20%)	3 (6%)
Supervisor	25 (18%)	6 (13%)
Race/ethnicity		
Black	25 (18%)	6 (13%)
Hispanic	9 (7%)	7 (15%)
White non-Hispanic	102 (75%)	34 (72%)
Gender		
Female	123 (91%)	40 (85%)
Male	12 (9%)	7 (15%)
Age		
19-29 years	36 (28%)	14 (32%)
30-39 years	30 (24%)	10 (23%)
40-49 years	25 (20%)	9 (20%)
50 years or more	36 (28%)	11 (25%)

Forty-nine individuals completed follow-up evaluations (**Table 5**). As with the same-day surveys, most individuals were peer support service providers (31% were youth peer support service providers, 50% family peer support service providers), White non-Hispanic (72%), Female (85%), and either aged 19-29 years (32%) or 50 years and older (25%). The mean time since training was 6 months (median 4 months).

Same-day knowledge.

Table 6 provides descriptive statistics related to same-day knowledge. Overall, the mean same-day knowledge score for all trainees was 5.8 of a possible 7, or about 83%. By role, youth and family peer support service providers had mean scores of 5.95 (85%) and 5.82 (83%), respectively, while care managers and supervisors had scores of

5.67 (81%) and 5.52 (78%), respectively. Trainees were highly accurate in their understanding that health habitus is shaped by the interaction between health choices and health-related opportunities and resources (98% correct) and that recognizing biases is a component of practicing cultural and structural humility (98.5% correct), but only 63% of trainees responded that the health habitus qualitative interview is a purposeful guided conversation.

Table 6. Trainee knowledge assessment, perceived utility of Health Habitus Integration training, and intention to elicit client health habitus, from the same-day evaluation, N=138.

Measures	N answering correctly/ Answering Yes (%) of 138
Knowledge assessment	
Health habitus is shaped by interaction between health choices and health-related opportunities and resources	131 (98%)
Being self-aware, recognizing one's own biases, and respecting different world views and experiences will help in the practice of cultural and structural humility	134 (98.5%)
The health habitus qualitative interview is a purposeful guided conversation	80 (63%)
Characteristics of an active listener	110 (83%)
The purpose of the health habitus note is to record information from the health habitus qualitative interview	124 (93%)
The purpose of health habitus note to integrate information into family encounters	111 (87%)
The purpose of health habitus note to help the family follow their care plan	99 (76%)
Perceived utility of CSC Training components	
Writing own health habitus	126 (94%)
Practicing health habitus interviewing	125 (96%)
Using Interview Guide	128 (97%)
Writing health habitus note as a group	114 (90%)
Do you plan to elicit a client's health habitus in the next 30 days?	
Yes	88 (64%)
No	33 (24%)
Missing	17 (12%)
If yes, when:	
At my next family visit	26 (30%)
When I meet with the youth alone	14 (16%)
When I meet with the family alone	33 (37.5%)
When accompanying a family member or youth to a provider appointment	2 (2%)
At some other time	13 (15%)
If no, reason (check all that apply):	
Families for HFW are not yet enrolled	16 (48.5%)
I feel I need more training in health habitus	12 (36%)
I feel I need more training in HFW	12 (36%)
I have families I work with, but need more time to schedule a visit	5 (15%)

Same-day perceived utility of and intention to elicit health habitus. Trainees reported high perceived utility of CSC training components. The mean utility score of the training components was 6.04 out of a possible 8. At least 90% of trainees reported that it was useful to write their own health habitus, practice the health habitus interview, use the

interview guide, and write a health habitus note as a group. Of note, youth peer support service providers showed the highest perceived utility score (6.74), followed by family peer support service providers (6.26), care managers (6.26), and supervisors (4.92).

When trainees were asked if they planned to elicit a client's health habitus in the next 30 days after the training, 64% said that they would, but 24% reported that they would not; notably, 17 (12%) individuals skipped the question. Of those who responded in the affirmative, most planned to complete their client's health habitus in a family visit setting. Of the trainees who responded negatively, 48% noted that their families were not yet enrolled in HFW; 36% reported that they needed more training in health habitus; 36% reported needing more training in HFW; and 15% indicated that they have families to work with, but needed more time to schedule a visit.

Follow-up assessment of the implementation of health habitus into practice. Table 7 provides distribution of health habitus implementation overall, and by HFW role (where youth and family peer support service providers were grouped with care managers).

At follow-up, almost half (46%) of respondents reported that they had conducted a health habitus interview, at least partially, since their training. Almost half (47.5%) of facilitation team members reported conducting a health habitus interview since training, as compared to one-third (33%) of supervisors. Of those who did conduct an interview, 62% noted that the interview guide was not used, a positive finding given that trainees were encouraged to develop their own guide. Additionally, over one-third (38%) of those who reported conducting health habitus interviews noted that the interview was conducted during the second meeting with the family.

Table 7. Trainees reporting implementation of health habitus by HFW role, Follow-Up survey, N=48.

Measures	All	By HFW Role	
	N (%)	Peer support service providers & Care Managers	Supervisor
	48 (100%)	42 (87.5%)	6 (12.5%)
Conducted a health habitus interview, even partially, since last training[1]	21 (46%)	19 (47.5%)	2 (33%)
Written health habitus note, even partially, since last training[2]	17 (37%)	15 (37.5%)	2 (33%)
See yourself eliciting a client's health habitus in the next 30 days[3]	28 (65%)	24 (65%)	4 (67%)

[1]missing=2 [2]missing=3 [3]missing=6

About one-third of respondents (37%) reported that they had written a health habitus note since training; rates were similar between roles. Of those, almost all (94%) found it useful.

Finally, follow-up respondents were asked if they could see themselves eliciting a client's health habitus in the next 30 days from the evaluation; 65% noted that they could. Rates were similar between roles.

PRELIMINARY DATA SUMMARY AND NEXT STEPS

To date, there is evidence of health habitus knowledge and perceived utility of health habitus at the end of the in-person training. While nearly two-thirds of trainees reported anticipated elicitation of client's health habitus in the upcoming 30 days, early follow-up data suggested that fewer (approximately half of trainees) had integrated health habitus into practice, and fewer had written a health habitus note (37%). However, we are encouraged by nearly two-thirds of those surveyed at follow-up reporting *intention* to elicit a client's health habitus.

These preliminary findings will be confirmed when survey data collection and analyses are completed in Year Four and contextualized with analysis of qualitative interview data.

Section VI. Cross-Cutting Themes & Conclusions

Significant work has been done across the past three years to build infrastructure for cross-system collaboration across NYS, train providers in HFW knowledge and skills, support implementation of these approaches and practices, and improve youth and family experiences and outcomes. Data from many different sources was analyzed and integrated to determine progress in each domain, and point to potential next steps for both implementing partners and the evaluation. Across all of this work, several themes are apparent.

NYS SOC HAS BUILT CAPACITY TO ENHANCE LOCAL SOCS

First, NYS SOC has endeavored to build capacity to enhance local SOC through a variety of mechanisms and at multiple levels. NYS SOC leaders have promoted adoption of the SOC approach in multiple sectors (such as in schools and through partnership with Project AWARE) and in multiple counties (through technical assistance and "SOC 101" presentations), and have developed sets of tools local jurisdictions can employ to build their local systems of care (such as the SOC 101 and 201 training materials, SOC marketing toolkits, and new SOC planning curriculum developed by Policy Research Associates). These efforts have happened alongside shifts in the roles of C-SPOAs, as they become coordinators of local SOCs.

These efforts represent a promising step toward sustainability, as these resources have been created for local use; OMH may consider continuing to support their implementation and monitoring their impact. Additional efforts could include using the RiTATs or local C-SPOAs to further promote the SOC approach and encourage local infrastructure development. Future iterations of the SOC Implementation Survey, including administrations beyond even the current grant, may help assess these efforts.

PROVIDERS NEED ADDITIONAL SUPPORT FOR COMPLETING REQUIRED HFW DOCUMENTATION

A second theme concerns the difficulty of completing required HFW documentation, potentially as related to the impact of rapid HFW expansion over the course of the grant period. HFW has significant documentation demands, which are sometimes seen as being in "competition" with the requirements of other systems, such as that for HHSC. Care managers frequently expressed being overwhelmed and confused by all the paperwork and documentation needed for HFW, especially when some of it is seen as redundant with their HHSC work. Other documentation is unique to HFW, but is not completed to model fidelity standards or do not seem to be well-understood by providers. Utilization of the WRAP-NY system website appears to be lagging behind practice, leading to the perception that model implementation lacks fidelity or that HFW work is simply not happening.

This strain may, in part, stem from NYS's rapid expansion of HFW training implementation over the course of the grant. NYS has built their internal capacity for training through the creation of the Wraparound Training and Implementation Institute. Many care management agencies and individual care managers and/or supervisors have taken advantage of this opportunity to receive HFW training. Peer support service providers have also benefited from the state's capacity to build training curricula, as the state's Wraparound Peer Readiness and Implementation Training has trained several cohorts of peer support service providers, thereby expanding the availability of peer support service work. In addition to these HFW-specific trainings, providers are also participating in the Cultural and Structural Competence training, designed to enhance their cultural humility and skills in incorporating in their practice the social and cultural determinants of health through the Health Habitus Integration training. This increased pool of trainees has resulted in greater numbers of providers trained in HFW than anticipated at the outset of the grant.

The effects of this increase are twofold. On the one hand, this expansion increases the potential for more families to participate in HFW. On the other, WTII's capacity to monitor implementation fidelity via documentation and support

provider documentation efforts may be strained. Additionally, this increased training availability has happened alongside many significant changes in the landscape of children's mental health services in NYS, such as the establishment of peer support services as Medicaid-reimbursable and new CFTSS/HCBS benefits. These multiple demands have made it difficult to ensure that practices have been documented faithfully, which is reflected in low rates of youth with records of essential Crisis Plan and Plan of Care documents, low rates of peers providers conducting and documenting health habitus interviews, and confusion about how to bill for services.

Additional efforts toward documentation review, by NYS OMH or available partners, may ameliorate some of these difficulties, at least in the short term. Documentation review represents the most feasible and sustainable means of assessing HFW practice fidelity to the model. It is essential to ensuring that HFW is adopted as expected, and that good practices are sustained over time. In the short term, NYS OMH may consider methods of identifying efficient means of supporting providers in meeting the demands of HFW, thus hopefully boosting provider's abilities to meet the documentation requirement. In the longer term, if HFW ultimately becomes a Medicaid-billable service, and thus becomes available to youth statewide, a single documentation system integrating HFW and HHSC forms and paperwork would likely become necessary. Taking steps toward considering such a system is thus likely to be the most sustainable option in the long-term.

PROVIDERS DEMONSTRATE CONSISTENT STRENGTHS AND CHALLENGES IN IMPLEMENTATION OF PRINCIPLES OF HFW

Beyond paperwork, though, providers and care teams demonstrated consistent implementation of several HFW principles and practices, but were less consistent in others. Families, care team members, and external observers consistently reported that HFW meetings were strength-based and family-driven, and that providers worked to support family voice and choice, suggesting they have kept families' perspectives at the center of the HFW process. Consistent challenges were reported by all involved in domains such as integrating natural and community-based supports, meeting timely engagement standards, and in documentation (as discussed above).

Care managers tended to agree with findings from the fidelity assessment, generally recognizing family voice and choice as the principle making the most positive impact in families' lives, but also requesting assistance in the areas that fidelity data showed were implemented inconsistently, particularly in developing families' natural support network and meeting timely engagement standards. Celebrating pilot implementation of principles implemented consistently (voice and choice) via forums with wide reach (e.g., NYS SOC listserv monthly update) can highlight pilot implementation successes thus far and potentially motivate enhanced practice even further. Additionally, supporting care managers in areas they identified as difficult could boost fidelity. This support could be channeled through care manager supervisors; for example, WTII could provide explicit instructions on how supervisors can support care manager HFW skill development. Instructing supervisors to use specific tools that promote fidelity to practices (e.g., adapted from HFW fidelity instruments) could be one way of addressing this need.

FAMILIES DEMONSTRATE IMPROVEMENT AFTER HFW PARTICIPATION

Of course, the key outcome and goal of the NYS SOC grant and efforts is the improvement of family and youth health and functioning. Importantly, participating families do appear to be improving after their participation in HFW, even if practice implementation could use additional support. Families reported positive outcomes and shifts, and had less severe symptoms, after participation. Specifically, families reported feeling more empowered, more socially connected, less strained, healthier and more able to function, and with lessened symptom severity.

Given these promising family-level improvements, it may be worthwhile to explore the features of the HFW model that are especially critical for working with such high-acuity families, and which can be less emphasized. Increasing the number of youth with sufficient records to conduct fidelity assessment, and increasing the number of interviews obtained, is therefore an important goal for the evaluation over Year Four, as it will permit analyses that can demonstrate which elements of HFW practice are most strongly associated with outcomes.

Further, it remains to be seen whether these improvements translate into cost savings and reduced high-intensity health service utilization, which will be key components of the Medicaid analyses to be completed in Year Four. These

analyses will have strong implications for decisions about whether to make HFW the standard of care for HHSC-enrolled youth with the highest acuity.

NEXT STEPS FOR EVALUATION

CHSR will continue to monitor progress and outcomes in each of the four focus areas of our evaluation over Year Four of the grant. First, more families will enroll in the pilot over the year, and have the opportunity to complete reassessment or discharge interviews, broadening the sample and allowing for more extensive pre-post comparisons. Re-administration of the SOC Implementation Survey will help determine statewide progress in SOC infrastructure development over the year. Training surveys and feedback will continue to be monitored to support WTII's training and certification process. Fidelity assessments will continue to be performed; among other elements, this information can be used by supervisors to coach their care managers, and by WTII in coaching the supervisors. And finally, the planned Medicaid analyses will be carried out towards the end of Year Four, thus addressing the question of whether HFW is able to effect a positive shift in service utilization and costs for participating families, and providing key information for questions surrounding project sustainability after the end of the grant itself. This work is hoped to direct attention to areas requiring additional support to promote continued strong implementation, and smooth the path to sustainable practice in Year Four and beyond.

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Appendix

TABLE OF DATA SOURCES USED IN REPORT

Data source	Data collection method	Sample/Subject	Frequency/ Timepoint	Description	Total N
Administrative records	SPOA and/or care managers complete documentation from records data	Caregiver and youth/ young adult	Baseline, 6 month reassessments, and discharge	Administrative records collect some data on every family, including demographics, referral information, systems involvement, diagnoses, services received, level of family engagement, and level of peer participation.	Total= 384 Baseline= 194 Reassess-ments= 92 Discharge= 98
Administrator surveys	Online survey	County administrators and supervisors (staff who do not provide direct service, but participate in HFW implementation)	Annual (end of each year of the project)	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.	28
CANS-NY	SPOA and/or care managers complete documentation	Caregiver and youth/ young adult	Baseline, 6 month reassessments, and discharge	Assessment tool completed by the provider with the family. It identifies needs and strengths of the youth (primarily) and caregiver in various domains: Trauma, Behavioral Health, Medical Health, Developmental, Substance Use, Impairment in Self Care, Child Needs & Functioning, Risk Factors & Behaviors, and Caregiver Strengths & Needs. Acuity is based on how items are scored in certain domains.	Total= 390 Eligibility= 235 Baseline= 38 Reassess-ments= 76 Discharge= 41
Cohesion surveys	Online survey	Care managers, youth and family peer support service providers, supervisors	Once after the final training for each cohort	Cohesion surveys include questions to better understand how care managers, youth and family peer support service providers function as a team.	N=21
Cultural and Structural Competence / Health Habitus Integration training surveys	In-Person survey, Follow-Up survey	Training attendees (youth and family peer support service providers, care managers, supervisors)	Following each training session, and at least three months after training session	Same-day surveys included questions on health habitus knowledge, CSC training experience, and respondent demographics. Follow-up surveys included questions on health habitus knowledge, attitudes, and practices since training.	Baseline= 138 Follow-up= 49

Data source	Data collection method	Sample/Subject	Frequency/ Timepoint	Description	Total N
Fidelity instruments - Documentation review 45-Day Review 2nd CFTM Review	Documentation: review and coding of records in online documentation system (WRAP-NY), administrative records, and materials (agendas) from team meetings.	Documentation	After family has been enrolled/registered for 45 days, after 2 CFTMs have occurred, and after a family has discharged (and has had at least 2 CFTMs)	The documentation review tools measure the extent to which practice reflects the wraparound model as evidenced through documentation at various time-points while a family is enrolled in HFW. Domains include: Timely Engagement, Meeting Attendance, Driven by Strengths and Families, Natural and Community Supports, Needs-Based, Outcomes-Based Process, Safety Planning, Crisis Response, Transition Planning, and Outcomes.	45 day review= 141 2nd CFT review= 35
Fidelity instruments - Team Observation Measure (TOM) 2.0	Observation of child and family team meeting using a validated tool	Child and family team - care manager, youth and family peer advocate, family, other team members	Once per case, anytime between the 3rd-7th CFTM	The TOM 2.0 measures the extent to which practice reflects the wraparound model during a CFTM. Domains include: Full Meeting Attendance, Effective Teamwork, Driven by Strengths and Families, Based on Priority Needs, Use of Natural and Community Supports, Outcomes-Based Process, and Skilled Facilitation.	25 CFTM observations, observed by five observers
Fidelity instruments - Wraparound Fidelity Index (WFI-EZ) surveys	In-person survey	Child and family team - care manager, youth and family peer advocate, family, other team members	Once per case, anytime between the 3rd-7th CFTM	The WFI-EZ surveys measure the extent to which practice reflects the wraparound model by looking at care manager, family, and team member experience and satisfaction with the wraparound process.	103
Interviews with Youth and Families	In-person and phone interviews	Caregiver and youth/ young adult	Baseline, 6 month reassessments, and discharge	These interviews are optional and include NOMS, CFOS, and other assessments of functioning, social connectednesss, empowerment, hope, perception of care, impairment, caregiver strain, housing, education, and criminal justice status.	Total= 221 Baseline= 112 Reassessments= 57 Discharge= 52
IPP (Infrastructure, Development, Prevention and Mental Health Promotion) Survey	Online survey	NYS team and county representatives	Quarterly	Indicators include: number of policy changes completed, the number of people trained in areas consistent with the goals of the grant, the number of consumers/ family members who provide mental health-related services, the number of organizations that entered into formal written agreements consistent with the goals of the grant.	182 indicator entries
Local SOC toolkit use data collection	Survey	NYS SOC entities	Once, at the end of Year Three	Reports on marketing activities using Social Marketing Toolkits during Year Three	13

Data source	Data collection method	Sample/Subject	Frequency/ Timepoint	Description	Total N
NYS SOC Wraparound Certification Training surveys	Online survey	Training attendees (e.g., care managers, youth and family peer advocates, supervisors, RTF providers)	Following each training session	Training surveys ask attendees to provide feedback on the training style/format, segment specific impressions (how new was the material, how relevant was the material, how confident you will use the concepts, and how prepared do you feel), knowledge questions, and overall impression.	413
Provider interviews	Phone interviews	HFW providers (e.g., care manager, youth and family peer advocates)	Annual (end of each year of the project)	During interviews, providers describe their experiences with the project over the previous year. In year one, interviews were also conducted with supervisors and county administrators.	33
SOC Implementation survey	Online survey	Individuals identified as important to the county level SOC	Completed once, follow-up planned for Year Four	Rating Tool for Implementation of the System of Care Approach for Children, Youth, and Young Adults with Behavioral Challenges and Their Families (revised 2015). This tool is designed to "…assess progress in a community or region implementing the system of care approach for children, youth, and young adults with behavioral health challenges and their families."	930
Wrapaganza survey	In-person survey	Attendees of the 2019 Wrapaganza celebrations (mostly: care managers, supervisors, administrators, youth and family peer advocates)	Once, following Wrapaganza event	A survey was administered at the end of the conference to collect feedback on satisfaction with Wrapaganza, satisfaction with current SOC implementation support, benefits and challenges of the SOC/HFW model, ongoing needs, and general feedback.	58
Wraparound Readiness and Implementation Training surveys (Peer Training)	In-person survey	Training attendees (e.g., youth and family peer advocates)	Following each training session	Training surveys were developed by the OMH team to provide feedback on overall satisfaction, suggested changes, and ideas for webinars.	147

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