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Evaluation of Georgia Care Management Entities Using High Fidelity Wraparound Annual Report

Georgia Health Policy Center

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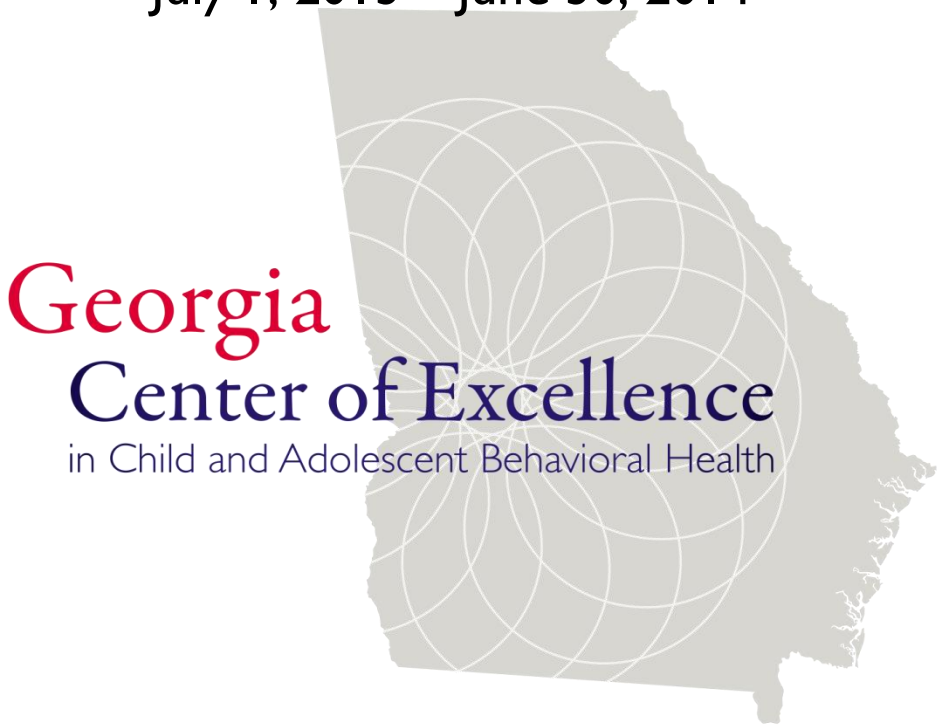
July 1, 2013 – June 30, 2014



Georgia
Center of Excellence
in Child and Adolescent Behavioral Health

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Georgia State University in Partnership with the Department of Behavioral Health and Developmental Disabilities

Prepared for the Office of Children, Young Adults, and Families, Georgia Department of Behavioral Health and Developmental Development Disabilities by the Georgia Center of Excellence in Child and Adolescent Behavioral Health (COE), a part of the Georgia Health Policy Center housed within Georgia State University's Andrew Young School of Policy Studies.

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Executive Summary

The Office of Children, Young Adults and Families (OCYF) within the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) transferred Care Management Entity (CME) Annual Evaluation responsibilities to the Center of Excellence in Child and Adolescent Behavioral Health (COE) in June 2013. This is the first CME Annual Evaluation Report produced by the COE. It includes youth who were eligible for services during State Fiscal Year 2014 (SFY2014), spanning from July 1, 2013 to June 30, 2014.

High Fidelity Wraparound is an intensive, individualized care planning and management practice aimed at providing structure and support to help youth and families achieve positive outcomes (National Wraparound Initiative, 2014)[1]. In Georgia, two Care Management Entities are contractually charged with serving youth statewide: Lookout Mountain and View Point Health. As described in the DBHDD Care Management Entities Procedure Manual (2013), CMEs were originally established as service providers for the Community Based Alternatives for Youth Waiver program. Over time, CMEs have evolved to serve a broader group of children and youth who are at risk for out-of-community care. CMEs provide a single locus of accountability for youth involved in multiple child-serving agencies.

In Georgia, the **target population** for Wraparound is children, adolescents and young adults ages 21 years or younger who meet all of the following requirements: a) are uninsured or have Medicaid coverage; b) require participation in an intensive program in an out-of-home setting due to behavioral, emotional and functional problems that cannot be addressed in the home; and c) have a mental health diagnosis, co-occurring substance-related disorder and mental health diagnosis, or co-occurring mental health and intellectual/development disabilities diagnosis (Care Management Entities Procedure Manual, 2013).

Georgia supports High Fidelity Wraparound through the **Community Based Alternatives for Youth (CBAY)** service delivery model. CBAY provides funding to support additional services and supports not covered by Georgia's Medicaid plan for youth who qualify for Psychiatric Residential Treatment Facility (PRTF) level of care but choose to receive treatment in the community. **Georgia currently has two funding sources that support CBAY services**: Money Follows the Person (MFP) and the Balancing Incentive Program (BIP). Georgia previously supported Wraparound through a 1915c Medicaid waiver, often referred to as "**Waiver-C CBAY**," which completed enrollment effective September 30, 2012. It is important to recognize that level of care criteria differ among CBAY youth. While Waiver-C CBAY and BIP CBAY youth

[1] High Fidelity Wraparound may also be referred to as Intensive Customized Care Coordination

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must meet institutional level of care to qualify for CBAY services, MFP CBAY must have spent 90 consecutive days or more in an institution to qualify for CBAY services.

Non-Waiver youth also meet the eligibility criteria for Wraparound but do not qualify for CBAY or PRTF level of care. DBHDD finances the services provided to Non-Waiver youth on a fee-for-service basis through contracted mental health providers.

In this report, the COE builds upon the work completed by the previous evaluators and expands the scope to include a Wraparound literature review, qualitative stakeholder interviews, workforce development and Wraparound fidelity measures.

Also included in the report are results from Wraparound Fidelity Index 4 (WFI-4) interviews, Youth Satisfaction Survey – Families (YSS-F), Family Empowerment Survey (FES), and California Healthy Kids Survey (CHKS). Additionally, findings from the workforce development training evaluation surveys and from the Impact of Training and Technical Assistance (IOTTA) and Coaching Observation Measure for Effective Teams (COMET) reports produced on DBHDD's behalf by the Wraparound Evaluation and Research Team (WERT) at University of Washington are included.

Programmatic data for the analysis was obtained from a web-based case management system known as Synthesis. All data included in Synthesis is entered by CME and Family Support Organization (FSO) staff. Data entered into Synthesis include youth referral, demographics, assessment scores, and outcomes. In addition, team members, action plans, FSP notes, and Wraparound Fidelity process data are also entered by CME staff.

To summarize our findings, in SFY2014, 980 total youth received Wraparound services through Lookout Mountain CME (53%) or View Point Health CME (47%). Two-thirds of youth served reside in the DBHDD-defined regions where the CMEs are located: Regions 1 (Lookout Mountain) and 3 (View Point Health). The majority of services were provided to Non-Waiver youth (84%), and the remaining 16% of youth received Wraparound services through Waiver-C CBAY, MFP CBAY or BIP CBAY funding sources. Overall, 84% of youth receiving Wraparound services were enrolled in either fee-for-service Medicaid (50%) or Medicaid managed care (34%) within six months of CME enrollment.

Youth who are involved in multiple child serving agencies have more complex behavioral and emotional needs. This is supported by the referral sources of youth referred for Wraparound in SFY2014. The majority of youth enrolled in Wraparound were referred from other child serving agencies and providers including the Department of Juvenile Justice (DJJ), the Division of Family and Children Services (DFCS), Psychiatric Residential Treatment Facilities (PRTF) and Core

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DBHDD Behavioral Health Providers. Three-fourths of all referred youth were involved with one to three of these agencies upon enrollment into Wraparound.

More than half of the 683 discharged youth from Wraparound remained in the community upon completion of Wraparound (53%). An additional 24 percent experienced a Neutral outcome representing a change in program eligibility, or loss to follow-up. Twenty-two percent of discharged youth experienced a Negative out-of-community outcome indicating a return to a restrictive setting for care. MFP CBAY youth had the highest proportion of youth with an out-of-community discharge from a CME among all programs (49%). Most youth with an out-of-community discharge entered a PRTF or Residential Youth Detention Center (RYDC).

Youth who discharged from the CMEs showed improved levels in functioning upon discharge. More than half of discharged youth demonstrated improvement (i.e. lower levels of impairment) at the completion of Wraparound as assessed by caregiver on the Columbia Impairment Scale (CIS) (56.1%). However, 39% of caregivers reported that their youth experienced deterioration in function across all groups. Approximately 64% of Waiver-C CBAY and 59% of Non-Waiver youth demonstrated an improvement in functioning while approximately three-fourths of MFP CBAY youth demonstrated higher levels of impairment at discharge compared to baseline.

Youth and caregivers expressed overall satisfaction with the services received, measured through youth and caregiver satisfaction surveys. Results from the May 2014 administration cycle of the California Health Kids Survey (CHKS) showed that youth reported the highest average scores regarding their goals and aspirations, comfort in their home environment, and self-awareness. Results from the Youth Satisfaction Survey-Family (YSS-F) found that slightly more than half of caregivers agreed or strongly agreed with statements that their child was doing well in areas of daily life, school/work, getting along with family, friends and others, and doing things he/she wanted. Additionally, a majority of caregivers agreed or strongly agreed that they were satisfied with the services their youth received. However, slightly less than half of caregivers agreed or strongly agreed that their child was exhibiting improved symptoms and coping skills. Finally, results from the Family Empowerment Scale (FES) indicated that caregivers reported a fairly high level of family and service systems empowerment, particularly related to their confidence in navigating their child's behavioral health system.

Qualitative interview participants reinforced assessment and survey findings. Stakeholders reported that CME staff are very effective in providing youth and families with a voice, helping families identify and address their strengths and needs, and connecting them to community partners and resources that improve family empowerment. Stakeholders also noted that youth

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and families who willingly participate in Wraparound, rather than being mandated to participate, experience better outcomes. According to stakeholders, these youth and families typically experience improved resiliency, functioning, and empowerment outcomes and spend less time in institutionalized settings.

In addition to improved psychological functioning, discharged youth showed improved outcomes in the educational setting and decreased involvement in other child servicing agencies which is consistent with findings from studies presented in the literature review chapter of this report. Based on school records submitted by caregivers to the CMEs, 73% of youth who discharged from Wraparound had no unexcused absences, 82% had no suspensions and 98% experienced no expulsions while enrolled in Wraparound. Three-quarters of discharged youth experienced no new involvement with child welfare and two-thirds experienced no new involvement with the Department of Juvenile Justice (DJJ) or juvenile courts while enrolled in Wraparound.

Fourteen percent of discharged youth experienced crisis events and 41% of all discharged youth had an out-of-home placement while enrolled in Wraparound. Approximately half of these youth were placed in a Crisis Stabilization Unit (CSU) or Psychiatric Residential Treatment Facility (PRTF).

Although the evaluation identified numerous CME strengths in facilitating High Fidelity Wraparound, the evaluation also identified opportunities for improvement. Participants in qualitative stakeholder interviews report that System of Care (SOC) readiness, community knowledge of Wraparound, and limited community resources pose significant barriers to incorporating community-based resources into a youth's plan of care. Stakeholders noted that additional education is needed to increase community understanding and awareness of the benefits of the Wraparound model and to address the confusion many internal and external stakeholders have regarding the different programs that finance Wraparound. Limited community resources also provide challenges for CME staff in helping families secure informal and natural supports. For youth discharged in SFY2014, the most common informal/natural supports were immediate family members (e.g. mother, father, siblings, etc.) and grandparents.

Geographic decentralization of services was identified as a significant challenge for CME staff to effectively coordinate services for youth and families. The inconsistent pairing of CME staff and family support providers (FSPs) inhibits the development of a working relationship and steady communication, both of which are beneficial in serving families. Data suggest that geographic decentralization also negatively influenced the availability of care for some youth in the state. One-third of the counties in the state had no youth enrolled in Wraparound and just under half

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of the counties had 10 or fewer youth enrolled during SFY2014. These limited service areas are consistent with service deserts that exist for other child serving agencies. The state recognizes this limitation and is working to develop a strategy to help increase access to resources and services in these areas.

Another opportunity for improvement identified as a result of the evaluation includes improving practice fidelity to the Wraparound model. Findings from qualitative internal and external stakeholder interviews, Wraparound Fidelity Index 4 (WFI-4) interviews, and Wraparound Coaching Assessments indicate that practitioners are deviating from Wraparound fidelity. Stakeholder interviews revealed that there is a clear delineation among practitioners regarding the role of family voice and choice in guiding the Wraparound process. Approximately half of the stakeholders voiced that CME staff should honor family choice to participate in or include particular components of the Wraparound model, rather than adhere to all elements Wraparound model. Marginalizing of key components of the Wraparound model based on family choice and voice could result in the exclusion of key elements of Wraparound that are essential for the long-term sustainability of the youth and family once formal supports are removed. In addition, results from WFI-4 Interviews demonstrated lower levels of Wraparound fidelity when rated by caregivers and youth than by CME care coordination staff. Coaching Observation Measure for Effective Team (COMET) scores suggest that care coordinators face challenges in their ability to gather sufficient information about the family's situation to appropriately facilitate the meetings and develop an individualized plan of care.

Analyses of Synthesis data indicate that process measures to ensure Wraparound fidelity are not being achieved. A component of the Wraparound model is to ensure monthly meetings of the child and family teams (CFT) to discuss progress and challenges experienced by youth and/or their family. CME staff submit an exception report to indicate that a meeting did not take place. Monthly CFTM criteria were not met for 53% of youth discharged in SFY2014. While one exception report was submitted for 30% of youth who missed a monthly CFTM, two to three exception reports were submitted for 51% of youth who averaged less than one CFTM per month enrolled in Wraparound. Additionally, transition planning, one of Wraparound's primary phases important for youth and family sustainability post Wraparound formal support, was documented by CME staff for less than 70% of youth.

As the COE completes the SFY2014 CME Annual Evaluation, several initiatives are currently underway to help address challenging areas, including: the transition to a new, more user-friendly information system to collect CME service data; a new contractual arrangement among CMEs and family support organizations (FSOs) that should help to address communication and

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coordination issues; and an increased focus on coaching of Wraparound facilitators to help support fidelity to the Wraparound model.

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Introduction

The Office of Children, Young Adults and Families (OCYAF) within the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) transferred Care Management Entity (CME) Annual Evaluation responsibilities to the Center of Excellence in Child and Adolescent Behavioral Health (COE). This is the first CME Annual Evaluation Report produced by the COE. It includes youth who were eligible for services during State Fiscal Year 2014 (SFY2014), spanning from July 1, 2013 to June 30, 2014.

Along with 14 other states nationwide, Georgia utilizes the **High Fidelity Wraparound model**, often referred to as "Wraparound," to provide care coordination services to children, adolescents and young adults with severe-emotional disturbances (SED). High Fidelity Wraparound is a family-driven approach focused on developing self-sufficiency, building natural supports, and increasing family capacity to respond to crises. The Wraparound process is led by a facilitator who brings multiple systems together with the child and family to create a highly individualized plan to address complex emotional needs.

The **goals of High Fidelity Wraparound** are to meet the needs prioritized by youth and family, improve their ability and confidence to manage their own services and supports, develop or strengthen the natural supports, and integrate the work of all child servicing systems and natural supports into one streamlined plan.

High Fidelity Wraparound services are provided in Georgia by two Care Management Entities who are contractually charged with serving youth statewide: Lookout Mountain and View Point Health. As described in the Department of Behavioral Health and Developmental Disabilities (DBHDD) Child Behavioral Health Care Management Entity Procedure Manual (November 1, 2013), CMEs were originally established as service providers for the Community Based Alternatives for Youth (CBAY) Waiver program. Over time, CMEs have evolved to serve a broader group of children and youth who are at risk for out-of-community care. CMEs provide a single locus of accountability for youth involved in multiple child-serving agencies.

In Georgia, the **target population** for Wraparound is children, adolescents and young adults ages 21 years or younger who meet all of the following requirements: a) are uninsured or have Medicaid coverage; b) require participation in an intensive program in an out-of-home setting due to behavioral, emotional and functional problems that cannot be addressed in the home; and c) have a mental health diagnosis, co-occurring substance-related disorder and mental health diagnosis, or co-occurring mental health and intellectual/development disabilities diagnosis (Care Management Entities Procedure Manual, November 1, 2013).

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As mentioned previously, Georgia supports High Fidelity Wraparound through the **Community Based Alternatives for Youth (CBAY)** service delivery model. CBAY provides funding to support additional services and supports not covered by Georgia's Medicaid plan for youth who qualify for Psychiatric Residential Treatment Facility (PRTF) level of care but choose to receive treatment in the community. CBAY focuses on an intensive, family-driven care management service which coordinates behavioral health services to help sustain the family in the community and reduce reliance on residential treatment.

Georgia currently has two funding sources that support CBAY services: Money Follows the Person (MFP) and the Balancing Incentive Program (BIP). Georgia previously supported Wraparound through a 1915c Medicaid waiver, often referred to as "Waiver-C CBAY," which completed enrollment effective September 30, 2012. A small number of youth residually financed via Waiver-C CBAY funding transitioned from the CMEs in SFY2014.

The **Money Follows the Person** (MFP) grant program helps states to transition children and young adults from institutions into the community. Home- and community-based services are offered to prevent re-institutionalization. To qualify for Wraparound services through MFP, youth must have been institutionalized for 90 days or more, have qualified for Medicaid for at least one day during the institutionalized period, and transitioning to a qualified home setting.

The **Balancing Incentive Program** (BIP CBAY) began on January 1, 2014 as a funding mechanism through the Center for Medicare and Medicaid services to support the delivery of home- and community-based services to Medicaid enrolled individuals who meet an institutional level of care.

Non-Waiver youth also meet the eligibility criteria for Wraparound but do not qualify for CBAY or PRTF level of care. DBHDD finances the services provided to Non-Waiver youth on a fee-for-service basis through contracted mental health providers.

In this report, the COE builds upon the work completed by the previous evaluators and expands the scope to include a Wraparound literature review, qualitative stakeholder interviews, workforce development and Wraparound fidelity measures, and correlation analyses and regressions that evaluate the relationships of various factors including demographics, length of enrollment in Wraparound, and Wraparound fidelity, on youth outcomes.

The Center of Excellence in Child and Adolescent Behavioral Health (COE) obtained youth enrollment, assessment and utilization data from the Synthesis case management database system. Data in Synthesis is entered by CME staff and Family Support Partners (FSPs). Demographic, outcome and Wraparound fidelity data were reviewed for youth served through

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CBAY and for Non-Waiver youth. Youth involved in each of these programs have varying levels of behavioral health needs and eligibility requirements based on their financing.

Also included in the report are results from Wraparound Fidelity Index 4 (WFI-4) interviews, Youth Satisfaction Survey – Families (YSS-F), Family Empowerment Survey (FES), and California Healthy Kids Survey (CHKS). Additionally, findings from the workforce development training evaluation surveys and from the Impact of Training and Technical Assistance (IOTTA) and Coaching Observation Measure for Effective Teams (COMET) reports produced on DBHDD's behalf by the Wraparound Evaluation and Research Team (WERT) at University of Washington are included.

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Wraparound Literature Review

High Fidelity Wraparound is a family-driven approach focused on developing self-sufficiency, building natural supports, and increasing family capacity to respond to crises (Bruns, Pullmann, Sather, Brinson, & Ramey, 2014). Wraparound services are intended for youth with severe emotional disturbances (Ogles et al., 2006). In Georgia, this practice model is utilized for youth in Medicaid's Community Based Alternatives for Youth (CBAY) program, as well as high-risk youth ineligible for CBAY. High Fidelity Wraparound, hereafter referred to as Wraparound, is an integrated, facilitated process where multiple systems converge with the youth and family to create a highly individualized plan that addresses complex emotional needs (Rauso, Ly, Lee, & Jarosz, 2009).

The goals of Wraparound are to meet the needs prioritized by a youth and family, improve their ability and confidence to manage their own services and supports, develop or strengthen their natural supports, and integrate the work of all child serving systems and natural supports into a single streamlined plan ("WFI :: Wraparound Fidelity Assessment System," n.d.).

One of Wraparound's main goals is to keep youth in their communities as opposed to residential treatment facilities (Bruns et al., 2014). This process brings people from all aspects of a child's life together to help coordinate activities and help accomplish the families' goals and vision. Although the Wraparound process may vary slightly between different communities, ten key components of Wraparound are implemented in every step of the process, as seen in Figure 1.

The Wraparound process consists of four phases: engagement and team preparation; initial plan development; plan implementation; and transition (Suter & Bruns, 2009). The initial process, engagement and team preparation, consists of making a strengths list and compiling a goal and family vision statement. In the second phase, a facilitator or care coordinator coordinates with all team members to ensure that the family creates a mission statement and a strategic plan that employs several ways to meet the families' needs. As the team implements the plan in the third phase, the team completes action steps to meet the goals of the family. Finally, the transition phase, which occurs throughout the Wraparound process, strengthens the family's supports and resources to guarantee post-Wraparound success of the family (Suter & Bruns, 2009).

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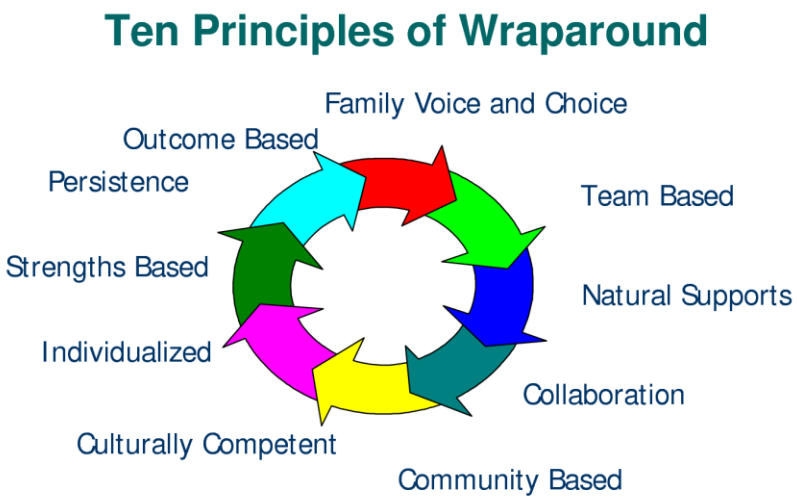

Figure 1. http://www.docstoc.com/docs/45400997/Care-Coordinator-Family-Partner-Dyad-presentation-(PDF)

High Fidelity Wraparound has been deemed a "promising practice," and the model is currently under review for inclusion in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP). Many studies have been published evaluating Wraparound and its efficacy; however, very few of these studies have been recognized as rigorous and strong methodologically (Suter & Bruns, 2009). Due to the lack of rigorously-controlled trials, the Wraparound model maintains a "promising practice" status, rather than an "Evidence-Based Practice" (EBP) status (Suter & Bruns, 2009). In this chapter we summarize the findings of recent published studies that assess outcomes and fidelity to the Wraparound model and we describe how other states are using the Wraparound model and measuring its impact.

Fidelity and Outcomes

The Wraparound Fidelity Assessment System is a collection of tools used to assess the quality of Wraparound services. Assessing fidelity to the Wraparound model is highly important so that youth and families experience improvement in outcomes. The Wraparound Fidelity Index 4.0 (WFI 4.0) (Pullmann, Bruns, & Sather, 2013), an interview tool used by the state of Georgia to evaluate Wraparound fidelity, is a set of four interviews that measures the integrity of the four phases of Wraparound: Engagement and Team Preparation, Initial Planning, Implementation, and Transition. The 40 items of the WFI 4.0 interview correlate with the 10 principles of

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Wraparound to assess the adherence to each principle. Interviews are conducted with the Care Coordinator or Facilitator, a team member, the caregiver, and the youth ("WFI :: Wraparound Fidelity Assessment System," n.d.). Another tool utilized to measure fidelity is the "Team Observation Measure," or TOM. This tool is utilized by external evaluators to assess adherence to the Wraparound principles and practice. The evaluator attends a team meeting, and fidelity is assessed using the 20 item tool. The TOM can be calculated to reveal a total fidelity score as well ("WFI :: Wraparound Fidelity Assessment System," n.d.). At this time, Georgia assesses fidelity using the WFI-4.0.

Several studies have explored Wraparound fidelity and the association between fidelity and outcomes. In 65 communities in Indiana, Wraparound processes were assessed using the WFI 4.0 (Effland, Walton, & McIntyre, 2011). Of the 515 participants, 41.3% received high fidelity Wraparound, 32.6% received adequate Wraparound, and 15.5% received Wraparound at borderline fidelity. Sixty-one percent of youth in these communities experienced reduced needs, as assessed by the Child and Adolescent Needs and Strengths (CANS) assessment tool (Lyons, 2009). The CANS tool is another commonly used measurement tool for Wraparound outcomes and assesses child strengths, functioning, behavioral/emotional needs, risk behaviors, and caregiver strengths and needs (Effland et al., 2011). The researchers found a small, but significant association between improvement in CANS scores and Wraparound fidelity (β=-0.14, $p<0.001$) (Effland et al., 2011).

Additional outcome assessment tools have found positive outcomes when analyzing fidelity to the Wraparound model. For example, one study analyzed Wraparound fidelity via five outcomes: (1) Child and Adolescent Functional Assessment Scale (CAFAS) scores; (2) the Behavioral and Emotional Rating Scale (BERS); (3) the Restrictiveness of Living Environment Scale (ROLES); (4) caregiver satisfaction with services; and (5) caregiver satisfaction with youth improvement (Bruns, Suter, Force, & Burchard, 2005). The ROLES scale translates the restrictiveness of 26 different residential settings into numeric values, with 0.5 being the least restrictive setting (i.e. living independently) and 10 being the most restrictive setting (i.e. jail) (Hawkins, Almeida, Fabry, & Reitz, 1992). Strong adherence to Wraparound, measured by WFI 4.0, was associated with a reduction in restrictiveness of living, measured by ROLES, as well as caregiver satisfaction with services and youth progress. However, high fidelity to the Wraparound model, as indicated by WFI 4.0 scores, was not associated with an improvement in CAFAS scores in this study (Bruns et al., 2005).

In a 2014 study, researchers randomized Wraparound services as an intervention and traditional intensive case management as a control group to evaluate the effectiveness of Wraparound on child outcomes and the role of fidelity to Wraparound. Both the team observation measure (TOM) and the WFI 4.0 were used as fidelity measures. Both of these

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measures originate from the Wraparound Fidelity Assessment System ("WFI :: Wraparound Fidelity Assessment System," n.d.). WFI-4.0 and TOM scores for 47 youth receiving Wraparound services revealed low fidelity to the Wraparound model. The WFI-4.0 and TOM scores were lower than the national average; the WFI 4.0 scores were in the 39th percentile compared to the national average of 44th percentile. Similarly, the TOM scores fell in the 14th percentile compared to the 21st percentile national average. Consequently, the researchers found less encouraging outcomes of the Wraparound model. Children receiving Wraparound services experienced no improvement in functioning compared to a control group of children receiving Intensive Case Management, potentially due to the lack of fidelity to the Wraparound model (Bruns et al., 2014).

Contrary to the previous findings, which correlate high adherence to the Wraparound model with improved child and family outcomes, an earlier study observed opposite findings. This study utilized a different fidelity tool, the Wraparound Observation measure, similar to the TOM, which indicated that youth were receiving high fidelity Wraparound (Ogles et al., 2006). Although their findings suggested that goal attainment, after three months enrolled in Wraparound, was significantly correlated with Wraparound adherence, adherence to Wraparound was negatively correlated with family functioning. No other relationships examined were significant. Overall, this study suggests that the degree of Wraparound adherence is unrelated to specific treatment outcomes (Ogles et al., 2006).

Generally, the literature suggests that high fidelity Wraparound is correlated with improved outcomes, and adherence to the model is essential to providing high quality care to youth and families.

Measured Youth Outcomes

Home Permanency & Restrictiveness of Placement: Maintaining a youth's residence within the community and providing services in low-restriction settings are two of Wraparound's primary goals. Community-based treatment is typically more cost-effective, as it limits the number of days spent in residential facilities. One of the first articles examining Wraparound outcomes studied the effects of Wraparound services on placement outcomes for foster care children (Clark, Lee, Prange, & McDonald, 1996). The sample consisted of children with emotional or behavioral disturbances who were in temporary custody of the state of Florida. Children were randomized to one of two groups: one that employed the standard practice of foster care (the control group) or one that employed the Wraparound model within the foster care setting (the intervention group). The outcomes of interest were placement changes (i.e. movement from one provider to another for more than 30 days), runaway status, and incarceration. Their findings revealed a decrease in the number of placement changes for the intervention group compared to the control group. The intervention group receiving Wraparound also experienced

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a decrease from 2.1 to 1.6 runaway episodes per year compared to the control group (Clark et al., 1996). A related study evaluating post-graduation placement outcomes between Wraparound graduates and comparison youth found similar results: 44% of Wraparound graduates had no subsequent out-of-home placements, as opposed to only 9% of comparison youth (Rauso et al., 2009).

Several studies used ROLES as a tool to measure the youth's restrictiveness of residential settings. A study examining Vermont's Wraparound Care Initiative indicated a reduction in restrictiveness of living as indicated by ROLES scores for youth after the one-year follow-up period; 89% of youth still remained in the community after one year (Bruns, Burchard, & Yoe, 1995). Similarly, another study evaluating Vermont's implementation of Wraparound showed a decline in residential restrictiveness measured by ROLES for youth in Wraparound (Yoe, Santarcangelo, Atkins, & Burchard, 1996). Analogous results were found in a study assessing Wraparound effectiveness in Nevada; Wraparound youth showed more movement towards less restrictive placement settings compared to youth receiving traditional foster care management (Mears, Yaffe, & Harris, 2009). Bruns and his colleagues compared adherence to the Wraparound model to restrictiveness of placement settings using the ROLES scale (Bruns et al., 2005). Their analysis revealed a significant association between high fidelity to Wraparound and low-restriction living environments (Bruns et al., 2005, p. 529).

Cox, Baker, & Wong (2010) examined the effectiveness of Wraparound in expediting youth from residential treatment facilities to home settings in Sacramento, California. The authors found a less pronounced impact of Wraparound on home placement settings, where only 57% of Wraparound participants were discharged to a home setting. In contrast, another study revealed a 60% decrease in residential treatment usage and an 80% decrease in inpatient psychiatric hospitalization following Wraparound implementation (Kamradt and Office of Juvenile Justice and Delinquent Prevention [Dept. of Justice], 2000). This decrease in usage led to a decline in the average cost of residency per child by approximately $2,000 per month (Kamradt and Office of Juvenile Justice and Delinquent Prevention [Dept. of Justice], 2000, p. 20).

Juvenile Justice Outcomes: Involvement of multiple child-serving agencies, including Child and Family Services and the Juvenile Justice System, is common for children involved in Wraparound, which further stresses the importance of multi-agency participation in a child's Wraparound process. Children involved in the Juvenile Justice system may have complex emotional and behavioral needs, indicating the need for high fidelity Wraparound. In 2003, Carney and Buttell evaluated the effect of Wraparound on 141 youth involved with the Juvenile Justice system in Columbus, Ohio, randomizing youth to a Wraparound intervention group and a traditional court services control group. Logistic regression modeling at six-, 12- and 18-month

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follow-up periods revealed that the intervention group was less likely to engage in delinquent acts than the control group, evident by less suspensions, less assaultive behavior, and less police involvement (Carney & Buttell, 2003). Additionally, youth participating in Wraparound spend fewer days incarcerated compared to those receiving standard services (Clark et al., 1996).

In 2006, Pullmann and colleagues evaluated the effect of Wraparound on Juvenile Justice recidivism by calculating the number of days between the youth's discharge from Juvenile Justice and any subsequent substantiated offenses or felony offenses (Pullmann et al., 2006). Chi-square tests revealed that youth receiving Wraparound services were one-third less likely to commit any type of offense compared to youth receiving traditional court services (Pullmann et al., 2006).

Child Functioning Outcomes: Another goal of the Wraparound model is to improve child functioning. A commonly used tool to gauge a youth's function is the Child and Adolescent Functional Assessment Scales (CAFAS) (Hodges, 1990). The CAFAS measures the effects of a youth's behavioral and emotional problems on their functioning across several categories, including Behavior Toward Self and Others, Mood/Emotions, Substance Abuse, Role Performance and Thinking (Hodges, 1990). CAFAS scores are summed to produce a total score, where a score of 0 to 40 indicates minimal impairment, a 50 to 90 indicates moderate impairment, a 100 to 130 indicates marked impairment, and a 140 and above indicates severe impairment. Higher impairment scores predict increased restrictiveness of care, number of services received, and costs of services (Cox, Baker, & Wong, 2010).

In a study assessing functionality with the CAFAS, 62% of youth receiving Wraparound services who started in the marked or severe impairment range were categorized in the minimal to moderate range at discharge (Cox et al., 2010). Similarly, results from a Wraparound program in Nevada revealed statistically lower CAFAS scores upon discharge from Wraparound services compared to a group receiving traditional services (Mears et al., 2009). Finally, a study evaluating Wraparound Milwaukee showed a decrease in CAFAS scores for youth receiving Wraparound upon discharge, with the average score decreasing from a high level of impairment to a moderate level of impairment (Kamradt and Office of Juvenile Justice and Delinquent Prevention (Dept. of Justice), 2000).

Reduction in Emotional and Behavioral Symptoms: Several measures are used to evaluate the reduction in emotional and behavioral symptoms of youth involved in Wraparound services. The Child Behavior Checklist (CBCL) instrument assesses behavioral problems and social competencies of children from the parent's perspective (Achenbach & Ruffle, 2000). The CBCL assesses externalizing symptoms (e.g. aggressive and delinquent behaviors) and internalizing symptoms (e.g. withdrawn behaviors, anxiety and depression) (Achenbach & Ruffle, 2000). One

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study examining CBCL scores six-months post-Wraparound initiation showed a reduction in problem behaviors in the youth, and another study using CBCL scores revealed a decline in internalizing and externalizing behaviors after 6 months enrollment in Wraparound (Toffalo, 2000; Bruns et al., 1995).

What Components of Wraparound Make Wraparound Effective? There are certain characteristics of Wraparound that warrant analysis of its effectiveness. One study found a relationship between CAFAS score improvement and strong adherence to the Child and Family Team and Strengths-Based care principles of Wraparound (Cox et al., 2010). Additionally, adherence to the Community-Based and Natural Support principles was significantly higher for youth who met treatment goals and for youth who discharged into a home setting (Cox et al., 2010). This study further highlights the importance of maintaining fidelity to the Wraparound model, specifically within the principles of Community-Based care, Strengths-Based care, and involvement of Natural Supports.

Meta-Analysis: The Overall Effect of Wraparound on Outcomes: A 2009 meta-analysis explored studies that documented the differences between youth receiving Wraparound services compared to a control group (Suter and Bruns, 2009). The authors reported effect sizes, calculated using the standardized mean difference, for individual outcomes and the collective effect size for all outcomes. Positive effect sizes indicated better outcomes for youth receiving Wraparound and negative effect sizes indicate better outcomes for the control group, with small effect sizes falling between 0.0 and 0.20 and medium effect sizes falling between 0.20 and 0.50 (Cohen, 1977). The youth's living situation revealed the largest effect size of 0.44, indicating a positive effect of Wraparound on maintaining the youth in their community. Mental health outcomes had an effect size of 0.31 ($p=0.05$) and overall youth functioning revealed an effect size of 0.25 ($p=0.02$) (Suter and Bruns, 2009). Borderline statistically significant effect sizes included school functioning ($p=0.09$) and juvenile justice-related outcomes ($p=0.07$). Overall, the pooled mean effect size was 0.33, indicating a medium effect size for all outcomes of youth receiving Wraparound (Suter and Bruns, 2009). Importantly, the authors emphasize that the effect size may be underestimated due to the exclusion of a large number of studies that lacked a comparison group from this meta-analysis.

Wraparound in the Nation

States and areas across the United States who are using Wraparound are collecting data to help support the model as an Evidence-Based Practice, or EBP. Fidelity to the model and outcome data are equally important in moving towards the classification of an EBP.

To monitor fidelity to the Wraparound model, WFI-EZ, WFI-4, and TOMS are used, with the majority of programs using the new WFI-EZ to monitor fidelity. WFI-EZ is a shorter, self-

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reported version of the WFI-4 interviews. Similar outcomes are measured across programs, including CAFAS, CANS, CBCL, out-of-home placements, satisfaction, juvenile justice involvement, educational outcomes, and use of psychiatric inpatient facilities ("Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs," n.d.).

States across the country have initiated Wraparound using an array of varied funding sources. Areas with programs classified as "Established Wraparound Programs" include those that use high-quality Wraparound with sustainable funding streams and a full spectrum of services for children with severe emotional and behavioral disturbances. Current Established Wraparound Programs include Louisiana, Massachusetts, Michigan, Nebraska, New Jersey, Cuyahoga County, Ohio, Dane County, Wisconsin, and Milwaukee, County Wisconsin. A common theme for these established programs include the presence of a Medicaid funding stream. Established Wraparound Programs also employ standard eligibility screening criteria, with a majority using CANS or CAFAS. All established areas have entities that provide quality improvement, fidelity tracking and outcome tracking ("Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs," n.d.).

The state of Georgia, along with Maryland, Clermont County, Ohio, and Oklahoma, falls into the category of "Evolving Wraparound Programs". This category includes areas where Wraparound programs are expanding, or areas that are revamping their approach to Wraparound by utilizing various approaches, such as new Medicaid strategies for sustainability. A common theme throughout these programs includes varied funding streams. Most areas utilize Medicaid funds and SAMHSA grant funds, along with several other sources. While Evolving Wraparound Programs have several funding streams, established programs are primarily funded through Medicaid alone. However, evolving Wraparound programs also utilize entities, such as universities or state agencies, for fidelity monitoring and tracking outcomes ("Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs," n.d.).

New developments within the Wraparound model include the expansion of services to Transition Age Youth (TAY), young adults from 18 to 25 years old that have emotional, behavioral or addiction disorders. For example, Ohio is implementing a statewide system to implement Wraparound services to TAY through ENGAGE, Engaging the New Generation to Achieve their Goals through Empowerment. ENGAGE is funded through a variety of streams, including part of a $4 million System of Care Expansion Grant through SAMHSA, Medicaid funding, state funding for non-Medicaid services, and grant-funded services. The Ohio Department of Mental Health and Addiction Services (OhioMHAS), the entity developing this infrastructure, plans to collect electronic health records and outcomes for these youth to

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evaluate effectiveness. ENGAGE will also include workforce development, capacity building, fidelity monitoring, and virtual regional technical assistance. OhioMHAS predicts a 30% reduction in hospital admissions and residential placements, a 20% reduction in use of intensive services, a 15% increase in obtaining employment, and a 30% improvement in housing stability for TAY youth participating in ENGAGE ("Ohio Developing Statewide System For Wraparound Services For Transition Age Youth," n.d.).

Other states that have expanded their eligibility criteria to serve TAY include Nebraska, Oklahoma, and Wyoming, and many states that have not already expanded their services to meet this population's needs are contemplating how to do so ("Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs," n.d.).

In summary, Wraparound continues to move towards classification as an Evidence-Based Practice as more positive findings across states emerge. The evidence of these studies, with varying methodological weaknesses and strengths, suggests that Wraparound is an effective practice. As the populations benefitting from Wraparound services increase to include TAY and youth in a variety of mental health and Juvenile Justice settings, more research is needed to evaluate Wraparound's effectiveness in a variety of populations.

A summary of all articles included in this literature review may be found in *Appendix A.*

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Profile of Children Served by Care Management Entities

In this chapter, the COE provides a descriptive profile of youth who were enrolled in CME services during SFY2014. Additionally, we present youth outcomes, family satisfaction, child service agency involvement, and Wraparound fidelity for youth who were discharged from a CME during SFY2014. Percent totals presented in the report may not equal 100 due to rounding variation. Data sources and methodology used to analyze the data are included in Appendix B.

Enrolled Youth

Between July 1, 2013 and June 30, 2014, 980 children were served by CMEs in Georgia. Of these children, 550 were newly enrolled on or after July 1, 2013 and prior to July 1, 2014, and 430 had ongoing enrollments with an enrollment date prior to July 1, 2013. Ongoing enrollments include 29 children who were enrolled and remained active throughout this report period and 401 children who were active but discharged between July 1, 2013 and June 30, 2014.

Youth Enrolled in Wraparound in SFY2014

	Newly Enrolled		Ongoing		Total Enrolled Youth	Percentage of Total
Program	n	%	n	%		
Waiver-C CBAY	0	0.0%	48	11.2%	48	4.9%
MFP CBAY	98	17.8%	11	2.6%	109	11.1%
BIP CBAY	7	1.3%	0	0.0%	7	0.7%
Non-Waiver	445	80.9%	371	86.3%	816	83.3%
Total	**550**	**100.0%**	**430**	**100.0%**	**980**	**100.0%**

As shown below, 53% of the enrolled population was served by Lookout Mountain CME, while the remaining 47% were served by View Point Health CME. The majority of all children served were in the Non-Waiver funding category, financed through DBHDD fee-for-service dollars.

Youth Enrollment by CME

CME	Waiver-C CBAY	MFP CBAY	BIP CBAY	Non-Waiver	Total	Percentage of Total
Lookout Mountain	12	35	0	469	516	53%
View Point Health	36	74	7	347	464	47%
Total	**48**	**109**	**7**	**816**	**980**	**100%**

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During SFY2014, 247 youth were referred to but not enrolled in CMEs.

Youth Referred but Not Enrolled in Wraparound

Non-Enrollment Reason	Frequency	Percentage
Does Not Meet Criteria	90	35%
Missing/Unknown	68	26%
Unable to Contact Parent / Guardian	42	16%
Parent / Guardian Declined	30	12%
Other	25	10%
No Capacity	3	1%
Total	**258**	**100%**

- More than one-third of youth referred were not enrolled in CME services because they did not meet criteria defined by DBHDD.
- Reason for non-enrollment was unknown for 26% of youth.

For youth ineligible for Wraparound through either CBAY or Non-Waiver funding, CMEs provide referrals to community providers, partners and organization in their community. CMEs commonly refer to this as System of Care (SOC) Coordination services. One CME, View Point Health, began collecting data on the youth for whom these services are provided. Between November 1, 2013 and June 30, 2014, View Point Health provided SOC Coordination services to 70 youth who were referred to but ineligible for CME Wraparound services.

Demographics

The following table reflects the demographic profile of the population enrolled and served during SFY2014.

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Demographics of Enrolled Youth

Demographic		Waiver-C CBAY		MFP CBAY		BIP CBAY		Non-Waiver		Total	Percent of Total
		n	%	n	%	n	%	n	%	N	%
Gender	Female	23	47.9%	28	25.7%	3	42.9%	329	40.3%	383	39.1%
	Male	25	52.1%	81	74.3%	4	57.1%	486	59.6%	596	60.8%
	Transgender	0	0.0%	0	0.0%	0	0.0%	1	0.1%	1	0.1%
	Total	**48**	**100.0%**	**109**	**100.0%**	**7**	**100.0%**	**816**	**100.0%**	**980**	**100%**
Race/Ethnicity	Caucasian	25	52.1%	53	48.6%	1	14.3%	409	50.1%	488	49.8%
	African American	18	37.5%	44	40.4%	3	42.9%	316	38.7%	381	38.9%
	Other Biracial/ Multiracial	3	6.3%	26	23.9%	0	0.0%	36	4.4%	45	4.6%
	Hispanic	1	2.1%	1	0.9%	1	14.3%	29	3.6%	32	3.3%
	Other	1	2.1%	2	1.8%	1	14.3%	8	1.0%	12	1.2%
	African American/ Caucasian	0	0.0%	0	0.0%	0	0.0%	8	1.0%	8	0.8%
	Asian	0	0.0%	0	0.0%	0	0.0%	4	0.5%	4	0.4%
	Caucasian/ Hispanic	0	0.0%	0	0.0%	0	0.0%	3	0.4%	3	0.3%
	Native American	0	0.0%	0	0.0%	0	0.0%	2	0.2%	2	0.2%
	Missing/Unknown	0	0.0%	3	2.8%	1	14.3%	1	0.1%	5	0.5%
	Total	**48**	**100.0%**	**109**	**100.0%**	**7**	**100.0%**	**816**	**100.0%**	**980**	**100.0%**
Age	≤ 12	7	14.6%	45	41.3%	3	42.7%	197	24.1%	252	25.7%
	13-17	30	62.5%	55	50.5%	4	57.1%	512	62.7%	601	61.3%
	≥ 18	11	22.9%	9	8.3%	0	0%	101	13.1%	127	13.0%
	Total	**48**	**4.9%**	**109**	**11.1%**	**7**	**0.7%**	**816**	**83.3%**	**980**	**100.0%**
Region	Region 1 - Northwest GA	11	22.9%	33	30.3%	0	0.0%	375	46.0%	419	42.8%
	Region 2 - East GA	8	16.7%	19	17.4%	3	42.9%	101	12.4%	131	13.4%
	Region 3 - Metro Atlanta	10	20.8%	30	27.5%	3	42.9%	191	23.4%	234	23.9%
	Region 4 - Southwest GA	2	4.2%	6	5.5%	0	0.0%	24	2.9%	32	3.3%
	Region 5 - Southeast GA	8	16.7%	10	9.2%	1	14.3%	51	6.3%	70	7.1%
	Region 6 - Central West GA	9	18.8%	11	10.1%	0	0.0%	69	8.5%	89	9.1%
	Missing/Unknown	0	0.0%	0	0.0%	0	0.0%	5	0.6%	5	0.5%
	Total	**48**	**100.0%**	**109**	**100.0%**	**7**	**100.0%**	**816**	**100.0%**	**980**	**100.0%**

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Within the enrolled population:

- Approximately half of the youth were white; a majority were male (61%) and between the ages of 13 and 17 (61%).
- The largest proportion of youth came from Region 1 in Northwest Georgia while the smallest proportion came from Region 3 in Southwest Georgia (43% and 24%, respectively).
- The following map provides a geographic illustration of youth who were actively enrolled in Wraparound for at least one day during SFY2014.

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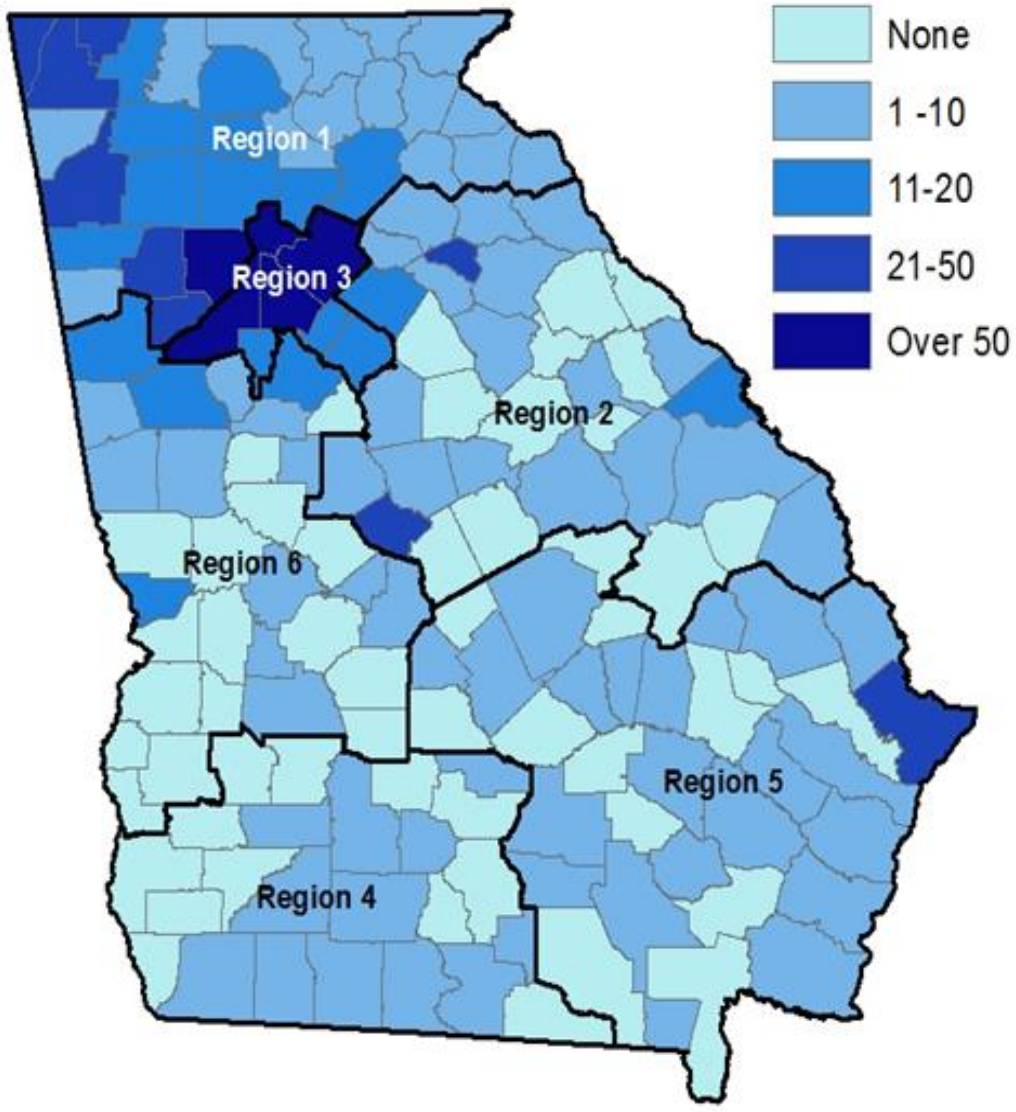
Number of Active Youth by County and DBHDD Region



- Most youth enrolled in Wraparound in Regions 1 and 3. As the map illustrates, urban counties in Regions 2, 5 and 6 had 50 or more youth enrolled in Wraparound during SFY2014 lived.

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- 53 counties in the state had no youth enrolled in Wraparound. In an additional 72 counties, ten youth or less were enrolled in Wraparound in SFY2014.

Referral Sources

Youth may be referred to a CME for Wraparound from a variety of sources including mental health and primary care providers, other child serving agencies and community partners and organizations.

Referrals by Category and Program for Youth Enrolled in Wraparound

Category of Referral	Percent of Program				Percent of Total Youth Enrolled
	Waiver-C CBAY (n=48)	MFP CBAY (n=109)	BIP CBAY (n=7)	Non-Waiver (n=816)	
Residential Facility (PRTF)	79.2%	91.7%	57.1%	19.6%	30.8%
Department of Juvenile Justice (DJJ)	0.0%	0.0%	0.0%	16.1%	13.4%
Division of Family and Children Services (DFCS)	2.1%	0.9%	0.0%	12.7%	10.8%
DBH Core or Specialty Provider	6.3%	0.0%	0.0%	12.2%	10.5%
Parent/Guardian	0.0%	0.0%	0.0%	8.1%	6.8%
Behavioral Health Private Provider	4.2%	6.5%	14.3%	6.4%	6.4%
School	2.1%	0.0%	0.0%	6.7%	5.6%
Other	2.1%	0.0%	0.0%	5.3%	4.5%
CME	0.0%	0.9%	0.0%	5.2%	4.4%
Crisis Stabilization Unit	4.2%	0.0%	14.3%	3.6%	3.3%
LIPT	0.0%	0.0%	0.0%	1.8%	1.5%
Network Support	0.0%	0.0%	14.3%	1.6%	1.4%
Family Support Organization	0.0%	0.0%	0.0%	0.5%	0.4%
Physical Health Care Agency/ Clinic/Provider	0.0%	0.0%	0.0%	0.1%	0.1%
Self (youth referred himself or herself)	0.0%	0.0%	0.0%	0.1%	0.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Note: "DFCS" includes Family Preservation, Family Support, Fast Pass, Investigations, and Permanency categories. "DJJ" includes commitment, probation, and juvenile court (disposition and predisposition).

- Referral sources were documented by CMEs at youth intake.
- Approximately 65% of enrolled youth were referred from psychiatric residential treatment facilities (PRTF), the Department of Juvenile Justice (DJJ), the Division of Family and Children Services (DFCS), and the Department of Behavioral Health core and specialty providers.

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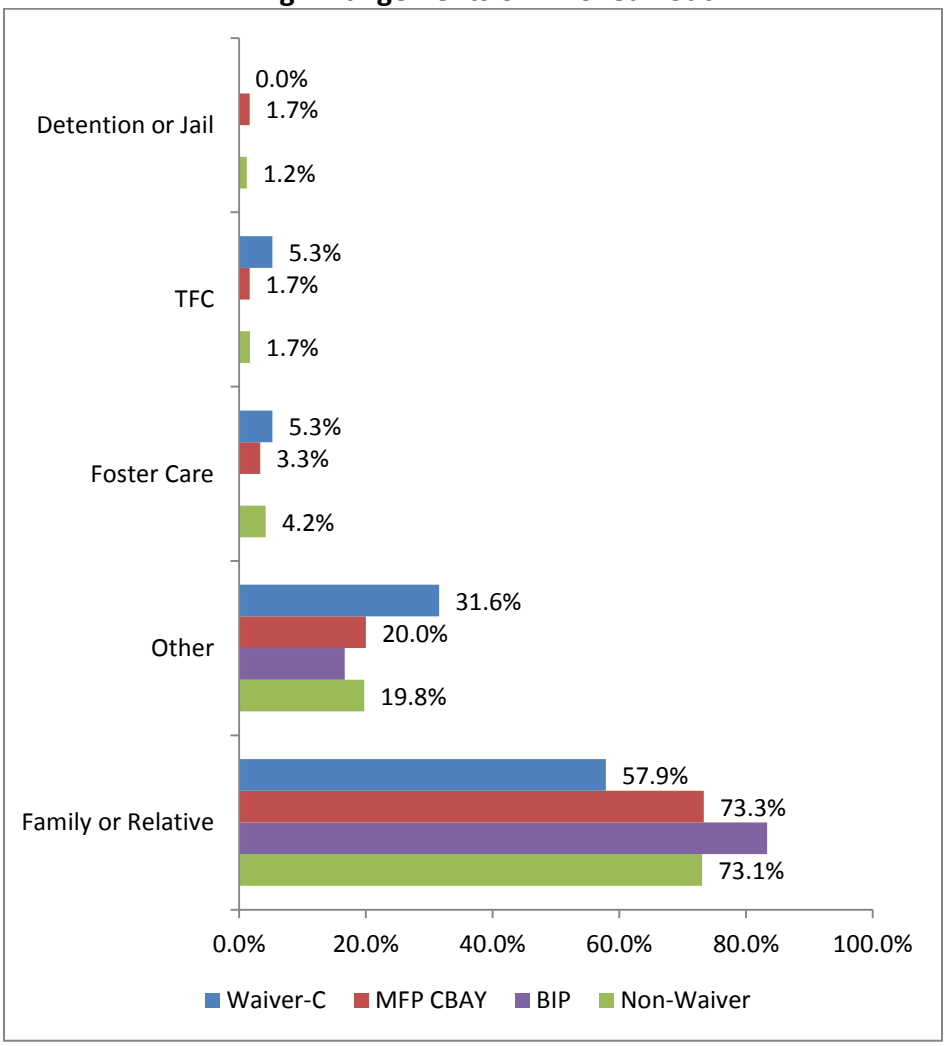
Living Arrangements at Enrollment

When enrolled to receive services 73% of children served lived with their family or a relative, four percent of children lived in foster care and one percent were committed to a detention or jail facility.

Living Arrangements of Enrolled Youth



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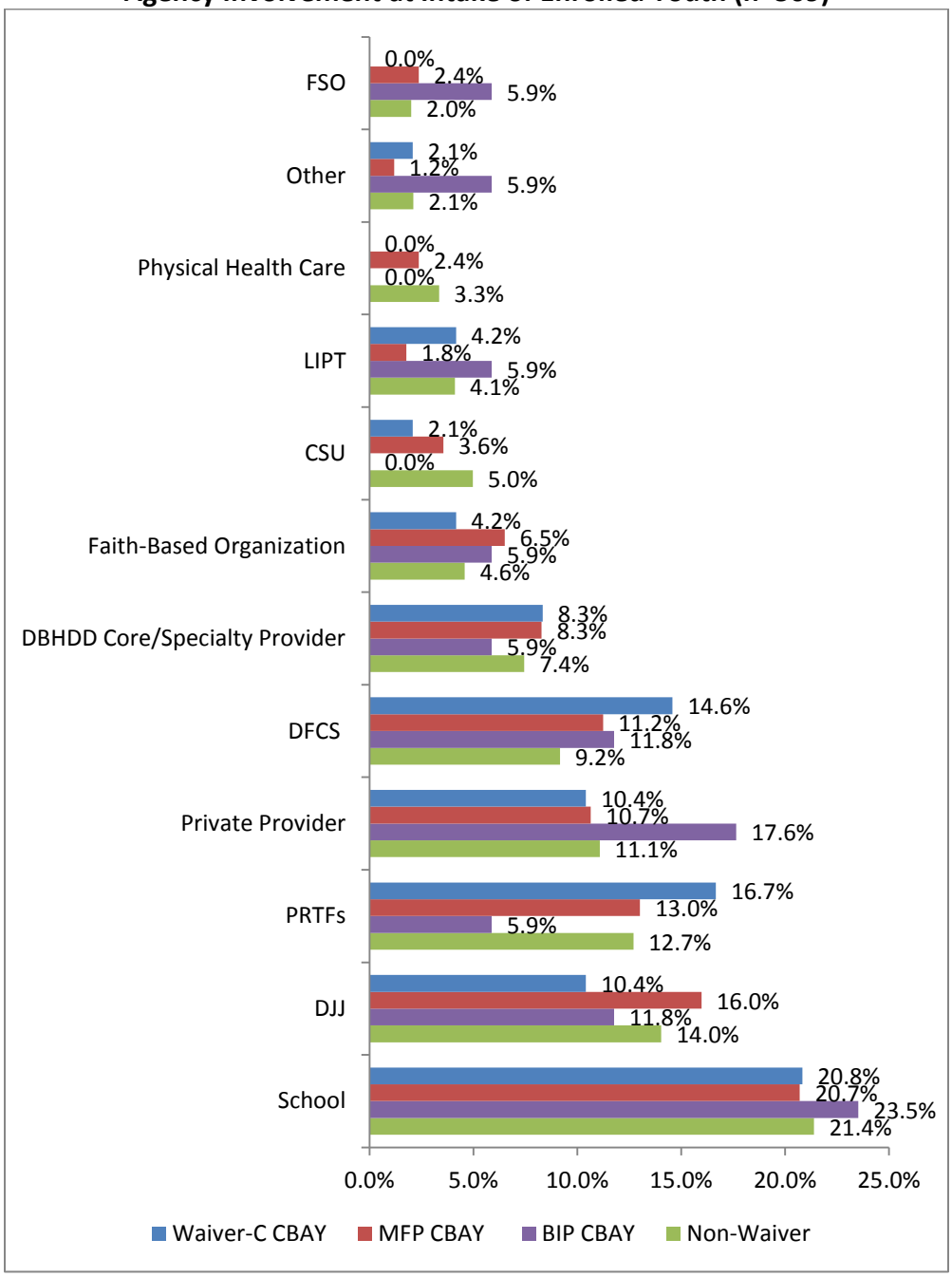
Agency involvement of enrolled youth at Intake

At intake, youth may be concurrently involved with several child servicing agencies. As a result, the frequency of agency involvement exceeds the total number of active youth. Agency involvement information was present in the data for 509 enrollments, or 52% of active youth.

Agency Involvement at Intake of Enrolled Youth (n=509)



Note: Other includes: Self, Early Care, GCCO, Network Support, Substance Abuse Agency, Private Inpatient Hospital, and Unspecified.

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- The agencies most involved with the youth were schools (21%) and the DJJ (14%). Based on discussions from CME Quality Council meetings, there is ambiguity as to how agency involvement is defined, especially around school involvement. Some CME staff members interpret school involvement to mean a youth is enrolled in school while others interpret it to mean the youth is having problems or requires special accommodations while in school.
- 13% of youth were involved with a PRTF.
- 11% of youth were involved with private mental health providers.
- Ten percent of youth were involved with DFCS.
- Interpretation of "involvement" varies by individuals entering data into Synthesis. While some interpret "involvement" to mean any interaction with an agency, others interpret "involvement' to mean negative interaction with an agency i.e. school involvement.

The frequency of agencies youth are involved at CME enrollment ranged from one to nine.

Frequency of Agency Involvement by Youth as Reported at CME Intake

Frequency of Agency Involvement at Enrollment	Waiver-C CBAY	MFP CBAY	BIP CBAY	Non-Waiver	Total	Percent of Total
1	4	10	1	91	**106**	20.8%
2	8	17	4	130	**160**	31.4%
3	5	15	0	97	**117**	22.9%
4	1	12	1	52	**66**	12.9%
5	2	3	1	27	**33**	6.5%
6	0	3	0	15	**18**	3.5%
7	0	1	0	6	**7**	1.4%
8	0	1	0	1	**2**	0.4%
9	0	0	0	1	**1**	0.2%
Total*	**20**	**62**	**7**	**420**	**510**	**100.0%**

**Total exceeds 509 as one youth was experienced more than one enrollment period with a CME during the evaluation period.*

- While 21% of youth were enrolled with only one agency at intake, more than half (54%) were involved with two to three agencies at CME enrollment.
- Approximately 20% of youth were enrolled in four to five agencies upon CME enrollment
- The remaining six percent to youth with agency involvement data were involved with six or more agencies at CME enrollment.

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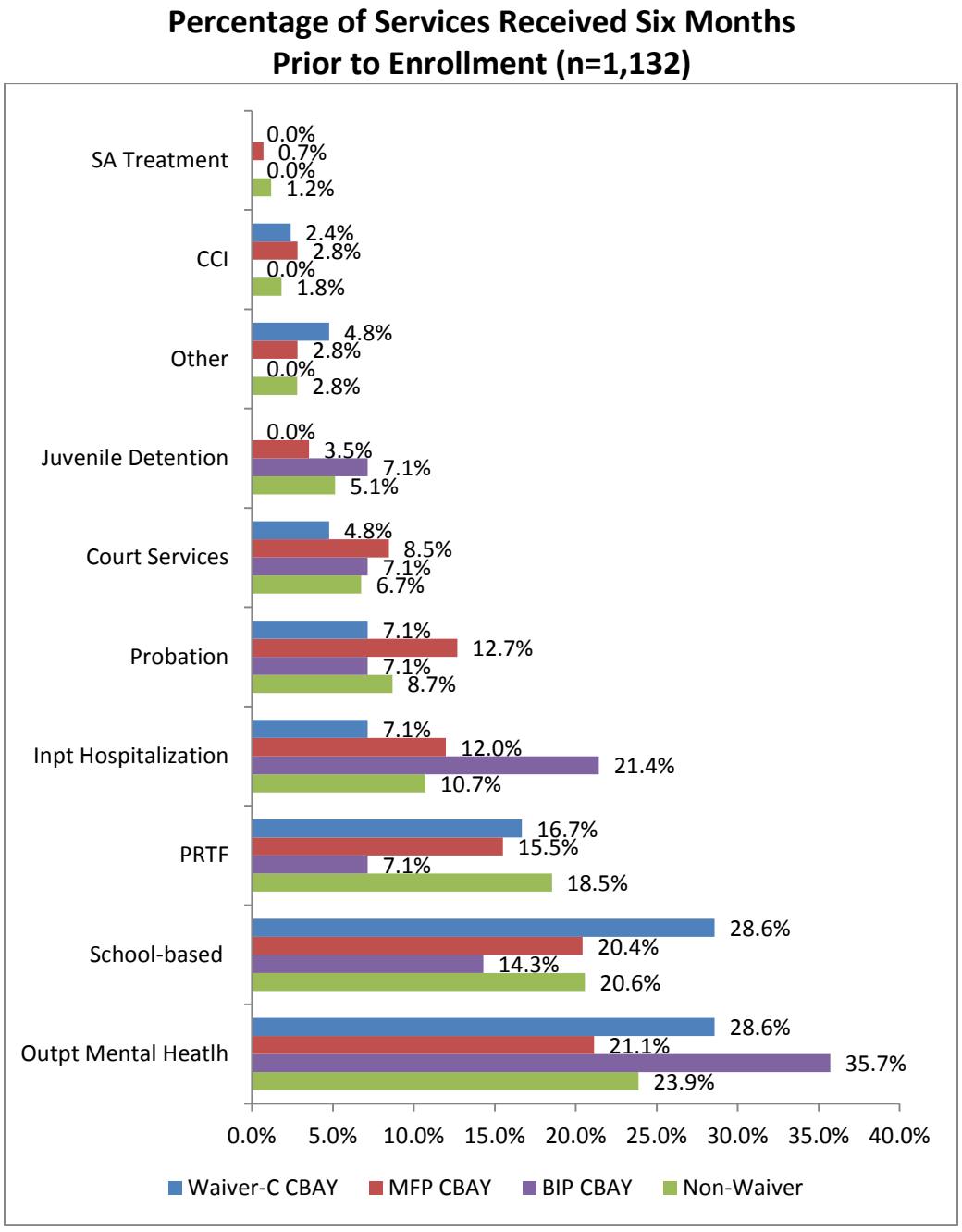
Services Received in the Six Months Prior to Intake

In the six months prior to their enrollment, some youth received multiple services including outpatient mental health services, court services, and substance abuse treatment. For 464 unique youth actively enrolled in CMEs during SFY2014, a total of 1,132 services were utilized prior to enrollment.



No descriptive data is entered into Synthesis to describe what constitutes "Other"

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- For all youth regardless of financing program, outpatient mental health (24%), school-based (21%) and PRTF (18%) the most frequently received services.

The number of services a youth received in the six months prior to CME enrollment as captured through the intake process was examined.

Frequency of Services Received by Youth as Reported at CME Intake

Frequency of Services	Waiver-C CBAY	MFP CBAY Enrolled	BIP CBAY	Non-Waiver	Total	Percent of Total
1	8	19	2	128	158	31.8%
2	5	19	4	121	149	30.0%
3	4	16	0	90	110	22.1%
4	3	4	1	52	60	12.1%
5	0	3	0	11	14	2.8%
6	0	1	0	4	5	1.0%
7	0	0	0	1	1	0.2%
Total	**20**	**62**	**7**	**407**	**497**	**100.0%**

- 32% of youth reported receiving one service prior to CME enrollment.
- More than half (52%) received two to three services and 16% received four or more services in the six months prior to enrollment in a CME.

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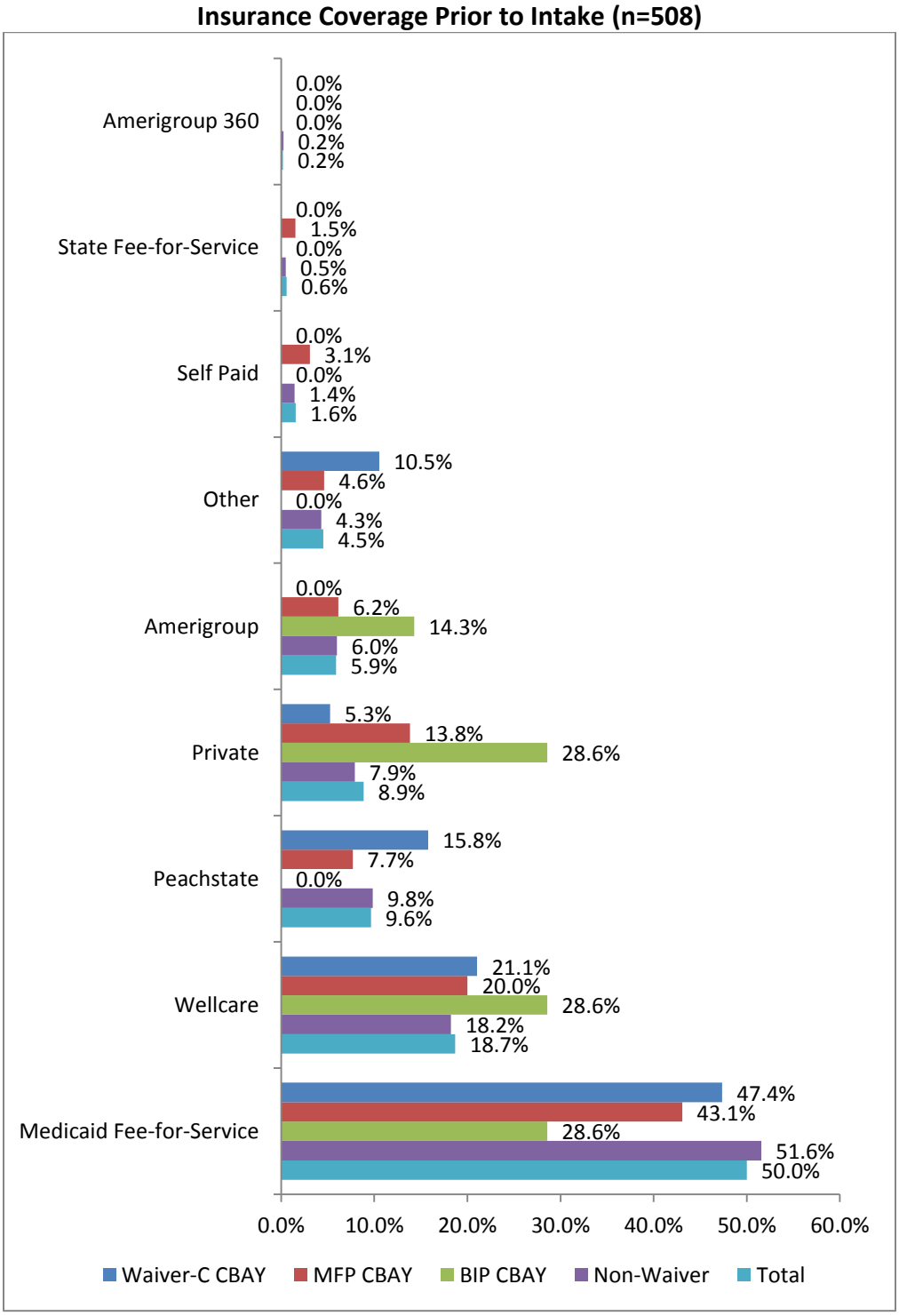
Insurance Coverage Six Months Prior to Intake

Fifty-two percent of all youth were enrolled in insurance coverage in the six months prior to their enrollment in Wraparound.



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Of the children with some type of insurance coverage:

- 50% were covered by APS Healthcare which is Fee-for-Service Medicaid.
- 34% by Medicaid Care Management Organizations (Amerigroup, Peachstate, and Wellcare)
- Nine percent were covered by private insurance
- Six percent by self-pay or Other. It is unclear what "Other" includes as Synthesis does not include a feature for direct text entry to capture this information.

Top Diagnoses

To determine the most frequent diagnoses found in this population, Axis I diagnoses (i.e. primary diagnoses) were reviewed for each financing program. The top five diagnoses for the CBAY and Non-Waiver programs are shown below.

Top Waiver-C CBAY Axis I Diagnoses (n=186)	**Percent of All Diagnoses**
Oppositional Defiant Disorder	12.9%
Attention-Deficit/Hyperactivity Disorder, Combined Type	8.1%
Post-traumatic Stress Disorder	7.5%
Attention-Deficit/Hyperactivity Disorder, NOS	6.5%
Bipolar Disorder NOS	6.5%

Top CBAY MFP CBAY Axis I Diagnoses (n=398)	**Percent of All Diagnoses**
Oppositional Defiant Disorder	11.4%
Attention-Deficit/Hyperactivity Disorder, Combined Type	10.1%
Bipolar Disorder NOS	6.1%
Post-traumatic Stress Disorder	5.9%
Mood Disorder NOS	5.7%

Top BIP CBAY Axis I Diagnoses (n=14)	**Percent of All Diagnoses**
Attention-Deficit/Hyperactivity Disorder (all diagnosis)	21.4%
Bipolar Disorder (all diagnosis)	21.4%
Cannabis Abuse	7.1%
Disruptive Behavior Disorder NOS	7.1%
Intermittent Explosive Disorder	7.1%

Top Non-Waiver Axis I Diagnoses (n=2,090)	**Percent of All Diagnoses**
Oppositional Defiant Disorder	11.8%
Attention-Deficit/Hyperactivity Disorder, Combined Type	11.3%
Attention-Deficit/Hyperactivity Disorder NOS	8.0%
Bipolar Disorder NOS	7.5%
Mood Disorder NOS	6.8%

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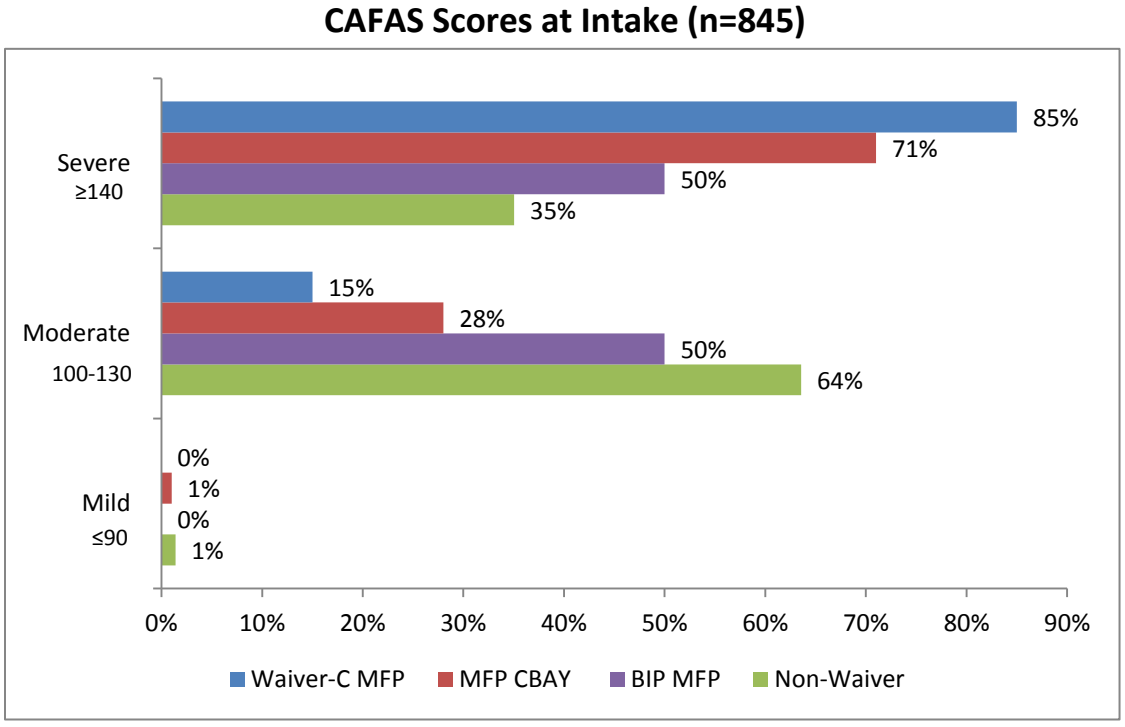
- Oppositional defiant disorder and combined attention-deficit/hyperactivity disorder were the top two diagnoses for Waiver-C CBAY, MFP CBAY, and Non-Waiver categories. These two diagnoses together accounted for 21% to 23% of the total diagnoses for each category, respectively.
- Another frequent diagnosis in the Waiver-C CBAY and MFP CBAY categories was post-traumatic stress disorder, which accounted for approximately 7.5% and 6% of the total diagnoses in each category, respectively.
- 14 Axis I diagnoses were present for the seven youth enrolled in CME services via BIP CBAY, and 42% of diagnoses were attributable to attention deficit/hyperactivity disorder and bipolar disorders.

CAFAS Scores

The Child and Adolescent Functional Assessment Scale (CAFAS) assesses and rates a youth's degree of impairment in day-to-day functioning due to behavioral, emotional, psychological, psychiatric or substance use problems. The CAFAS is also used for determining whether a youth's functioning improves over time. For the purposes of this report, CAFAS scores were divided into three risk categories: mild risk (≤ 90), moderate risk (100-130), and severe risk (≥140).

The following chart shows CAFAS scores upon intake for the enrolled population by risk and funding program.



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- Of all enrolled youth, 41% presented with severe risk CAFAS scores, and an additional 58% presented with moderate risk CAFAS scores.
- The majority of Waiver-C CBAY (85%) and MFP CBAY (71%) youth had severe risk scores (>130) at intake.
- Half BIP CBAY (50%) and Non-Waiver (64%) youth had moderate risk scores at intake.

Challenges Identified at Intake for Enrolled Youth (n=856)

Youth and families are asked to rate challenges on a scale of low, medium or high as part of the Wraparound model. The table below presents the percent of youth experiencing medium or high challenges as documented on the first action plan completed by CME staff on or after enrollment.

Challenges Identified for Enrolled Youth at Intake

Challenge	Waiver-C CBAY	MFP CBAY	BIP CBAY	Non-Waiver	Total
Emotional/Behavioral	91.8%	77.4%	83.3%	78.8%	**79.4%**
Safety	79.6%	69.8%	66.7%	66.4%	**67.6%**
Family	71.4%	51.9%	66.7%	62.8%	**62.0%**
Education	61.2%	50.0%	50.0%	56.5%	**55.9%**
Social	46.9%	46.2%	0.0%	46.0%	**45.7%**
Community	24.5%	47.2%	33.3%	32.8%	**34.1%**
Legal	12.2%	18.9%	16.7%	31.6%	**28.9%**
Housing	16.3%	8.5%	0.0%	20.0%	**18.3%**
Medical	24.5%	21.7%	0.0%	15.7%	**16.8%**
Vocational	14.3%	3.8%	0.0%	6.7%	**6.8%**
Other	6.1%	4.7%	0.0%	5.1%	**5.1%**
Cultural/Spiritual	0.0%	2.8%	0.0%	2.6%	**2.4%**

- Collectively across all funding programs, approximately 80% of youth experienced Emotional/Behavioral challenges.
- Safety was the second most challenging area for youth, with 68% identifying this as a medium or high level challenge area.
- Family was the third most challenging area, with 62% of youth noting it a challenge area.

Family Support Utilization

In addition to receiving formal care coordination services from the CMEs, family support services provided by peer partners are an equally important component of Wraparound. The following table shows the number of youth who were served by a family support partner, the total number of encounters, total contact time, and total time by program. Encounters were counted in unique days. Total time includes contact, travel, and documentation time.

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Family Support Partner Time Spent with Enrolled Youth

Program	Total Youth	Total Encounters (days)	Average Encounters/ Youth	Total Contact Time (hours)	Total Time (hours)	Percent of Total Time in Contact with Youth
Waiver-C CBAY	47	3,759	80.0	6,868.8	9,838.2	69.8%
MFP CBAY	103	2,999	29.1	4,624.7	6,639.5	69.7%
BIP CBAY	6	85	14.2	164.0	225.5	72.7%
Non-Waiver	759	30,340	40.0	43,358.1	67,610.1	64.1%
Total	**915**	**37,183**	**40.6**	**55,015.6**	**84,313.3**	**65.3%**

- 93% of active youth received family support services.
- A total of 37,183 daily encounters were provided to 915 youth, the majority of which were provided to Non-Waiver youth (82%).
- Waiver-C CBAY youth averaged the most number of encounters (80.0) while BIP CBAY youth encountered the fewest (14.2), consistent with the longer periods of enrollment in CMEs services by the two programs.
- On average, FSPs spent 65% of the total authorized time in contact with youth. Direct contact time with families was highest among BIP-funded youth (73%) and lowest among Non-Waiver youth (64%).

Youth and Caregiver Perceptions of Wraparound

Biannually, a set of three surveys is administered to actively enrolled youth and their caregivers. Youth were administered a section of the Resilience & Youth Development Module (RYDM) of the California Health Kids Survey (CHKS) in November 2013 and May 2014. Caregivers of active youth were asked to complete the family module of the Youth Satisfaction Survey (YSS-F) and the Family Empowerment Scale (FES). Findings from the November 2013 administration cycle were included in the *CME 6-Month Interim Evaluation Report*. In this report, we present the findings from the May 2014 administration cycle as well as present a longitudinal panel analysis for youth who completed surveys during both administration cycles.

California Healthy Kids Survey (CHKS)

May 2014 CHKS Administration Cycle Data: In May 2014, youth were administered a section of the Resilience & Youth Development Module (RYDM) of the California Health Kids Survey (CHKS). The RYDM CHKS measures youth resiliency, protective factors, and risk behaviors. Youth are given a series of statements and asked to indicate how true each statement was for them, on a scale from "Not at all true" (1) to "Very much true" (4). CHKS surveys were administered to 396 youth; youth were only eligible to complete the survey if they were aged 11 years or older. Surveys were completed and returned for 240 youth, lending a response rate of 60.6%. The optional section of the RYDM CHKS assesses a youth's home environment, their

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peer environment, and six internal assets or resilience traits. A combined resilience score is calculated by summing the previous eight survey components. A copy of the CHKS instrument is included in Appendix C.

The following table provides the mean score for the eight composite areas and the summary resiliency score for all youth completing the May 2014 administration of the CHKS survey. Observations were left out of the analysis if they were missing information from any of the composite areas.

May 2014 Composite Mean Scores

Composite Category	N	Mean Score
Goals and Aspirations	237	3.36
Empathy	233	2.95
Problem Solving	236	2.88
Self-efficacy	235	2.24
Cooperation and Communication	230	2.83
Self-awareness	233	3.01
Peer Environment	231	2.92
Home Environment	232	3.28
Resilience	200	24.7

- Youth reported the highest average score for their goals and aspirations, comfort in their home environment, and self-awareness. Youth reported the lowest average scores for self-efficacy, cooperation and communication, and problem solving.

Longitudinal CHKS Administration Cycle Panel Data: While it is acknowledged that the CHKS has low test-retest reliability, a longitudinal analysis of youth who were enrolled in Wraparound during two administration cycles suggests that youth who were enrolled in Wraparound during both administration cycle reported similar levels of resiliency. Prior to the May 2014 semi-annual CHIPRA survey administration cycle, youth were administered the CHKS in November 2013. For youth who completed the CHKS in both the November 2013 administration cycle and the May 2014 administration cycle, surveys were linked via the youth's unique Synthesis ID, creating a longitudinal panel dataset. This longitudinal dataset allowed for the comparison of CHKS scores between the two administration cycles. Below are data collected from the 106 youth who completed CHKS surveys during both administration cycles. A copy of the CHKS instrument is included in Appendix C.

The following table provides a comparison of the mean score of the eight composite areas and the summary resiliency score for all youth between November 2013 and May 2014.

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Observations were left out of the analysis if they were missing information from any of the composite areas.

Panel Comparison of Composite Mean Scores

Composite Category	N	Mean Score (Nov. 2013)	Mean Score (May 2014)	Difference
Goals and Aspirations	100	3.47	3.39	-0.08
Empathy	94	3.17	3.10	-0.07
Problem Solving	98	2.97	2.93	-0.04
Self-efficacy	100	3.39	3.34	-0.05
Cooperation and Communication	98	2.98	2.95	-0.03
Self-awareness	96	3.09	3.12	0.03
Peer Environment	99	3.12	3.04	-0.08
Home Environment	95	3.39	3.35	-0.04
Resilience	66	25.59	25.20	-0.39

- In both reporting periods, youth reported the highest average score for their goals and aspirations, comfort in their home environment, and self-efficacy. Youth reported the lowest average scores for cooperation and communication and problem solving.
- A majority of composite categories declined from November 2013 to May 2014. Overall, the resilience score of these youth declined by 0.40 points between November 2013 and May 2014. None of the observed differences were statistically significant.

Youth Services Survey-Family (YSS-F)

May 2014 YSS-F Administration Cycle Data: A total of 396 YSS-F surveys were distributed between both care management entities (CMEs), with Lookout Mountain CME distributing 189 surveys and View Point Health distributing 207 surveys. Lookout Mountain had 153 surveys returned by respondents, giving a response rate of 81%. View Point Health had 127 surveys returned by respondents, giving a response rate of 64%. The overall response rate for both CMEs was 66%. A copy of the YSS-F instrument is included in Appendix D.

The following table provides the mean score for the six composite areas of the survey. Observations were left out of the analysis if they were missing information from any of the composite areas.

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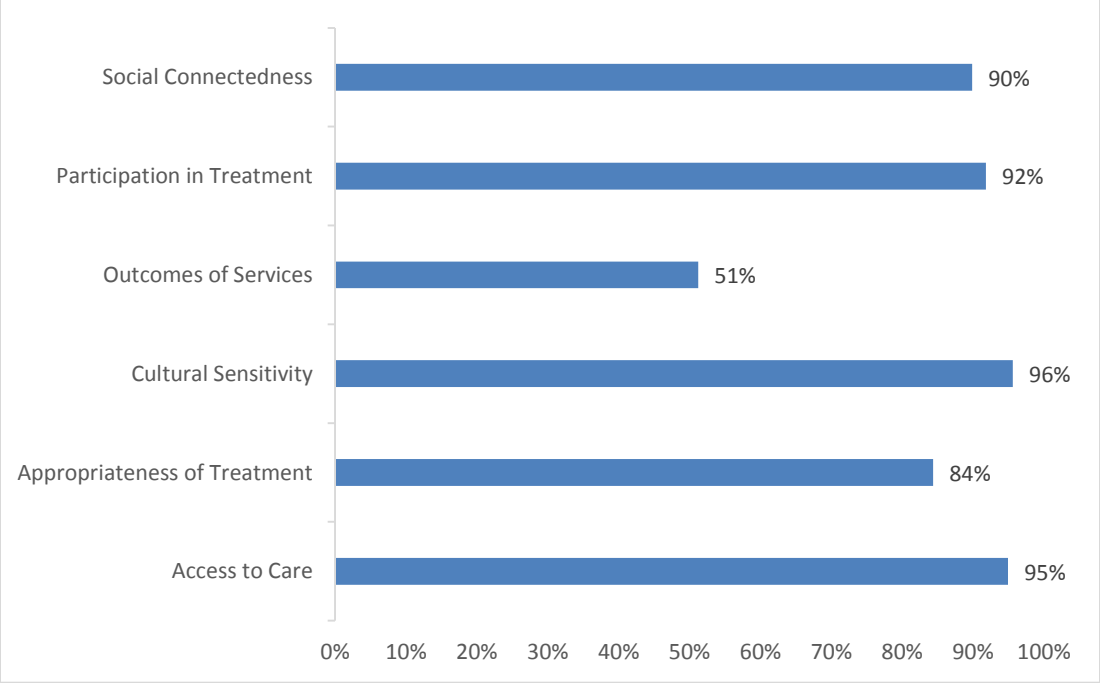
May 2014 YSS-F Mean Composite Scores

Composite Category	N	Mean Score
Access to Care	278	4.44
Appropriateness of Treatment	282	4.14
Cultural Sensitivity	275	4.51
Outcome of Services	283	3.46
Participation in Treatment	282	4.32
Social Connectedness	277	4.21

Caregivers were asked to rate their level of agreement with statements related to the care their child was receiving, ranging from strongly disagree (1) to strongly agree (5). Items were collapsed to form several subscales related to caregiver's satisfaction with treatment and scores greater than 3.5 were reported in the positive range. The following figure shows the percentage of caregivers with positive scores (> 3.5) on each of the six subscales.

Percent of Caregivers with Positive Responses Related to Satisfaction



- The majority of caregivers reported positive responses related to their satisfaction with their child's behavioral health services, with the highest percent of positive scores reported for cultural sensitivity, access to care services, participation in treatment and social connectedness.
- The lowest percent of positive scores were reported for outcomes of services.

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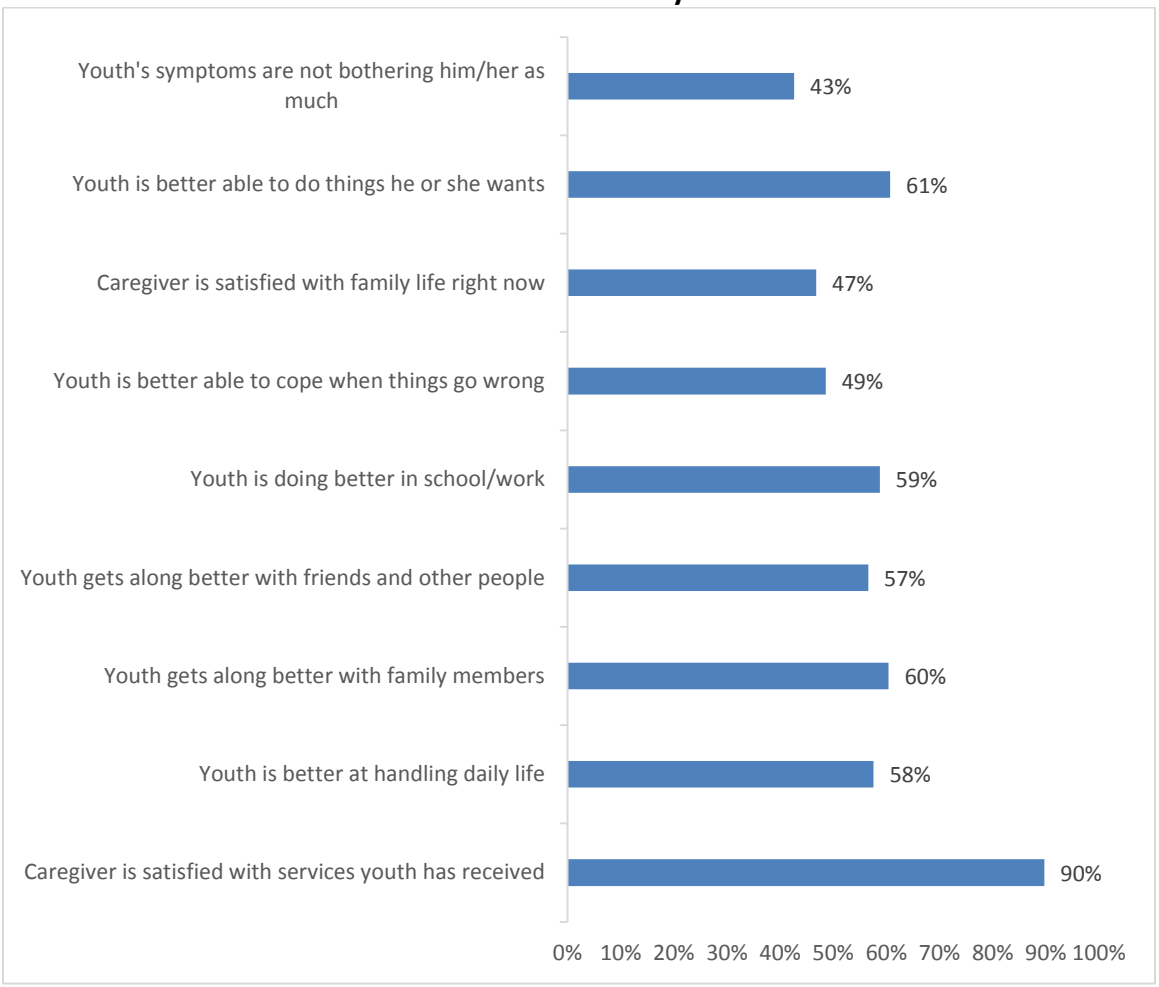
In contrast to subscale scores related to satisfaction with child behavioral health services, caregivers were somewhat less positive in regards to their child's current functioning and their satisfaction with family life.

Percent of Caregivers with Positive Responses Related to Child and Family Outcomes*



** Score greater than 3.5*

- Slightly less than half of caregivers agreed or strongly agreed with statements that their child had improved symptoms and coping skills.
- Approximately half of the caregivers agreed or strongly agreed with a statement that they were satisfied with their family life.
- Slightly more than half of caregivers agreed or strongly agreed with statements their child was doing well in areas of daily life, school/work, getting along with family, friends and others, and doing things he/she wanted.
- A majority of caregivers agreed or strongly agreed with a statement that they were satisfied with the services the youth has received.

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Longitudinal YSS-F Administration Cycle Panel Data: Prior to the May 2014 semi-annual YSS-F survey administration cycle, caregivers were administered the YSS-F survey in November 2013. For caregivers who completed the YSS-F for a youth in both the November 2013 administration cycle and the May 2014 administration cycle, surveys were linked via the youth's unique Synthesis ID, creating a longitudinal panel dataset. This longitudinal dataset allowed for the comparison of YSS-F scores between the two administration cycles. Between both CMEs, caregivers completed YSS-F surveys for a total of 136 youth during the two administration cycles. Below are data collected from these 136 caregivers. A copy of the YSS-F instrument is included in Appendix D.

The following table provides a comparison of the mean score for the six composite areas of the survey for youth between November 2013 and May 2014. Observations were left out of the analysis if they were missing information from any of the composite areas.

Panel Comparison of Composite Mean Scores

Composite Category	N	Mean Score (Nov. 2013)	Mean Score (May 2014)	Difference
Access to Care	114	4.41	4.43	0.02
Appropriateness of Treatment	111	4.07	4.18	0.11
Cultural Sensitivity	109	4.45	4.59	0.14
Outcome of Services	111	3.25	3.46	0.21
Participation in Treatment	112	4.23	4.33	0.10
Social Connectedness	113	4.15	4.21	0.06

Caregivers were asked to rate their level of agreement with statements related to the care their child was receiving, ranging from strongly disagree (1) to strongly agree (5). Items were collapsed to form several subscales related to caregiver's satisfaction with treatment and scores greater than or equal to 3.5 were reported in the positive range. The following figure shows the percentage of caregivers with positive scores (> 3.5) on each of the six subscales. The blue bars represent the subscale scores from the November 2013 cycle; the red bars represent the subscale scores from the May 2014 cycle.

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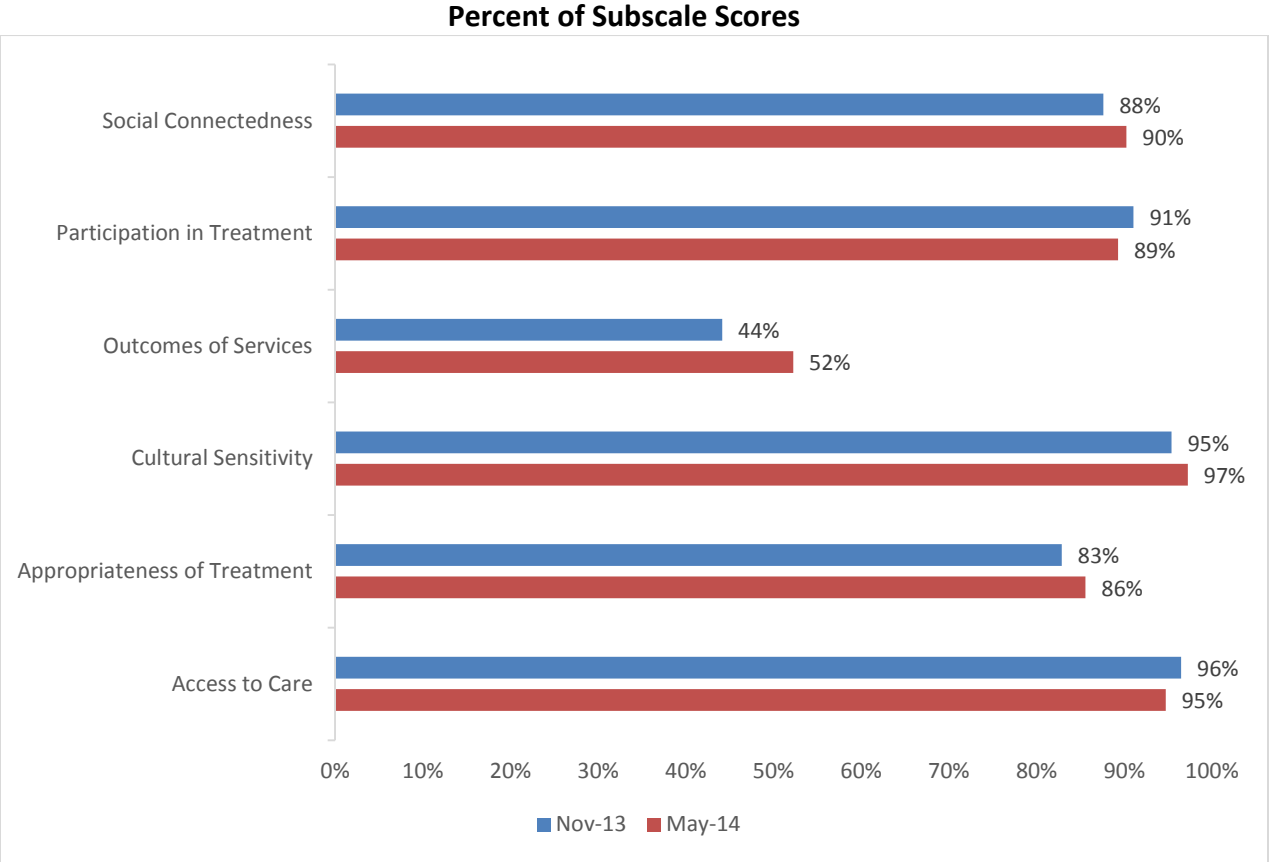

- Between November 2013 and May 2014, the majority of caregivers reported positive responses related to their satisfaction with their child's behavioral health services, with the highest percent of positive scores reported for cultural sensitivity, access to care services, participation in treatment and social connectedness.
- The lowest percent of positive scores were reported for outcomes of services.
- Four subscale scores improved between November 2013 and May 2014, and two declined. Most changes were marginal (i.e. one to two percent); however, outcomes of services increased by eight percent between the two cycles, from 44% to 52%. None of the observed differences were statistically significant.

In contrast to subscale scores related to satisfaction with child behavioral health services, caregivers were somewhat less positive in regards to their child's current functioning and their satisfaction with family life.

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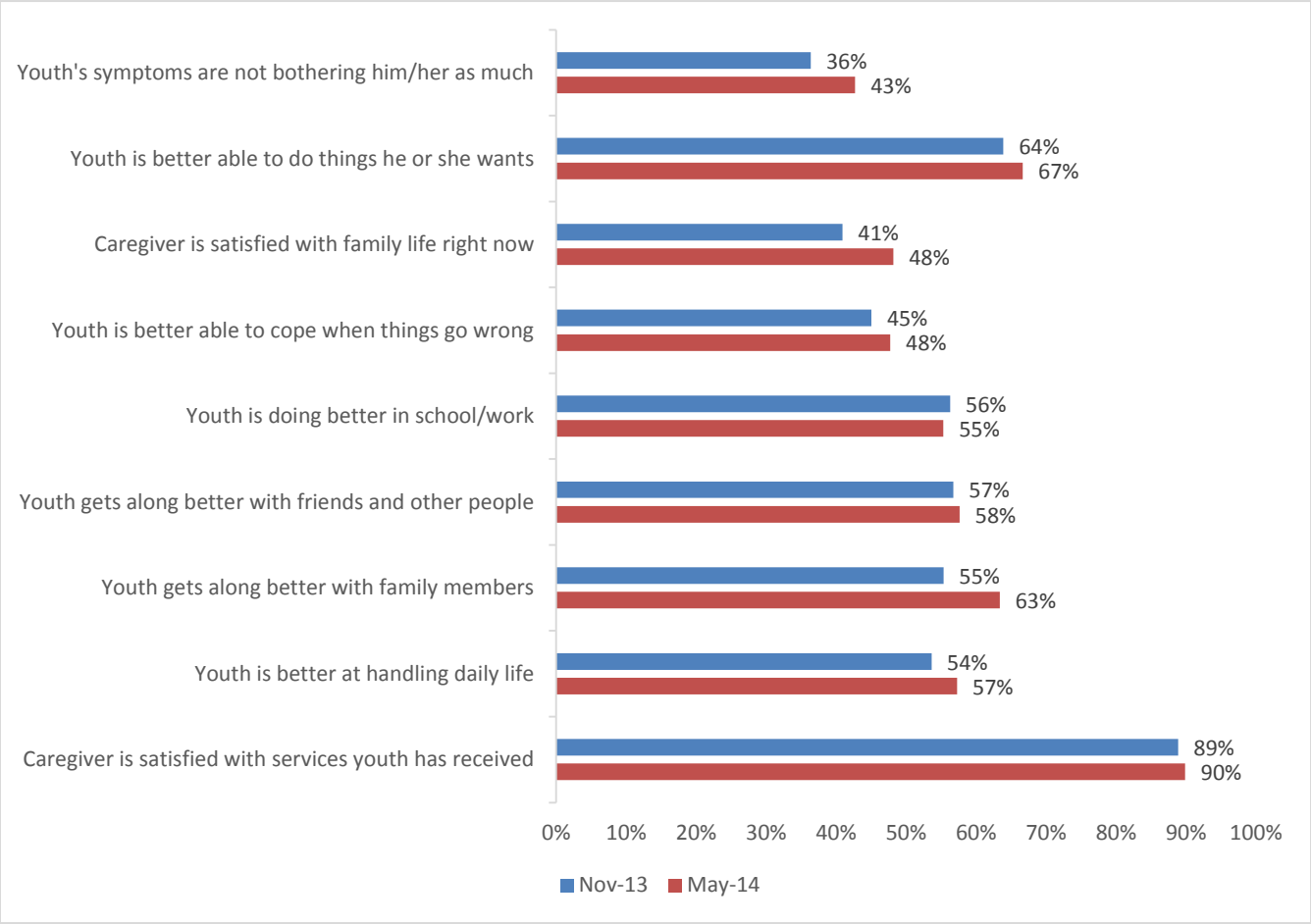
Percent of Caregivers with Positive Responses Related to Child and Family Outcomes



- For both administration cycles, less than half of caregivers agreed or strongly agreed with statements that they were satisfied with their family life and that their child had improved symptoms and increased coping skills.
- Slightly more than half of caregivers agree or strongly agreed with statements their child was doing well in areas of daily life, school/work, getting along with family, friends and others, and doing things he/she wanted.
- A majority of caregivers agreed or strongly agreed with a statement that they were satisfied with the services the youth has received.
- In comparing the two time periods, most of the differences between the two cycles were marginal. However, from November 2013 to May 2014, there was a seven percent increase in caregivers agreeing or strongly agreeing with statements that their child had improved symptoms, a seven percent increase in caregivers agreeing or strongly agreeing with statements that they were satisfied with family life, and an eight percent increase in caregivers agreeing or strongly agreeing with statements that their child was

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getting along better with family members. None of these differences were statistically significant.

Family Empowerment Scale (FES)

May 2014 Family Empowerment Scale (FES) Administration Cycle: The FES measures caregivers' own sense of their empowerment at the family level (12 items), the service system level (12 items), the community/political level (10 items), and an overall sense of total empowerment. Caregivers rated items from never occurring (1) to occurring very often (5). Scores were then summed across items for each of the subscales to provide a family empowerment score, with higher scores representing greater empowerment. FES surveys were administered to 396 caregivers, and surveys were completed and returned for 282 youth, lending a response rate of 71.2%. A copy of the FES instrument is included in Appendix E.

The following table provides a comparison of the mean score for the four empowerment levels during May 2014, analyzed by disposition. Observations were left out of the analysis if they were missing information from any of the composite areas.

May 2014 Composite Mean Scores

Empowerment Level	N	Mean Score
Family Level Empowerment (range: 12-60)	270	48.1
Service Systems Level Empowerment (range: 12-60)	271	52.8
Community/Political Level Empowerment (range: 10-50)	270	32.7
Total Empowerment Level (range: 34-170)	282	128.1

- Caregivers reported a fairly high degree of family level and service systems level empowerment, particularly related to their confidence in navigating their child's behavioral health system.
- Caregivers reported the lowest level of confidence on a community and/or political level.

Longitudinal FES Administration Cycle Panel Data: Prior to the May 2014 semi-annual FES survey administration cycle, caregivers were administered the FES survey in November 2013. For caregivers who completed the FES for a youth in both the November 2013 administration cycle and the May 2014 administration cycle, surveys were linked via the youth's unique Synthesis ID, creating a longitudinal panel dataset. This longitudinal dataset allowed for the comparison of FES scores between the two administration cycles. Between both CMEs, caregivers completed FES surveys for a total of 116 youth during the two administration cycles.

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Below are data collected from these 116 caregivers. A copy of the FES instrument is included in Appendix E.

The following table provides a comparison of the mean score for the four empowerment levels of the survey for youth between November 2013 and May 2014. Observations were left out of the analysis if they were missing information from any of the composite areas.

Panel Comparison of Composite Mean Scores

Empowerment Levels	N	Mean Score (Nov 2013)	Mean Score (May 2014)	Difference
Family Level Empowerment (range: 12-60)	102	47.93	47.77	-0.16
Service Systems Level Empowerment (range: 12-60)	103	51.17	52.47	1.30
Community/Political Level Empowerment (range: 10-50)	104	31.30	32.77	1.47
Total Empowerment Level (range: 34-170)	113	123.51	127.67	4.16

- In both reporting periods, caregivers reported a fairly high level of family level and service systems level empowerment, particularly related to their confidence in navigating their child's behavioral health system.
- Caregivers reported the lowest level of confidence on a community and/or political level. A majority of empowerment areas increased from November 2013 to May 2014.
- Overall, the total empowerment level of these caregivers improved by 4.2 points between November 2013 and May 2014. None of the observed differences were statistically significant.

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Wraparound Fidelity Index

The WFI is a fidelity monitoring tool that assesses the extent to which a Child and Family Team is adhering to the principles of Wraparound, with the assumption that increased fidelity will lead to better overall child and family outcomes. WFI interviews are administered to CBAY (Waiver-C, MFP and BIP) youth only three to six months post-enrollment in a CME for Wraparound. There are four WFI interviews conducted; one to the Care Coordinator, Team Member, Youth, and Care Giver, from a given Child and Family Team and each is asked a series of questions that fall along a three-point scale ranging from zero to two. Results from the interviews are entered into a WrapTrack, a database developed and managed by the Wraparound Evaluation and Research Team (WERT) at the University of Washington which calculates a Wraparound fidelity score. To calculate summary scores WrapTrack divides the sum of the items (e.g., for all completed items in the WFI-4) by the total possible score for completed items. The total possible WFI-4 score is 80 for the total score of the Care Coordinator, Team Member, and Caregiver forms; and 64 for the Youth form, which only has 32 items. A copy of each of the interview tools – the Care Coordinator, Team Member, Caregiver, and Youth tools – is included in Appendix F.

The COE began WFI administration in September 2012 from a previous vendor. From October 2012 through April 2013, WFI interviews were suspended as the Waiver-C CBAY enrollment period ended and no new youth were enrolled meeting the administration criteria. In May 2013 WFI interviews resumed on youth enrolled in the MFP CBAY and BIP CBAY program.

Of the youth discharged during the evaluation period, a total of 207 interviews were conducted. Of these 207 interviews, 83 were with care coordinators, 56 were with other team members, 47 were with caregivers, and 21 were with youth. As interviews were conducted in three to six-month range, some youth were interviewed more than once due to re-enrollment in Wraparound. The 83 care coordinator interviews represented 79 unique youth; the 56 team member interviews represented 54 unique youth; the 47 caregiver interviews represented 46 unique youth; and the 21 youth interviews represented 20 unique youth. In total, there were 21 youth for which all four telephone interviews were successfully completed, representing 20 unique youth. The graphs below portray the distribution of scores for each set of interviews.

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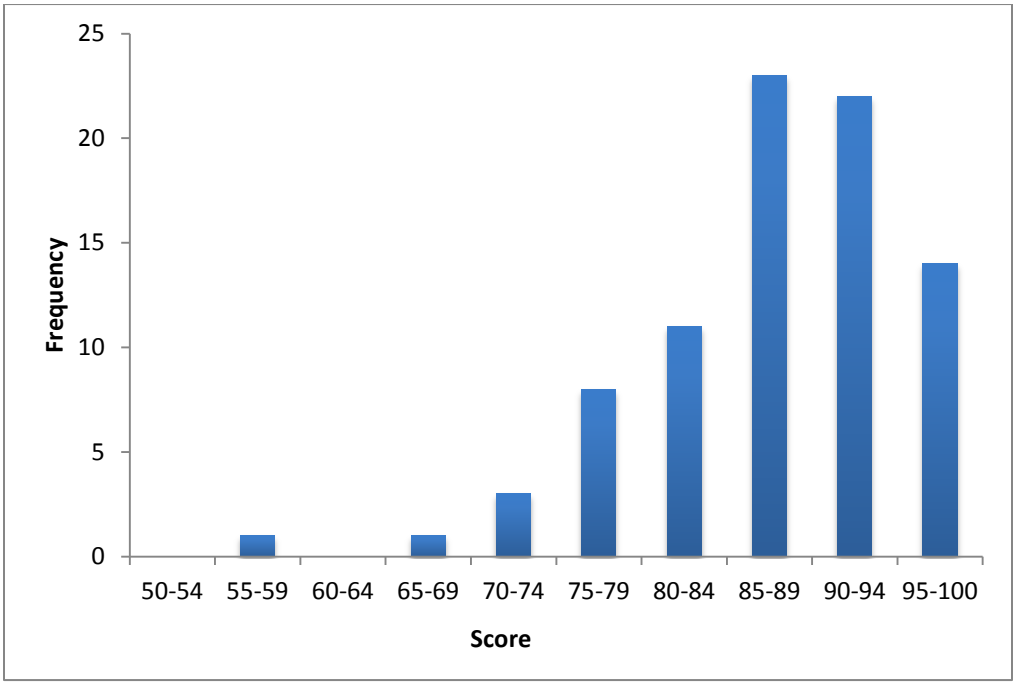
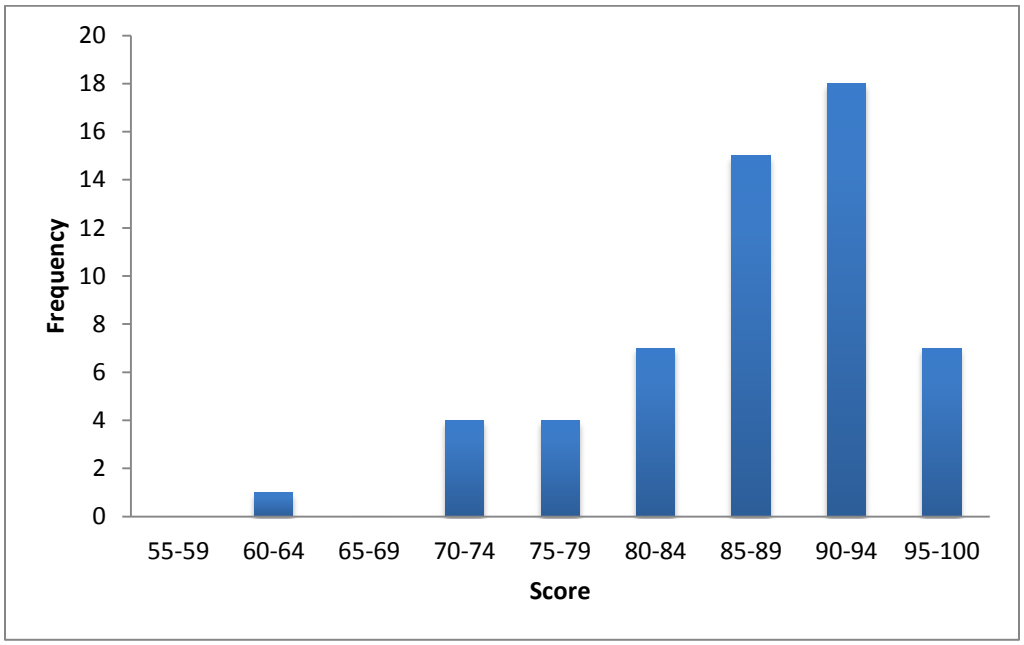
Distribution of Facilitator WFI Scores



- Out of the 83 care coordinator/facilitator interviews conducted, the lowest Wraparound Fidelity Index score attained was 59.5% and the highest score attained was 100.0%. The average score was 87.8%.

Distribution of Team Member WFI Scores



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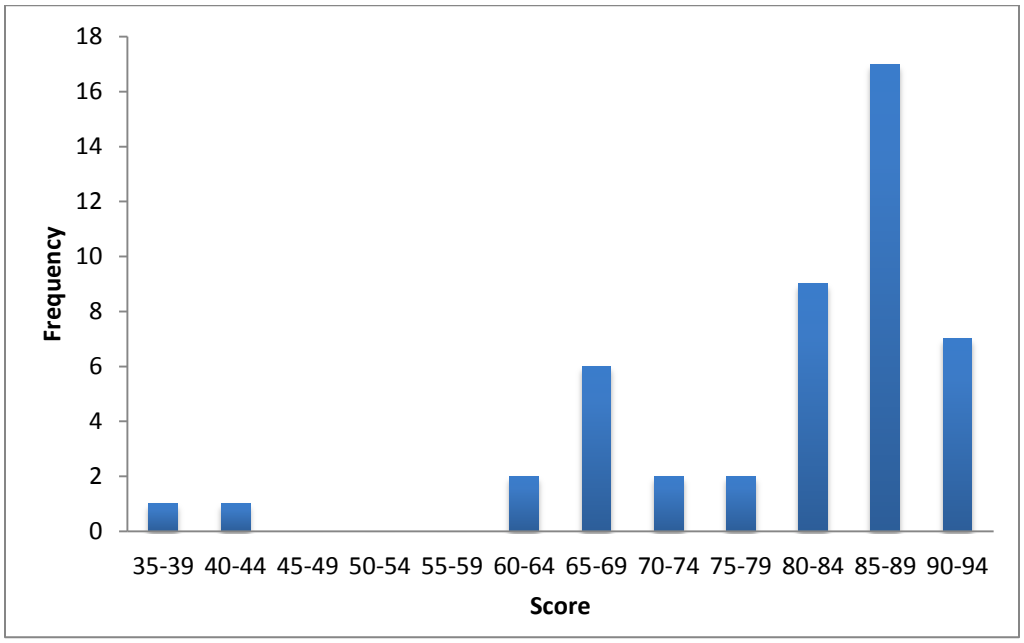
- Out of the 56 team member interviews conducted, the lowest Wraparound Fidelity Index score attained was 62.5% and the highest score attained was 100.0%. The average score was 86.9%.

Distribution of Caregiver WFI Scores



- Out of the 47 caregiver interviews conducted, the lowest Wraparound Fidelity Index score attained was 39.4% and the highest score attained was 93.8%. The average score was 80.6%.

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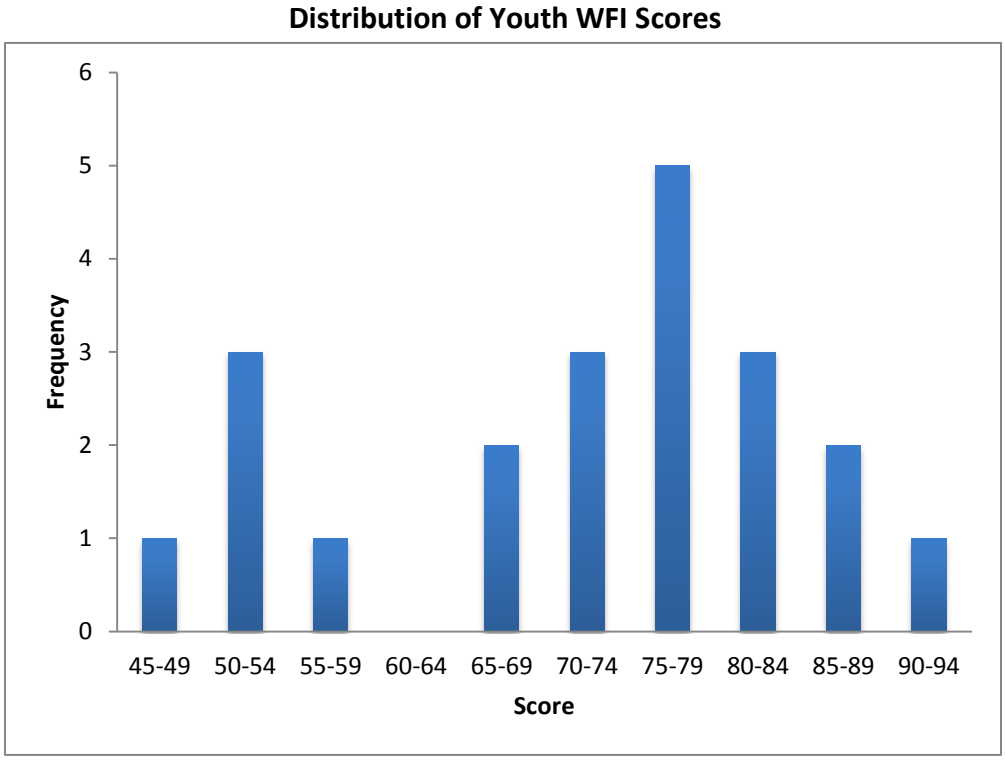

- Out of the 21 youth interviews conducted, the lowest Wraparound Fidelity Index score attained was 48.0% and the highest score attained was 90.6%. The average score was 72.5%.

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Wraparound Care Coordination Outcomes

Wraparound outcomes are reported on youth who discharged from a CME during the evaluation period. Outcomes reviewed for this report include CME discharge outcome, youth impairment and resiliency, caregiver satisfaction and empowerment, out of home placements, school attendance, and child welfare and juvenile justice involvement. Fidelity to the Wraparound model was also evaluated.

Discharged Youth

Of the 980 youth who received Wraparound services from a CME during the evaluation period, 683 (70%) were discharged during the evaluation period, one of which was discharged twice. Youth who were enrolled in a CME but who never left the PRTF were excluded from the discharged cohort. The table below provides a breakdown of discharged youth by program during this evaluation period.

Program	Discharged Youth	Percent of Total
Waiver-C CBAY	44	6.4%
MFP CBAY	47	6.9%
BIP CBAY	1	0.1%
Non-Waiver	591	86.5%
Total	**683**	**100.0%**

- The majority of discharged youth (87%) received Wraparound services through the Non-Waiver program.
- The percent of youth involved in the Waiver-C, MFP CBAY, BIP CBAY programs collectively represent 13% of the discharges during the evaluation period.

CME Length of Enrollment

CME *Length of Enrollment (LOE)* is calculated for each discharged youth by subtracting the enrollment date from the discharge date. LOE demonstrates the number of complete months a youth is enrolled in Wraparound services.

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Average Length of Enrollment by Program

Program	Avg. CME LOE*	Minimum CME LOE *	Maximum CME LOE*
Waiver-C CBAY	19.0	9.0	29.0
MFP CBAY	5.0	0.0	12.0
BIP CBAY	2.0	2.0	2.0
Non-Waiver	8.7	0.0	45.0
Total	**8.7**		

* (n=683) LOE in measured in complete months. A complete month is from a date *x* in one month through the *x*-1 date the following month.

- Discharged youth experienced lengths of enrollment (LOE) in a CME ranging from two months to as many as 45 months, with an average of 8.7 months.
- Youth in the Waiver-C program experienced longest average LOE of 19 complete months in Wraparound.
- MFP CBAY youth and BIP CBAY were enrolled in a CME an on average five months or less.
- The average LOE for Non-Waiver youth discharged during the evaluation period was 8.7 complete months.

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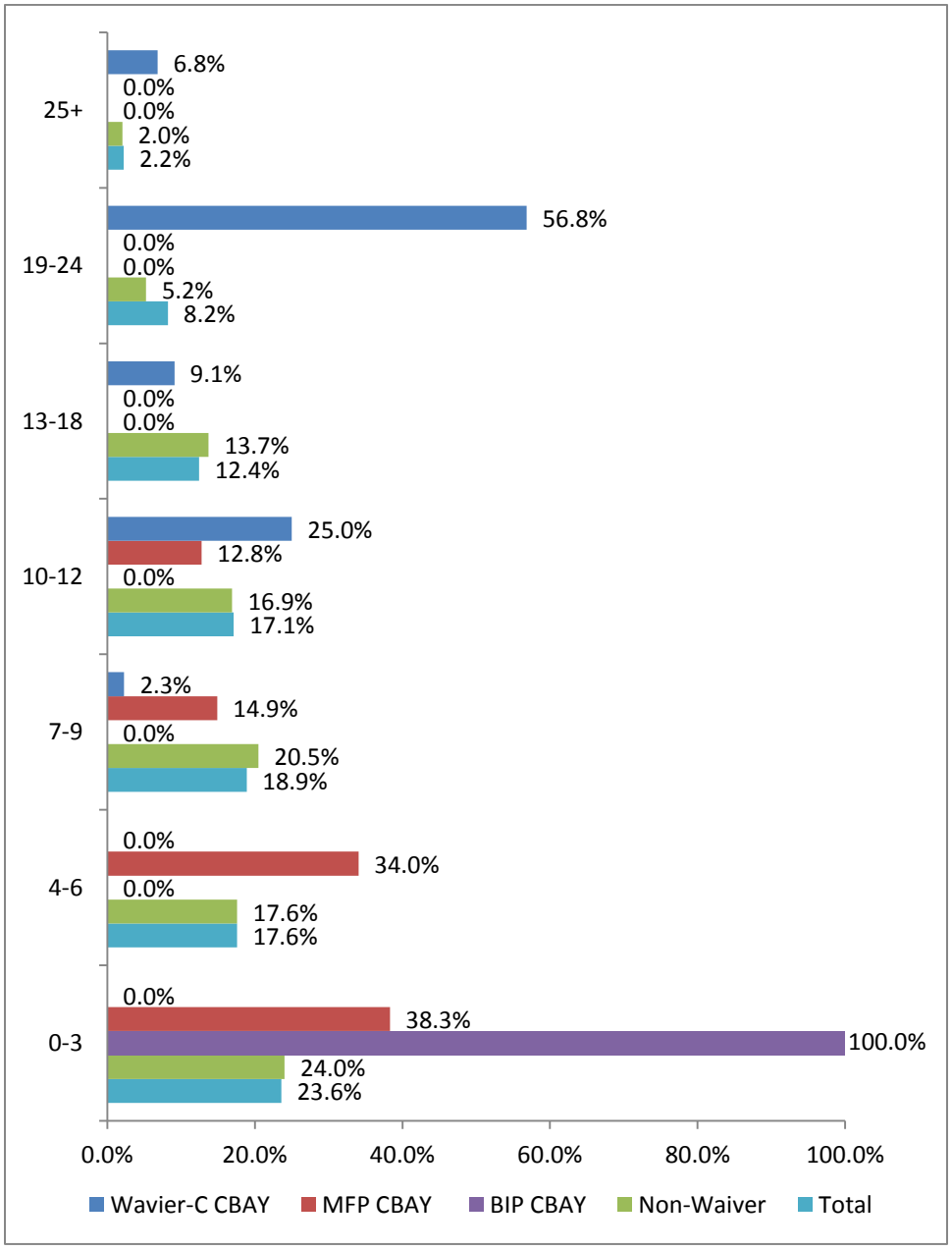
Distribution of Months Enrolled in CME by Program (n=683)



- The majority of Waiver-C youth (64%)were enrolled in Wraparound more than 19 months
- 72% of MFP CBAY youth were enrolled six months or less prior to discharge. While the remaining 28% were enrolled between seven and 12 months.
- The single BIP CBAY youth was enrolled two months prior to discharge.
- 42% of Non-Waiver youth were enrolled for six months or less prior to discharge. 37% were enrolled between seven and 12 months, 21% were enrolled for more than one year.

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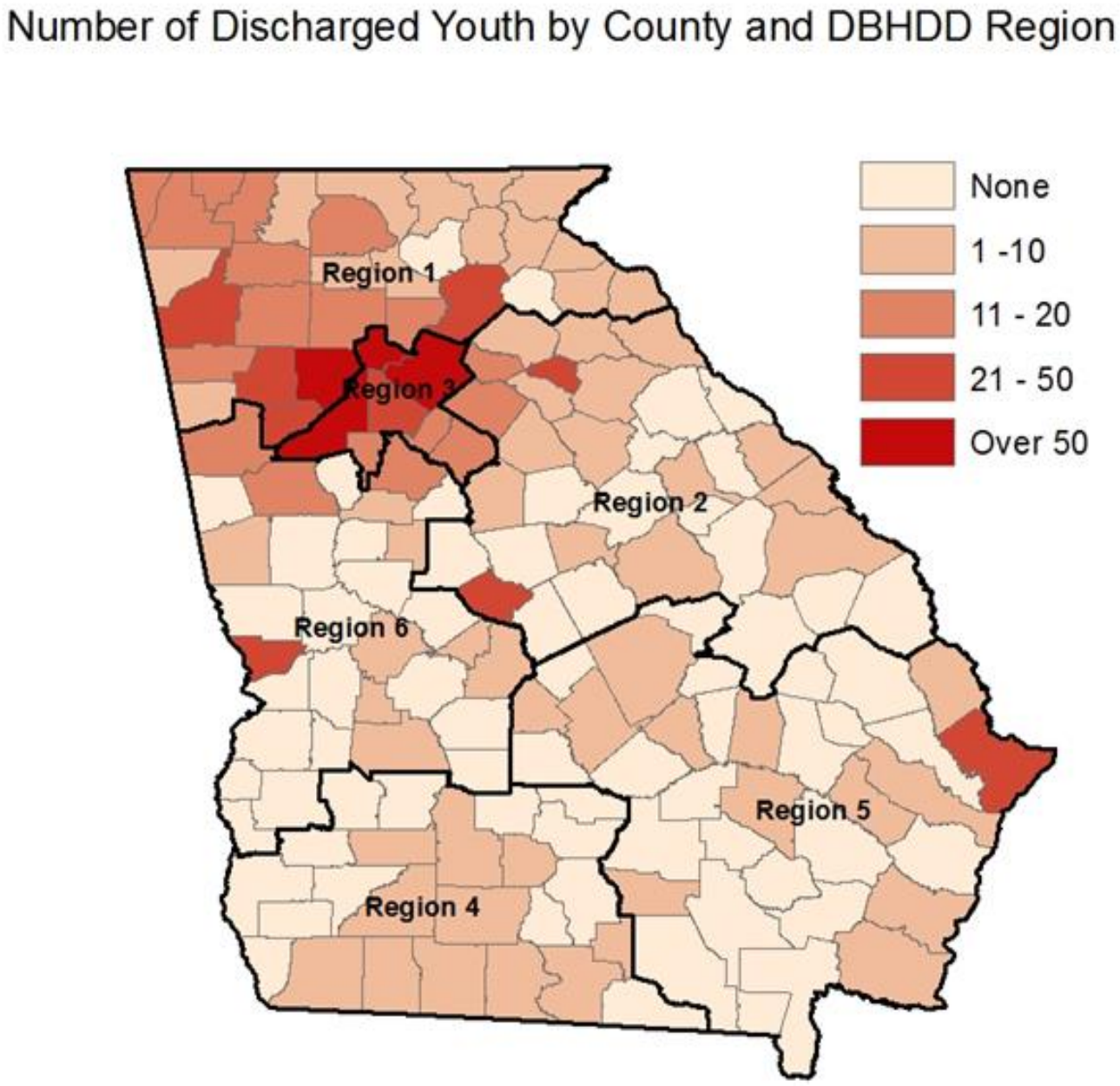
CME Discharge Outcome

683 youth were discharged from a CME during SFY2014. The following map provides a geographic illustration of where discharged youth reside in the state.



- Youth who discharged from Wraparound primarily reside in Regions 1 and 3 and in urban counties located in Regions 2, 5 and 6.
- 70 counties had no youth discharged and 58 counties had ten youth or less discharged from Wraparound in SFY2014.

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CMEs categorize youth discharges from Wraparound as either "in-community" or "out-of-community." Each CME discharge outcome category is delineated into more descriptive sub-categories to reflect the discharge disposition. Positive and neutral discharge subcategories are classified as an in-community outcome while negative discharges are classified as an out-of-community outcome. The following table identifies the top five dispositions for in-community and out-of-community discharge outcomes.

CME Discharge Outcome	Avg. LOE	Waiver-C CBAY	MFP CBAY	BIP CBAY	Non-Waiver	Total	Percent of Outcome Total*	Percent of Total Discharged Youth
Top 5 In-Community Discharges								
Positive - Successful Graduation	13.6	18	7	0	188	**213**	40.2%	31.2%
Positive - Successful Family Opt-out	6.7	9	4	0	137	**150**	28.3%	22.0%
Neutral - Loss of Contact With an Enrolled Youth	5.4	0	5	1	66	**72**	13.6%	10.5%
Neutral – Transfer to GA Families 360	8.9	0	0	0	42	**42**	7.9%	6.1%
Neutral - Moved out of service area	7.0	0	0	0	23	**23**	4.3%	3.4%
In-Community Subtotal*	***8.2***	***27***	***16***	***1***	***456***	***500***	***94.3%***	***73.2%***
Top 5 Out-of-Community Discharges								
Negative - Out of community for more than 30 days - RYDC/ YDC/ Jail	7.5	1	6	0	32	**39**	25.5%	5.7%
Negative - Out of community for more than 60 days - PRTF	8.6	3	3	0	32	**38**	24.8%	5.6%
Negative - Unsuccessful Family Opt-out	5.5	4	3	0	30	**37**	24.2%	5.4%
Negative - Out of community for more than 30 days - PRTF	7.6	1	7	0	17	**25**	16.3%	3.7%
Negative - Out of community for more than 30 days - Runaway	7.7	1	2	0	7	**10**	6.5%	1.5%
Out-of-Community Subtotal*	***6.2***	***10***	***21***	***0***	***118***	***149***	***97.4%***	***21.8%***
Total Discharges	**9.1**	**44**	**47**	**1**	**591**	**683**	**100.0%**	**100.0%**

** Percent of in-community or out-of-community discharges.*

- Of the top five in-community discharge subcategories:
  - 40% of youth successfully graduated from Wraparound and 28% experienced a successful family determination to end services.
  - Youth with a successful graduation from Wraparound had an average length of enrollment (LOE) of 13.6 months, which is significantly longer than the overall average of 8.2 months.

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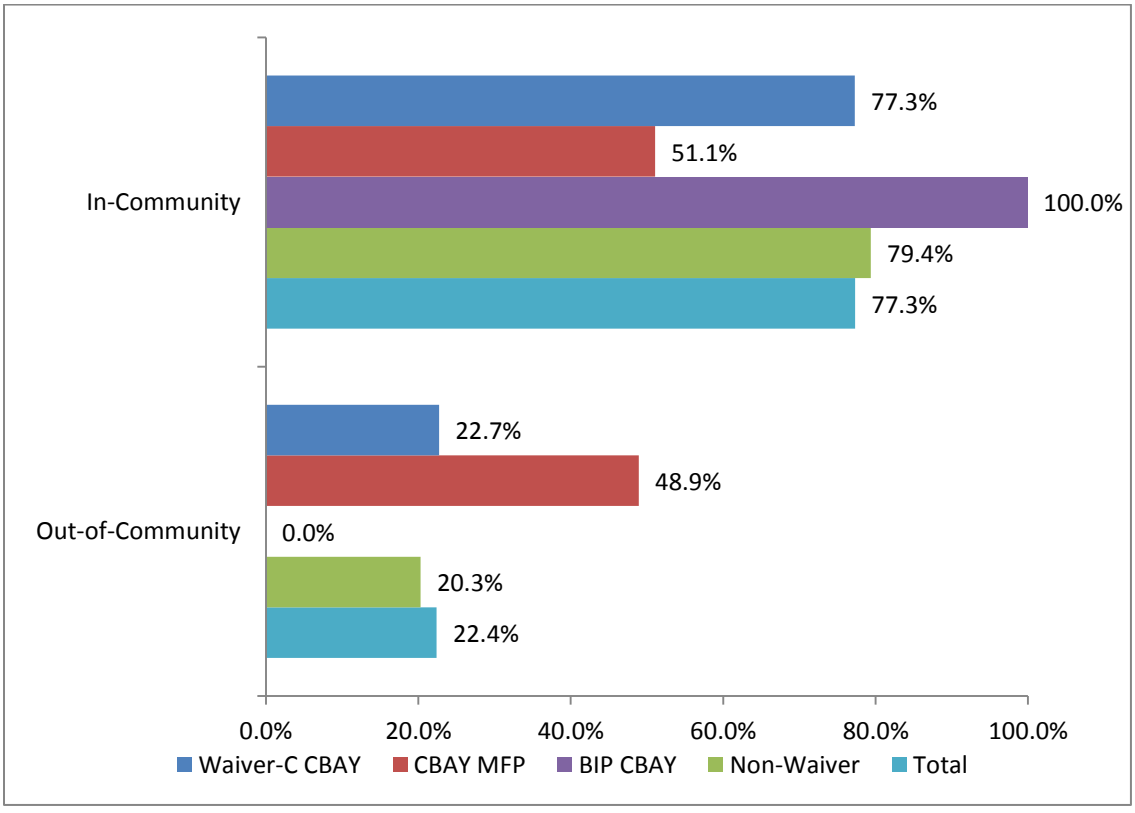
- 18% of discharged youth either moved out of the CME service area or the CMEs were unable to maintain contact with them.
- Eight percent of youth were discharged from a CME and transferred to Georgia Families 360, the care management organization who began providing behavioral health services to Medicaid eligible foster care and adoption assistance youth effective March 3, 2014.

- Of the top five out-of-community discharge subcategories:
  - Of those who experienced an out-of-community discharge, 26% returned to a RYDC/YDC/Jail for 30 days or more.
  - 25% of youth returned to a PRTF for 60 days or more and an additional 16% returned to a PRTF for 30 days or more.
  - Approximately one-fourth of youth "unsuccessfully opted out" of CME services.
  - Seven percent of youth were discharged because they were deemed Runaways.

When CME discharge outcomes are collectively reviewed for youth discharged during the evaluation period, more than three quarters were discharged into the community.

Percent of Youth by CME Discharge Outcome Category and Program (n=683)



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- The majority of Waiver-C CBAY, BIP CBAY and Non-Waiver youth returned to the community upon discharge from the CME (77%, 100% and 79%, respectively).
- MFP CBAY youth had the highest percentage of out-of-community discharges (49%).
- Approximately 20% of Waiver-C CBAY youth and Non-Waiver youth experienced an out-of-community placement upon discharge.

CME Recidivism

Five percent of youth who discharged from a CME during SFY2014 re-enrolled and discharged within the evaluation period. The table below compares the CME discharge outcomes for each enrollment period. Improved outcomes are defined as either 1) a change from a negative discharge outcome to either a neutral or positive outcome or 2) a change from a neutral to positive outcome at the completion of the second enrollment period. A worse discharge outcome is defined as either 1) a change from an initial discharge outcome of positive to either neutral or negative or 2) a change from neutral to a negative discharge outcome upon completion of the second enrollment period.

Discharge Classification for Youth who Re-enroll and Discharge from Wraparound
Improved Outcome: Negative → Neutral OR Negative → Positive OR Neutral → Positive
Worsened Outcome: Positive → Neutral OR Positive → Negative OR Neutral → Negative

Discharge Outcome Comparison for Youth Re-Enrolled in a CME

Discharge Outcome	Number of Youth	Percent of Youth	Avg. Time between Enrollments (Months)
Improved	12	38.7%	3.6
Same	11	35.5%	1.4
Worse	8	25.8%	1.5
Total	**31**	**100.0%**	

- Almost 40% of youth who re-enrolled and discharged from a CME within SFY2014, experienced an improved CME discharge outcome upon second discharge. The average time between the first discharge and re-enrollment for this cohort was 3.6 months.
- Approximately 36% of youth experienced the same discharge outcome during each enrollment period. For this cohort the average time between the initial discharge and re-enrollment was 1.4 months.
- Approximately 26% of youth experienced a worse CME discharge outcome during the second enrollment period than the first. The average time before re-enrollment was 1.5 months.

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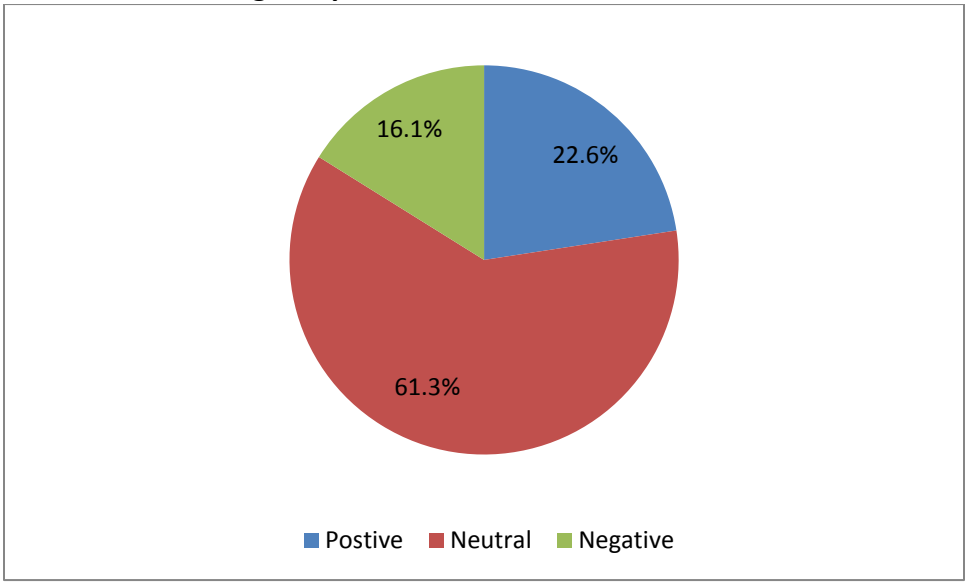
Final Discharge Disposition for Youth who Re-Enroll in a CME



- Approximately 23% of youth who re-enrolled in a CME experienced a positive final CME discharge outcome.
- The majority (61%) experienced a neutral final discharge outcome.
- 16% of youth experienced a negative final discharge outcome.

The following table identifies the final discharge disposition for youth who discharged and re-enrolled in a CME during SFY2014.

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Final Discharge Disposition Subcategories for Youth who Re-Enroll in a CME

Final Discharge Outcome	Number of Youth	Percent of Youth
In-Community: Positive		
Positive - Successful Family Opt-out	6	19.4%
Positive - Successful Graduation	1	3.2%
Subtotal	***7***	***22.6%***
In-Community: Neutral		
Neutral – Transfer to GA Families 360	9	29.0%
Neutral - Loss of Contact With an Enrolled Youth	4	12.9%
Neutral - CBAY Ineligible - LOC criteria no longer met	3	9.7%
Neutral - CBAY Ineligible - No longer Medicaid eligible	1	3.2%
Neutral - Moved from Non-Waiver to CBAY	1	3.2%
Neutral - Transfer to another CME	1	3.2%
Subtotal	***19***	***61.3%***
Out-of-Community		
Negative - Out of community for more than 30 days - Inpatient Hospital	2	6.5%
Negative - Out of community for more than 30 days - PRTF	2	6.5%
Negative - Out of community for more than 30 days - RYDC/ YDC/ Jail	1	3.2%
Subtotal	***5***	***16.1%***
Total	**31**	**100.0%**

- 19% of youth successfully opted-out and three percent successfully graduated from Wraparound upon completion of the subsequent enrollment period.
- 29% of youth who discharged were transitioned from the CME to Georgia Families 360.
- An equal percent of youth (6.5%) were discharged from the CME due to admission to a PRTF or inpatient hospital for 30 days or more.

Youth Functioning: Impairment and Resiliency

In this report, youth functioning is assessed by examining provider-administered functioning assessments pre- and post-Wraparound services and youth-reported assessments administered at a single point in time for active youth.

Columbia Impairment Scale

The Columbia Impairment Scale (CIS) is a 13-item questionnaire completed by the youth's caregiver that assesses the youth's functioning impairment, scored using a Likert-type scale from 0 ("no problem") to 4 ("very bad problem). Historically, the CIS was conducted monthly. However, effective November 1, 2013, administration of the survey was revised to the following schedule: 14 days, 30 days, 2 months, 5 months, 8 months, 11 months post-CME enrollment. For youth enrolled more than 1-year, CIS assessments are administered quarterly

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beginning at 14 months after the CME enrollment date. A copy of the CIS is included in Appendix G.

For this analysis, summary scores from the first CIS administered on or within 45 days of the CME enrollment date (baseline) are compared to assessments administered on or 45 days before discharge from Wraparound (discharge). Youth were excluded from the analysis if different questions were left blank on both the baseline and discharge CIS assessments. CIS scores were compared for 346 of 683 discharged youth (50.7%).

A one-point or more decrease in the discharge CIS score compared to the baseline CIS score is identified as an improvement. Conversely, deteriorated impairment is defined as a one-point or more increase in the discharge CIS compared to the baseline CIS. The table below displays the number of youth with completed baseline and discharge CIS by program and discharge disposition.

Discharged Youth with Completed Baseline and Discharge CIS

Program	In-Community	Out- of-Community	Total	Total Discharged Youth	Percent of Total Discharges
Waiver-C CBAY	8	6	14	44	*31.80%*
MFP CBAY	15	15	30	47	*63.80%*
BIP CBAY	0	0	0	1	0.00%
Non-Waiver	224	78	302	591	*51.10%*
Total	**247**	**99**	**346**	**683**	***50.70%***

- Baseline and discharge CIS were completed and compared for 32% of Waiver-C CBAY, 64% of MFP CBAY, and 51% of Non-Waiver youth discharged during the evaluation period.
- Comparable CIS data was not available for the single discharged BIP CBAY youth.

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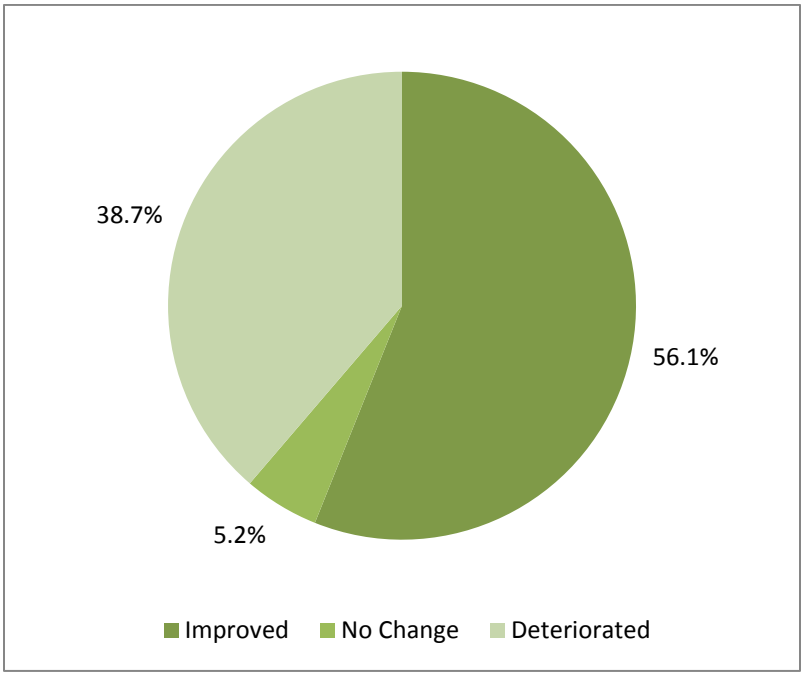
CIS Outcomes for Discharged Youth



- More than 56% of discharged youth demonstrated improvement (i.e. lower levels of impairments) at the completion of Wraparound services as reported by the caregiver.
- Deterioration in functional impairment was reported for 39% of youth by their caregivers.
- 5% of youth with baseline and discharge CIS reported no change in the CIS scores while enrolled in a CME.

Improved CIS Scores

In addition to singularly assessing the changes in impairment for discharged youth, cross-tabulations of functional impairment and CME discharge outcome by program were examined.

Youth with Improved CIS Scores at Discharge

Program/CME Discharge Outcome	In-Community	Out- of-Community	Total	Total Youth with Completed CIS	Percent of Completed CIS
Waiver-C CBAY	7	2	9	14	*64.3%*
MFP CBAY	6	2	8	30	*26.7%*
Non-Waiver	143	34	177	302	*58.6%*
Total	**156**	**38**	**194**	346	***56.1%***

- Approximately 64% of Waiver-C CBAY, 27% of MFP CBAY, and 59% of Non-Waiver youth demonstrated an improvement in functioning.

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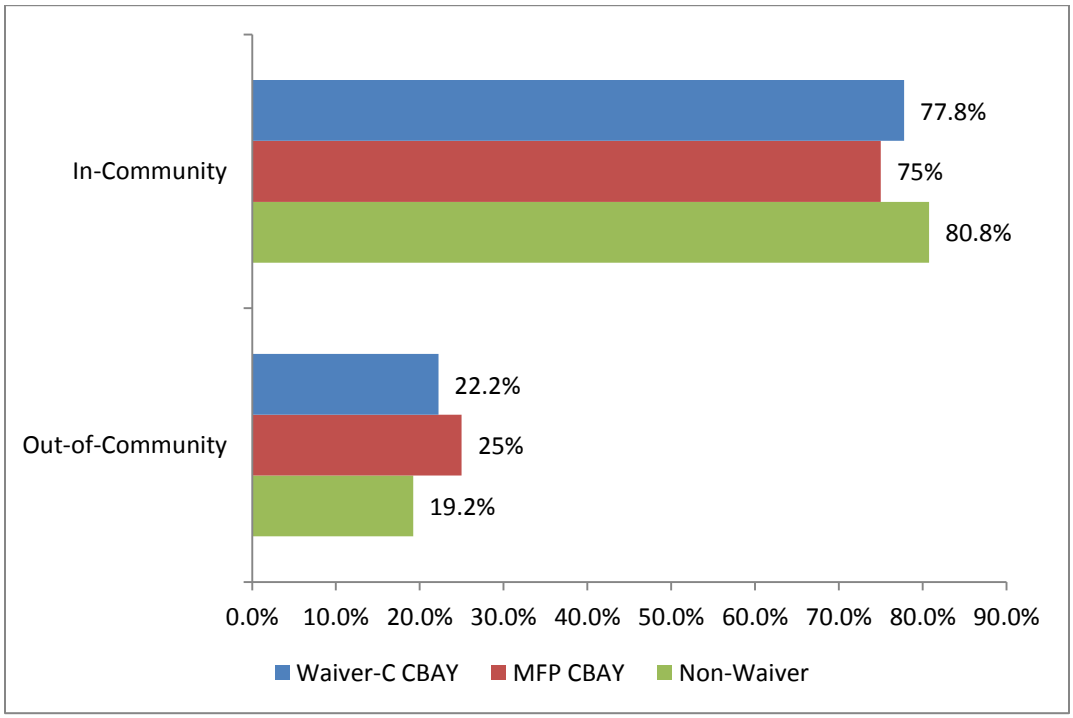
Percent of Youth with Improved CIS Scores
by CME Discharge Outcome and Program (n=194)



- The majority of youth with a positive improvement in their CIS score discharged in to the community
- Non-Waiver youth with an improved CIS score experienced the highest percent of discharges into the community (81%).
- MFP CBAY youth had the lowest percent of youth with an improved CIS score and who experienced an in-community discharge (72%).

Deteriorated CIS Scores

While 39 percent of youth demonstrated higher levels of impairment at discharge, 58 percent discharged into the community upon completion of Wraparound. This suggests that Wraparound may assist youth who are vulnerable for institutional placements (as evidenced by higher CIS scores at discharge) to remain in the community though their functional impairment has deteriorated.

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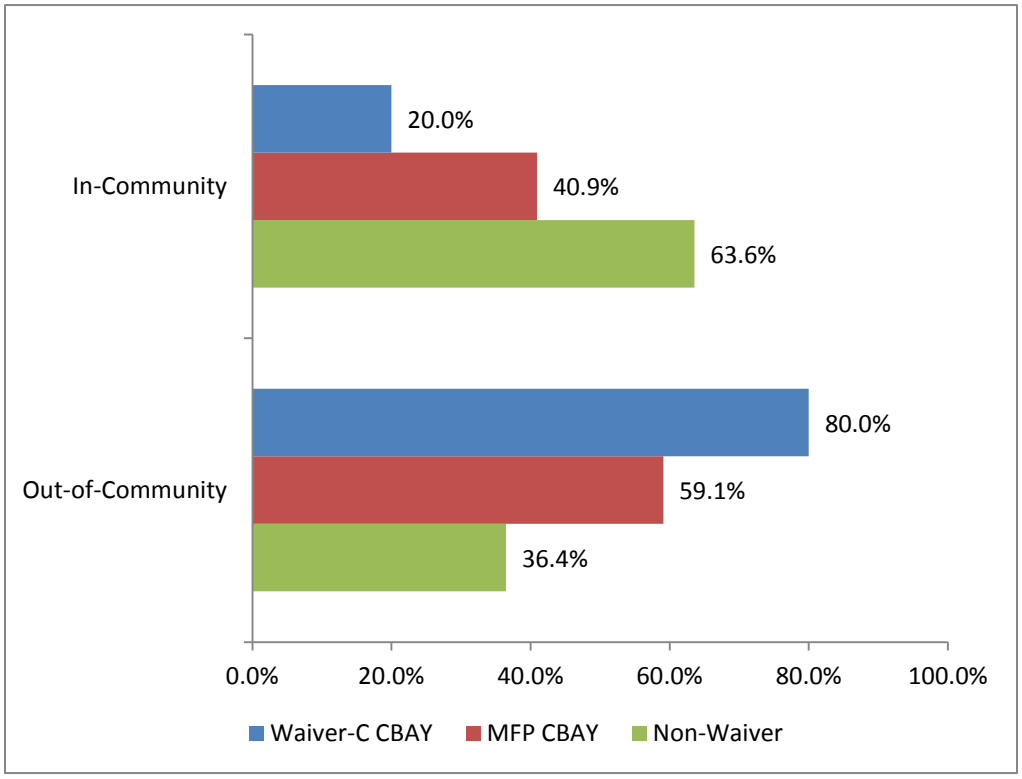
Youth with Deteriorated CIS Scores at Discharge

Program/CME Discharge Outcome	In-Community	Out- of-Community	Total	Total Youth with Completed CIS	Percent of Completed CIS
Waiver-C CBAY	1	4	5	**14**	*35.7%*
MFP CBAY	9	13	22	**30**	*73.3%*
Non-Waiver	68	39	107	**302**	*35.4%*
Total	**78**	**56**	**134**	**346**	***38.7%***

- Approximately one-third of the Waiver-C CBAY and Non-Waiver youth demonstrated a deteriorated CIS score at discharge.
- Conversely, approximately three-fourths of MFP CBAY youth demonstrated higher levels of impairment at discharge compared to baseline.

CME discharge outcome by funding program was also examined for youth who showed higher levels of impairment at discharge.

Percent of Youth with Deteriorated CIS Scores by CME Discharge Outcome and Program (n=134)



- The majority of CBAY youth with lower levels of impairment experienced an out-of-community discharge from Wraparound (80% Waiver-C CBAY and 59% MFP CBAY).

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- Conversely, 64% of Non-Waiver youth with higher levels of impairment discharged into the community upon completion of Wraparound.

Crisis Events

One of the Wraparound goals is to minimize the number of crisis events that youth experience by helping the family develop skills and secure resources to help address triggers that may initiate a crisis event. Ninety-five discharged youth experienced 155 crisis events while enrolled in a CME during SFY2014.

In this report, crisis events were examined by event type, placement type, and placement location.

Crisis Events by Program

Disposition	Unique Youth with Crisis Event	Percent of Total	Percent of Discharged Youth
Waiver-C CBAY	7	7.4%	15.9%
MFP CBAY	8	8.4%	17.0%
BIP CBAY	0	0.0%	0.0%
Non-Waiver	80	84.2%	13.5%
Total	**95**	**100.0%**	**13.9%**

- Approximately 16% of discharged Waiver-C CBAY and 17% of MFP CBAY youth experienced a crisis event while enrolled in a CME.
- No BIP CBAY youth experienced a crisis event.
- While Non-Waiver youth accounted for the majority of youth (84%) who experienced a crisis event while enrolled in a CME, only 13.5% of discharged Non-Waiver youth experienced a crisis event.

The following table displays the reasons identified for the crisis events experienced by youth in each program.

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Frequency of Crisis Event Reasons by Program

Event Reason	Waiver-C CBAY	MFP CBAY	Non-Waiver	Total*	Percent of Total
Physical Aggression (Minor)	3	1	10	14	9.0%
Physical Aggression (Severe)	0	3	10	13	8.4%
Running Away Overnight	3	0	10	13	8.4%
Suicidal Ideations	0	1	12	13	8.4%
Admission to Facility	1	1	9	11	7.1%
Self-Harm	0	0	11	11	7.1%
Suicidal (averted)	2	2	5	9	5.8%
Arrested	1	0	6	7	4.5%
Calls to 911	0	0	6	6	3.9%
Facility Placement	1	4	1	6	3.9%
Property Destruction	1	0	5	6	3.9%
Unexpected Medical Hospitalization	0	0	5	5	3.2%
Allegations of Sexual Assault	0	0	3	3	1.9%
Fire setting	0	0	3	3	1.9%
Shoplifting, Theft	0	0	3	3	1.9%
Substance Abuse	0	0	3	3	1.9%
Homicidal Planning	1	1	0	2	1.3%
Abandonment	0	0	1	1	0.6%
Allegations of Abuse/Neglect	0	0	1	1	0.6%
Allegations of Sexual Abuse	0	0	1	1	0.6%
Homicidal Attempts	0	0	1	1	0.6%
Homicide	0	0	1	1	0.6%
Inappropriate Sexual Behaviors	0	1	0	1	0.6%
Missing (no reason provided)	4	1	16	21	13.5%
Total*	**17**	**15**	**123**	**155**	**100.0%**

- Physical aggression accounted for more than 17% of the crisis event causes.
- Overnight runaway and suicidal ideations accounted for an equal percent of event reasons (8.4%), followed by a facility admission and self-harm (7.1%)
- 21 crisis events had no documented cause.

DBHDD categorizes crisis events as either risk management or critical incidents. The Care Management Entities (CME) Procedure Manual produced by DBHDD defines a critical incident as "any event that involves an immediate threat to the care, health or safety of any individual in community residential services, in community crisis home services, on site with a community provider, in the company of a staff member of a community provider, or enrolled in participant-directed services" (April 1, 2011). Risk management incidents are crisis events that do not meet "critical incident" level.

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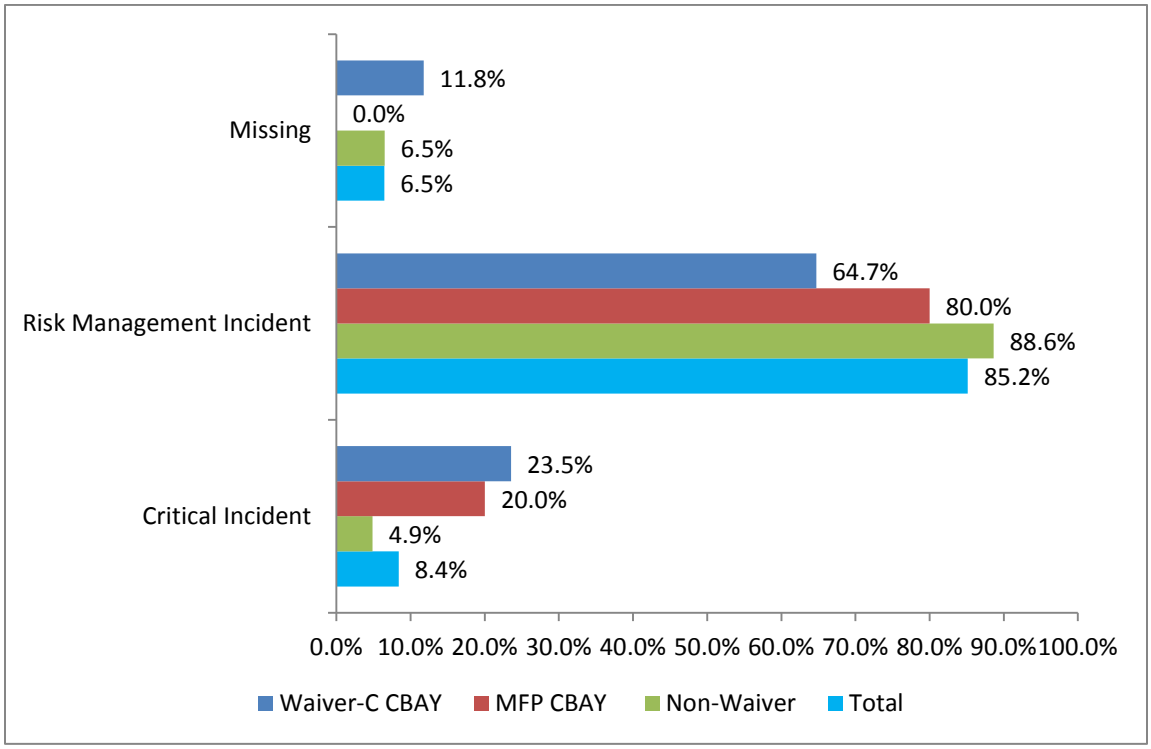
Crisis Event Type by Program



- Collectively, 85% of all crisis events were classified as risk management.
- 80% of MFP CBAY youth events and 89% of Non-Waiver youth events were classified as risk management.
- Waiver-C CBAY and MFP CBAY youth experienced the greatest percent of crisis events that were considered critical incidents (24% and 20%, respectively).
- Approximately 5% of Non-Waiver youth experienced critical crisis events.

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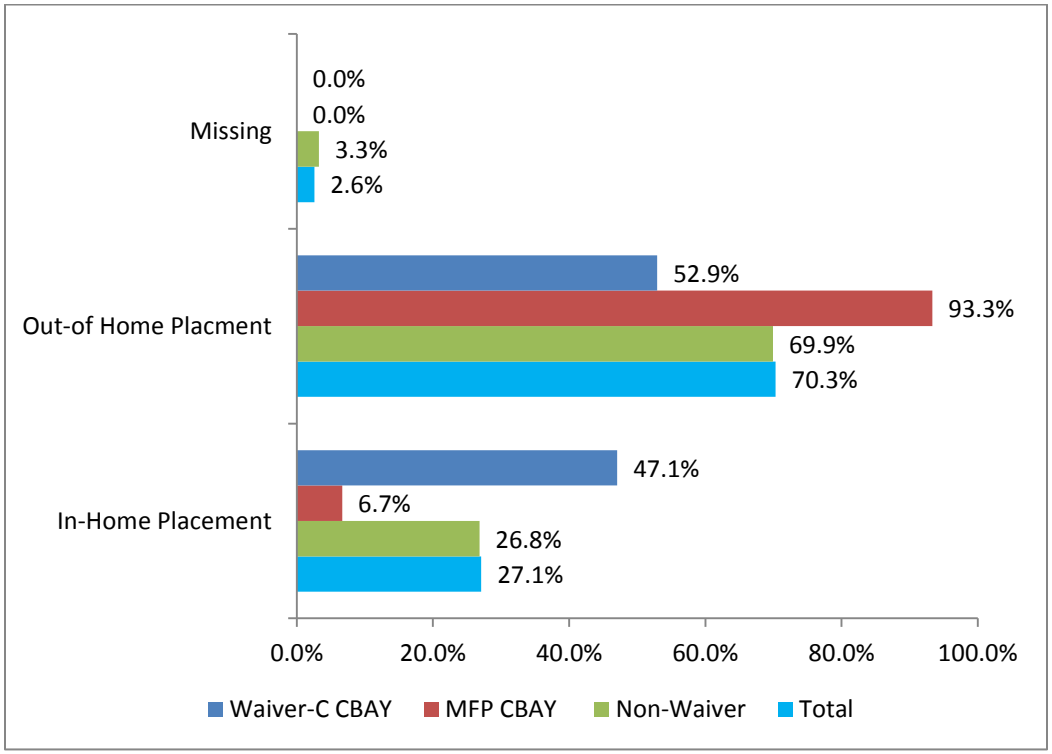
Crisis events may result in In-Home or Out-of-Home Placements.

Post-Crisis Event Placement Type by Program



- The majority of crisis events resulted in an out-of-home placement (70%). A smaller proportion of Waiver-C CBAY youth experienced an out-of-home placement (53%) than both MFP CBAY (93%) and Non-waiver youth (70%).
- 47% of Waiver-C CBAY youth remained in-home after experiencing a crisis event. Only 7% of MFP CBAY youth remained in-home. Approximately 27% of Non-Waiver youth experienced an in-home placement post crisis event.

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Out-of-Home Placements

While Wraparound seeks to minimize out-of-home placements, not all can be avoided and many are necessary for a youth to remain in the community long-term. 282 discharged youth experienced 773 placements while enrolled in a CME, as shown in the table below.

Out-of-Home Placements for Discharged Youth

Placement Type	CME Avg. LOE	Youth*	Percent of Placement Type			
			Waiver-C CBAY	MFP CBAY	Non-Waiver	Percent of Total Placements
Crisis Stabilization Unit/ Placement	12.3	216	32.0%	29.3%	26.9%	27.9%
Residential Youth Detention Center (RYDC) - Detention	11.4	124	9.0%	8.0%	18.6%	16.0%
Psychiatric Residential Treatment Facility (PRTF)	10.2	99	9.8%	20.0%	12.5%	12.8%
Inpatient Hospitalization (due to youth mental health needs)	11.5	62	4.1%	12.0%	8.3%	8.0%
CPA-Specialized Foster Home (SMWO)	12.1	58	4.9%	5.3%	8.3%	7.5%
Runaway	13.4	39	14.8%	0.0%	3.6%	5.0%
Child Caring Institute - MWO	13.9	33	4.9%	2.7%	4.3%	4.3%
In facility before enrollment and returning home	12.6	11	6.6%	4.0%	1.9%	2.8%
Jail	9.9	19	2.5%	2.7%	3.3%	3.1%
Youth Development Campus (YDC)	11.6	11	1.6%	0.0%	1.6%	1.4%
Child Care Institute - BWO	13.8	17	3.3%	1.3%	2.1%	2.2%
Child Protection Agency-Basic Foster Home (MWO)	14.0	21	0.8%	4.0%	3.0%	2.7%
Crisis Respite (due to youth mental health needs)	15.2	16	1.6%	0.0%	2.4%	2.1%
Missing Placement Data	8.9	17	1.6%	8.0%	1.6%	2.2%
Child Caring Institute- (AWO)	15.1	11	2.5%	0.0%	1.4%	1.4%
ILP (Independent Living Placement)	6.7	3	0.0%	2.7%	0.2%	0.4%
Total	**12.0**	**773**	**15.2%**	**6.1%**	**78.7%**	**100.0%**

**Total exceeds number of youth with out of home placements as a youth may experience >1 placement. BWO – Basic Watchful Oversight; MWO – Maximum Watchful Oversight; SMWO – Specialized Watchful Oversight.*

- No youth enrolled in BIP CBAY experienced an out-of-home placement while enrolled in a CME.

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- Youth who experienced an out-of-home placement were enrolled in a CME longer than the average LOE of all discharged youth (9.7 months vs. 8.7 months, respectively).
- 28% of youth who experienced an out-of-home placement while enrolled in a CME were placed in a Crisis Stabilization Unit (CSU).
- Approximately 21% of youth had a DJJ or Corrections placement in a Regional Youth Detention Center (RYDC, 16%), Jail (3%) or Youth Development Center (YDC, 1%).
- An additional 21% of placements included intensive treatment in either a PRTF (13%) or an inpatient hospital (8%) due to mental health needs.

The following figure illustrates out-of-home placement location by funding program

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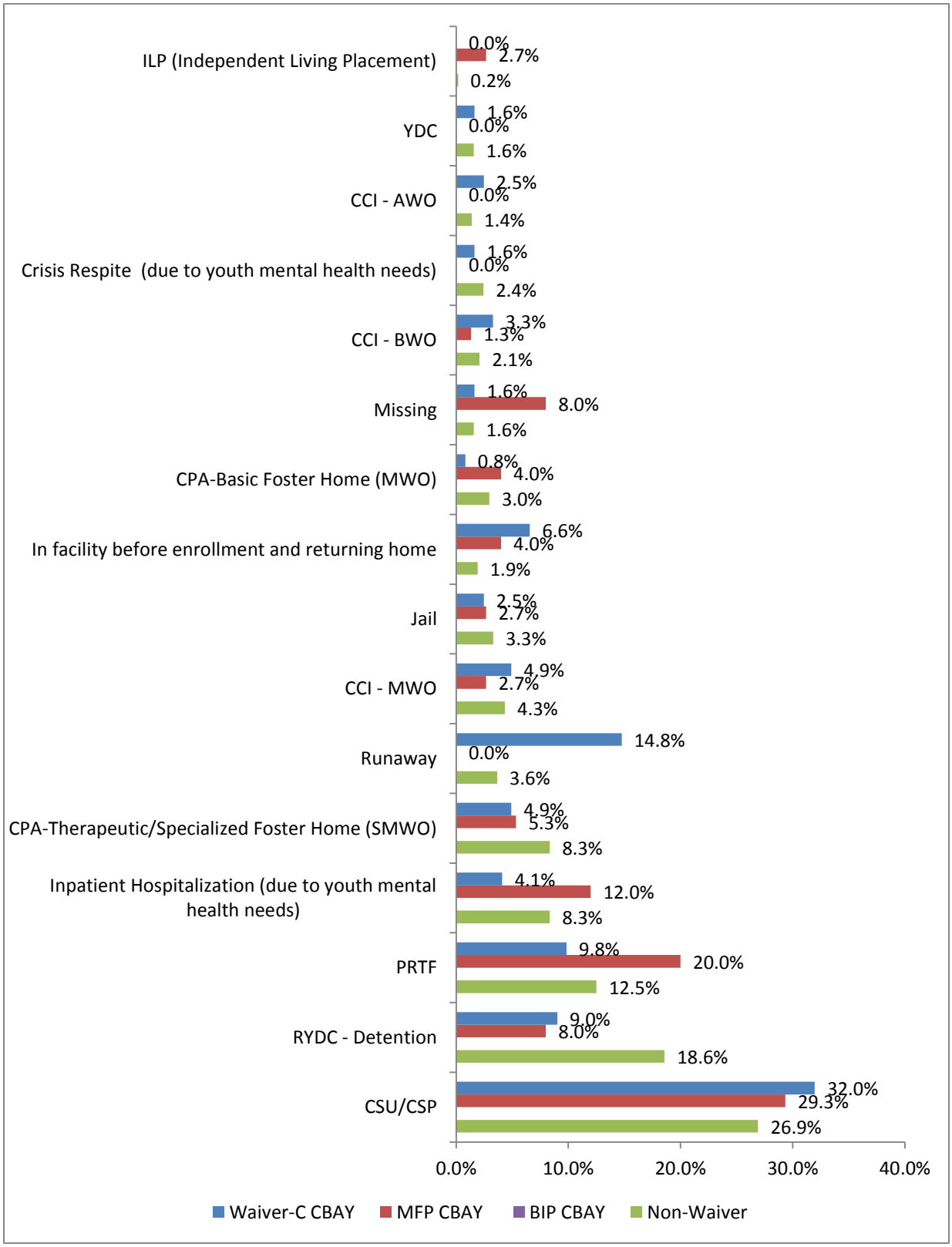
Percent of Placements by Program (n=129)



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- 42% of placements for Waiver-C CBAY youth required a more intensive level of care in either a CSU or PRTF. 15% of placements were identified as runaways. Nine percent of out of home placements by Waiver-C CBAY youth required detention at a RYDC.
- Approximately half of MFP CBAY youth who experienced an out-of-home placement were placed in a CSU or PRTF, and 20% were placed in a RYDC. An additional 12% experienced an inpatient hospitalization due to mental health needs.
- 40% of Non-Waiver youth were placed in a CSU or PRTF. An additional 19% of Non-Waiver youth experienced an out-of-home placement in a RYDC while eight percent experienced an inpatient hospitalization due to mental health need.

Child Welfare Involvement

Approximately 20% of discharged youth were involved with the child welfare system (Division of Family and Children Services, DFCS) upon enrollment in a CME.

Discharged Youth Involved with Child Welfare at Intake

Program	Youth with DFCS Involvement at Intake	Total Discharged Youth	Percent of Discharged Youth
Waiver-C CBAY	7	44	15.9%
MFP CBAY	13	47	27.7%
BIP CBAY	0	1	0.0%
Non-Waiver	116	591	19.6%
Total	136	683	19.9%

- 16% of discharged Waiver-C CBAY youth were involved with child welfare at the time they enrolled in Wraparound.
- More than one-fourth (28%) of MFP CBAY youth were involved with child welfare at enrollment.
- No discharged BIP CBAY youth were involved in child welfare at enrollment.
- 20% of Non-Waiver youth were involved with child welfare at enrollment.

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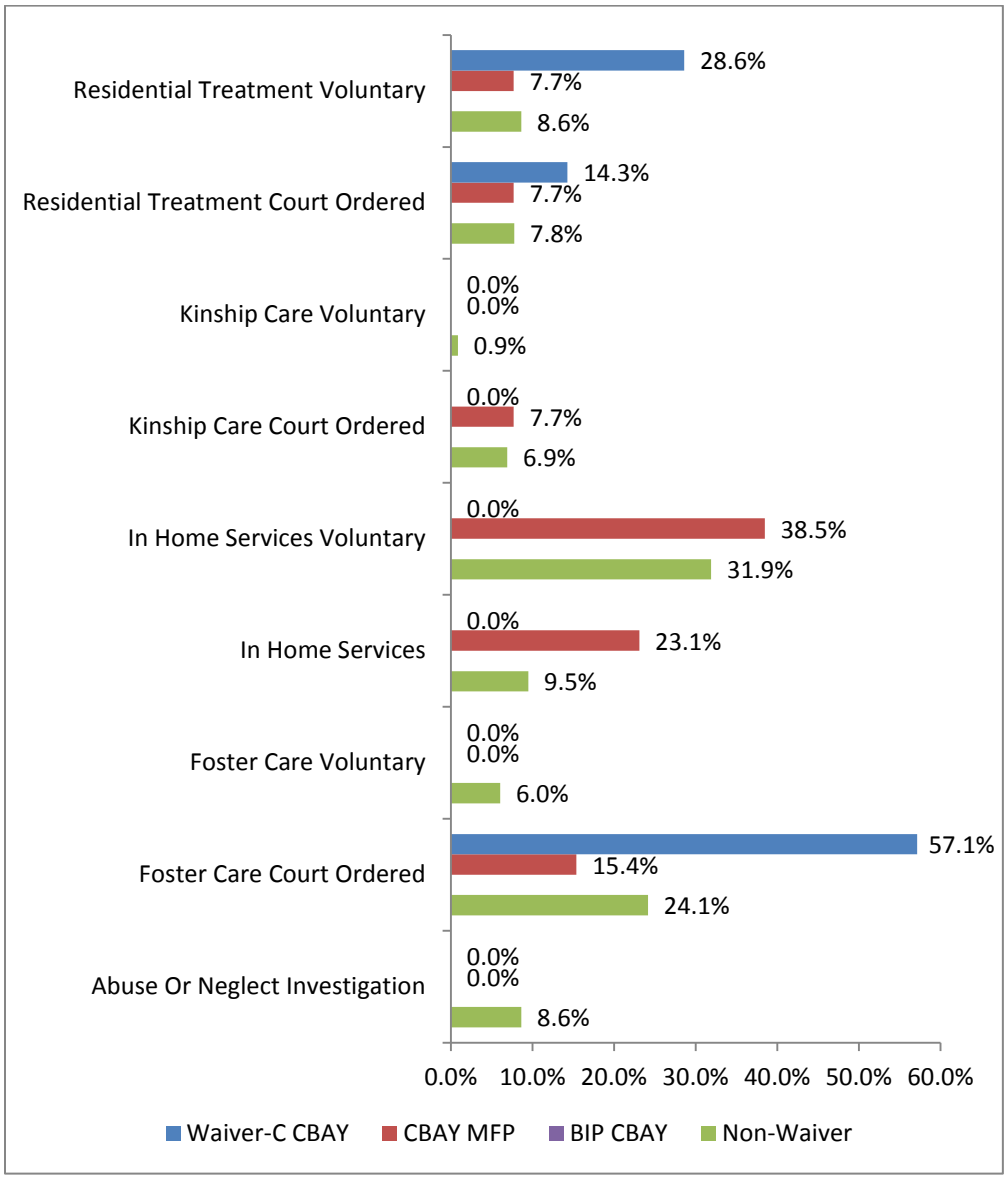
Child Welfare(DFCS) Referrals to CMEs

The following figure illustrates the types of child welfare involvement for the 136 youth as identified at intake.

Discharged Youth Referred with Child Welfare Involvement (n=136)



Note: Youth may have >1 category of child welfare involvement upon referral to a CME

- Waiver-C CBAY youth referred for CME services reported child welfare involvement through court-ordered foster care (57%) or through residential treatment (14% court-ordered and 29% voluntary).
- The majority of MFP CBAY youth experienced voluntary and court-ordered in home services (29% and 23%, respectively).

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- Non-Waiver youth had the broadest array of involvement with child welfare upon program enrollment. In home services collectively accounted for approximately 42% of youth involvement, followed by court-ordered foster care (15%), residential treatment (16%), and neglect/abuse (9%).

New Involvement with Child Welfare

By reviewing the "*Wraparound Fidelity / Agencies Involved With"* form in the Action Plan, child welfare involvement while enrolled in a CME was documented for 175 discharged youth. Important to note is that, as of March 3, 2014, Child Welfare was no longer able to refer youth to CMEs unless the youth met a PRTF level of care.

Discharged Youth with New Child Welfare Involvement while Enrolled in Wraparound

Program	Youth with DFCS Involvement during CME Enrollment	Total Discharged Youth	Percent of Discharged Youth
Waiver-C CBAY	16	44	36.4%
MFP CBAY	12	47	25.5%
Non-Waiver	147	591	24.9%
Total	**175**	**683**	**25.6%**

- Collectively, more than 25% of the 683 discharged youth had new child welfare involvement while enrolled in a CME for Wraparound services.
- 36% of discharged Waiver-C CBAY youth, 26% of MFP CBAY youth, and 25% of Non-Waiver youth had new child welfare involvement.
- No discharged BIP CBAY youth encountered new child welfare involvement while enrolled in a CME.

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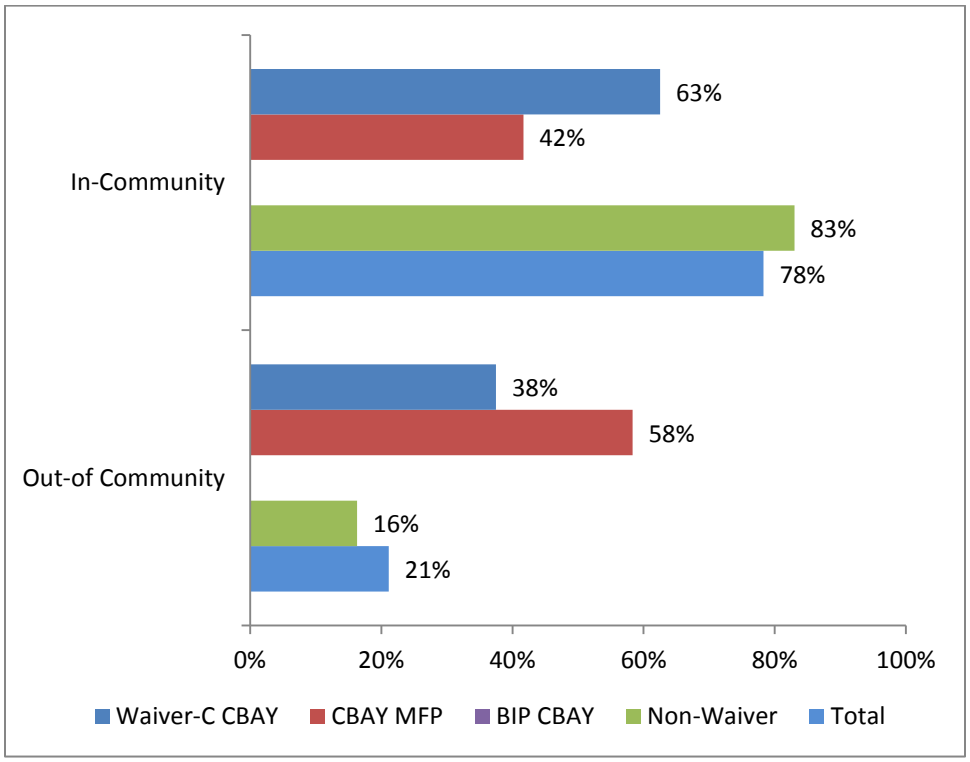
Of the 175 youth with new child welfare involvement, the majority remained in the community upon discharge from a CME.

CME Discharge Outcome for Youth with New Child Welfare Involvement by Program (n=175)



- Overall, 78% of all youth with new child welfare involvement experienced an in-community discharge from Wraparound.
- More than 60% of Waiver-C CBAY youth with new child welfare involvement discharged into the community.
- The MFP CBAY program had the lowest percent of youth with new child welfare involvement who discharged into the community (42%).
- Non-Waiver youth with new child welfare involvement experienced the fewest proportion of out-of-community discharges.

It is important that a youth's formal supports maintain an active role on the youth's child and family team (CFT). For youth with child welfare involvement, either at intake or newly developed while enrolled in Wraparound, 126 discharged youth had DFCS staff included on their CFT.

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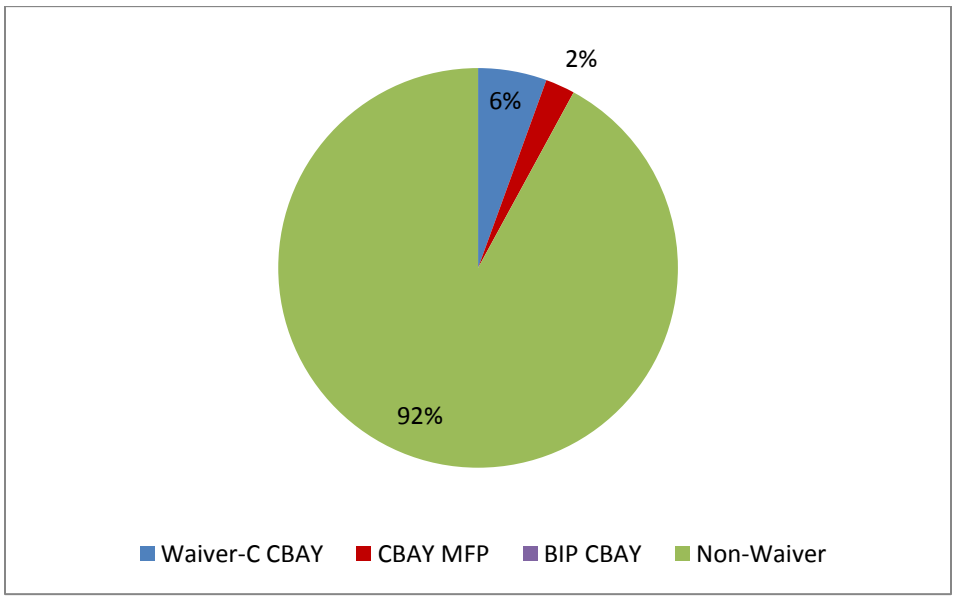
Youth with DFCS Staff on CFT by Program (n=126)



- Non-Waiver youth accounted for 92% of youth with DFCS Staff identified on the CFT list.
- Waiver-C CBAY youth and MFP CBAY youth accounted for the remaining eight percent (6% and 2%, respectively).

Juvenile Justice Involvement

Youth may be referred to the CMEs by different agencies or courts that are affiliated with the Juvenile Justice System (JJS), or they may have new incidents of involvement with this system during their enrollment in the CME. For the 683 youth discharged from CMEs during the evaluation period, 280 had *some* type of interaction with the Juvenile Justice System. CME discharge outcomes for youth with DJJ involvement were examined to determine if the involvement affected a youth's completion of Wraparound.

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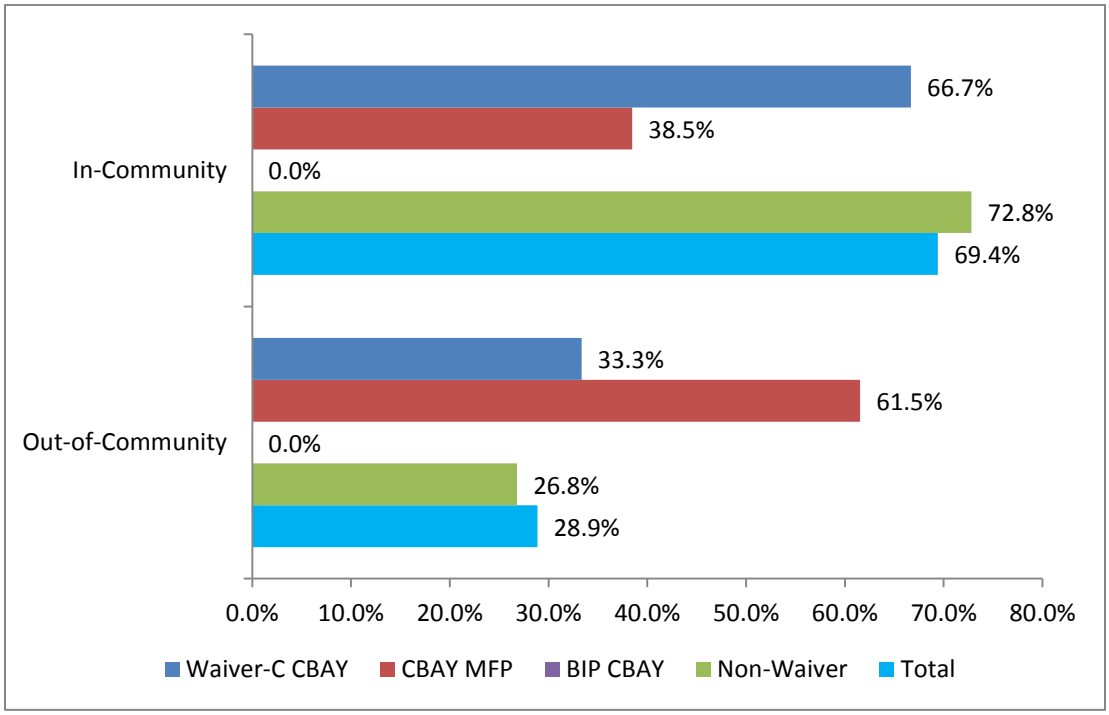
DJJ Involvement by CME Discharge Outcome (n=280)



- Approximately two-thirds of Waiver-C CBAY youth with Juvenile Justice involvement were discharged into the community.
- 39% of MFP CBAY youth with Juvenile Justice involvement experienced an in-community discharge while 62% experienced an out-of-community discharge.
- No DJJ involvement was documented for any BIP CBAY youth at either intake or while enrolled in a CME.
- Almost three-quarters of Non-Waiver youth with DJJ involvement discharged into the community from a CME.

Juvenile Justice Referrals to CMEs

87 discharged youth were referred to Wraparound from the Department of Juvenile Justice (DJJ) or the Juvenile Courts. This represents 13% of all youth discharged during the reporting period. Important to note is that, as of March 3, 2014, DJJ-committed youth placed in either a Child Caring Institute (CCI) or Child Placing Agency (CPA) could no longer be referred to CME services.

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Discharged Youth Referred to Wraparound from the Juvenile Justice System

Juvenile Justice System Referrals to CME	Waiver-C CBAY	MFP CBAY	Non-Waiver	Total	Percent Total
DJJ Commitment	1	1	39	41	47%
DJJ Probation	0	0	28	28	32%
Juvenile Court (Predisposition)	0	0	5	5	6%
Juvenile Court (Non-Specified)	0	0	3	3	3%
Juvenile Court (Disposition)	0	0	10	10	11%
Total	**1**	**1**	**85**	**87**	**100%**

- Two-thirds of all referrals from the Juvenile Justice System originated from DJJ (79%).
- One Waiver-C CBAY and one MFP CBAY youth were referred to Wraparound from either DJJ or the Juvenile Courts.
- Non-Waiver youth were most frequently referred for CME services by the Juvenile Justice System, accounting for 97% of DJJ referrals.

New Involvement with Juvenile Justice

By reviewing the "*Wraparound Fidelity / Agencies Involved With"* form in the Action Plan, 231 unique youth were identified as having new involvement with the following justice/corrections agencies while enrolled in a CME.

New Juvenile Justice Involvement for Discharged Youth while Enrolled in Wraparound

JJS Agency Involvement	Waiver-C CBAY	MFP CBAY	Non-Waiver	Total
Adult Probations/Corrections	10	3	47	60
DJJ	18	8	208	234
Juvenile Court	19	9	199	227
Total*	**47**	**20**	**454**	**521**
Unique Discharged Youth with DJJ Involvement	24	13	194	231
Average Involvement/Youth	**2.0**	**1.5**	**2.3**	**2.3**

**Youth may experience new involvement with >1 agency while enrolled in a CME.*

The following figure illustrates by program the percent of youth with JJS involvement by agency type.

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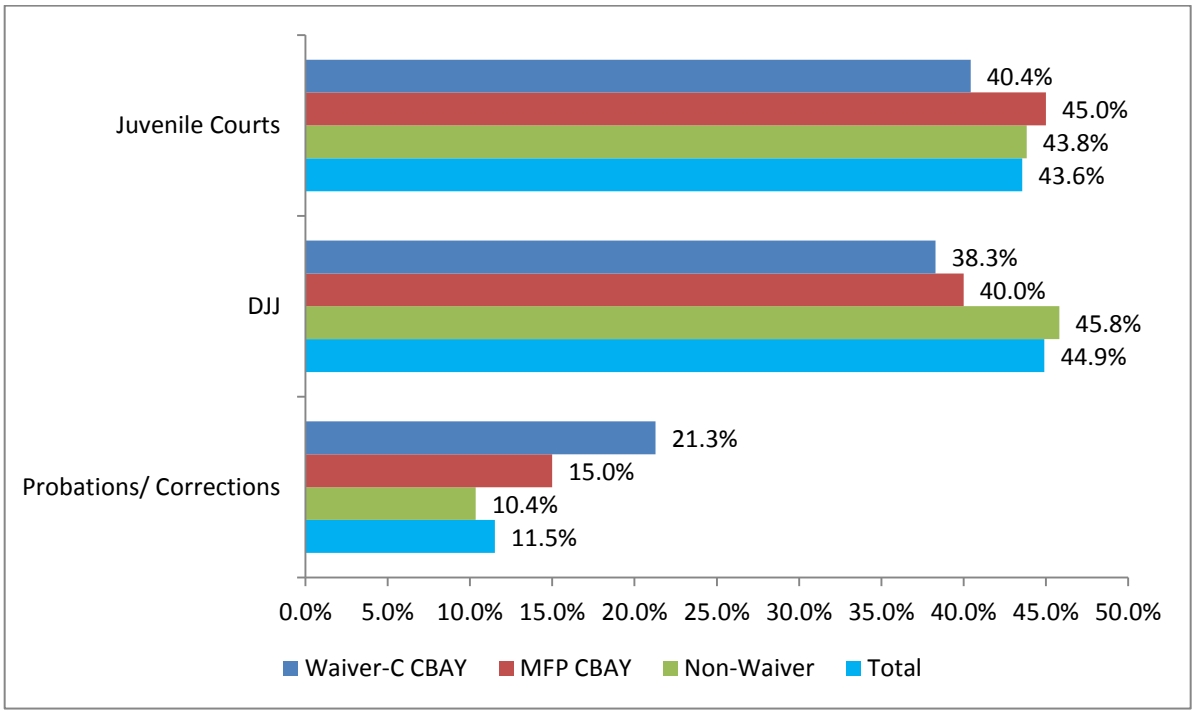
Juvenile Justice System Involvement by Program



- Approximately 44% of all youth with new JJS involvement while enrolled in a CME were involved with the Juvenile Courts.
- A larger proportion of MFP CBAY youth were involved with Juvenile Courts (45%) than DJJ (40%) while enrolled in a CME.
- 46% of Non-Waiver youth experienced new involvement with the JJS through involvement with DJJ.
- Across all programs the percent of youth with new involvement with Adult Probations and Corrections ranged from 10% (Non-Waiver) to 21% (Waiver-C CBAY).

Juvenile Justice System Placements

79 DJJ/Corrections placements were made for 57 youth while enrolled in a CME for matters that occurred prior to CME enrollment. This represents 18% of the total youth discharged during the reporting period.

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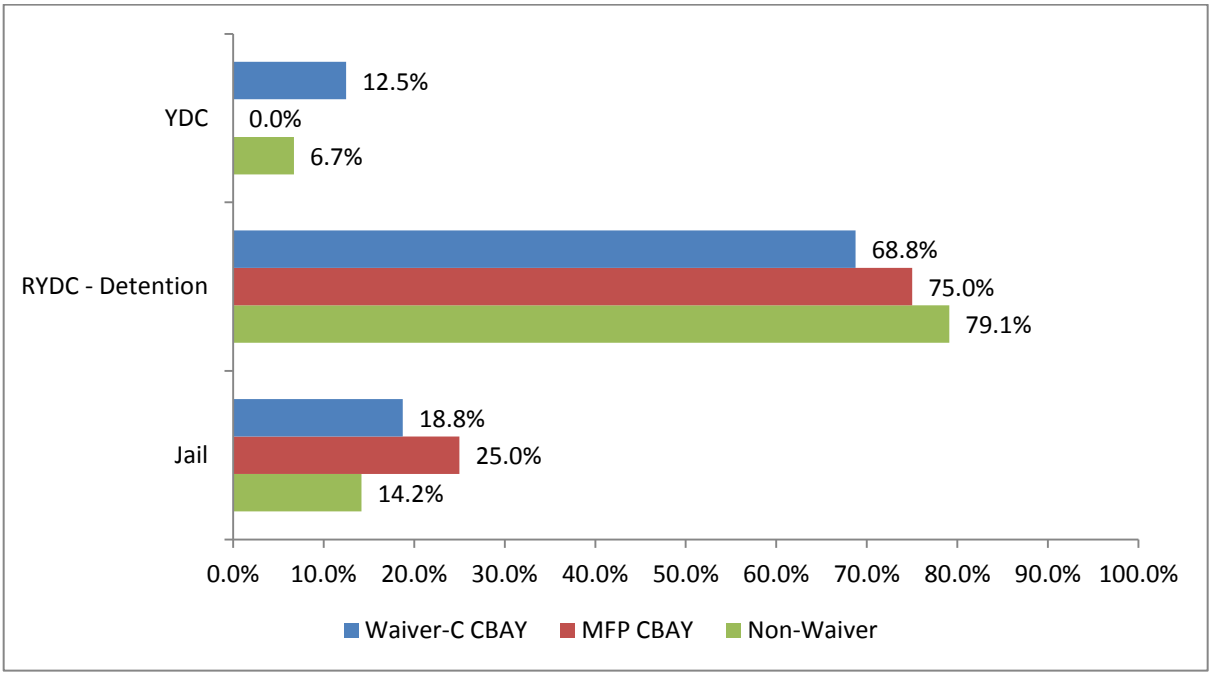
Discharge Youth Juvenile Justice System Placements while Enrolled in Wraparound

DJJ Placement	Waiver-C CBAY		MFP CBAY		BIP CBAY		Non-Waiver		Total	
	n	%	n	%	n	%	n	%	n	%
Jail	3	18.8%	2	25.0%	0	0.0%	19	14.2%	24	15.2%
RYDC - Detention	11	68.8%	6	75.0%	0	0.0%	106	79.1%	123	77.8%
YDC	2	12.5%	0	0.0%	0	0.0%	9	6.7%	11	7.0%
Total Placements	**16**	**100.0%**	**8**	**100.0%**	**0**	**0.0%**	**134**	**100.0%**	**158**	**100.0%**

The figure below illustrates the percent of youth by program type that were placed in a DJJ/Corrections facility while enrolled in Wraparound.

Juvenile Justice System Placements while Enrolled in Wraparound



- The majority of discharged youth with a JJS placement while enrolled in a CME were placed in a Regional Youth Detention Centers (RYDC) for detention.
- 13% of Waiver-C CBAY and seven percent of Non-Waiver youth were placed in a Youth Development Campus (YDC) while enrolled in a CME.
- All MFP CBAY youth who experienced a JJS placement during their enrollment in a CME were placed in a RYDC or in jail for detention. No MFP CBAY youth were placed in an YDC while in a CME.
- 94% of Non-Waiver youth were placed in an RYDC or jail while enrolled in a CME.

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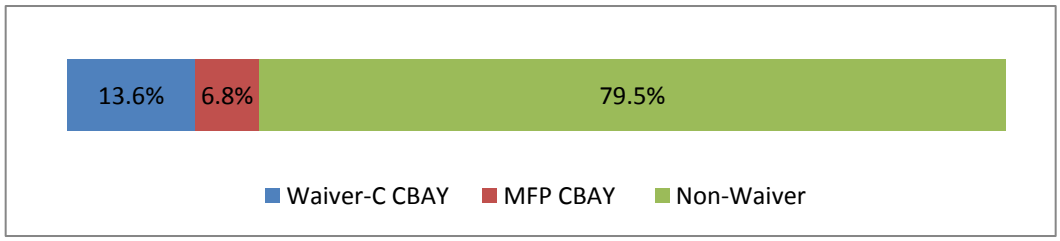
Juvenile Justice Offenses

Juvenile justice offenses were incurred and documented for 44 discharged youth during their enrollment.



**Total exceeds 100% due to rounding.*

- Waiver-C CBAY and MFP CBAY youth accounted for 21% of all youth with new juvenile justice offenses while enrolled in a CME.
- Non-Waiver youth accounted for the remaining 80% of youth with juvenile justices offenses.

The 44 youth were charged with committing 70 offenses in the following offense categories as presented in the following table.

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Offenses Incurred by Discharged Youth while Enrolled in Wraparound

Offense	Waiver-C CBAY	MFP CBAY	Non-Waiver	Total
Battery	3	0	6	9
Theft	0	0	7	7
Runaway	2	0	4	6
Criminal Trespass	0	0	4	4
Disrupting a Public School	1	0	3	4
Other Offense - Type Unknown	1	0	3	4
Unruly	0	0	4	4
Threats to Injure or Accuse of Crime	0	0	3	3
Disorderly Conduct	1	0	1	2
Drug Offenses - Possession	0	0	2	2
Probation Violation	0	0	2	2
Underage Drinking	0	0	2	2
Criminal Damage to Property	0	0	2	2
Other Offense - Sexual	0	1	1	2
Simple Assault-Dismissed	0	0	2	2
Burglary	0	0	2	2
Aggravated Assault	2	0	0	2
Other Offense- Assault	0	1	0	1
Physically Aggressive with Staff	0	0	1	1
Physically Aggressive with Others		1	0	1
Probation Violation-Dismissed	0	0	1	1
Giving False Information to Law Enforcement Officer	1	0	0	1
Disruptive Behaviors	0	0	1	1
Obstructing an Officer	0	0	1	1
Destruction of Public Property	0	0	1	1
Self-harming; Behavioral Problems at School	0	0	1	1
Assault	0	0	1	1
Contempt of Court	0	0	1	1
Total	**11**	**3**	**56**	**70**
Percent of Total	*15.7%*	*4.3%*	*80.0%*	*100.0%*

- Battery, theft and runaway offenses accounted for 30% of all documented offenses.
- Waiver-C CBAY youth accounted for 19% of the offenses incurred.
- MFP CBAY youth accounted for seven percent of documented offenses.
- 74% of offenses incurred while enrolled in a CME were attributal to Non-Waiver youth

Juvenile Justice outcomes were documented for 44 youth with 70 documented offenses. However, one-quarter of youth with offenses had an unknown or missing outcome.

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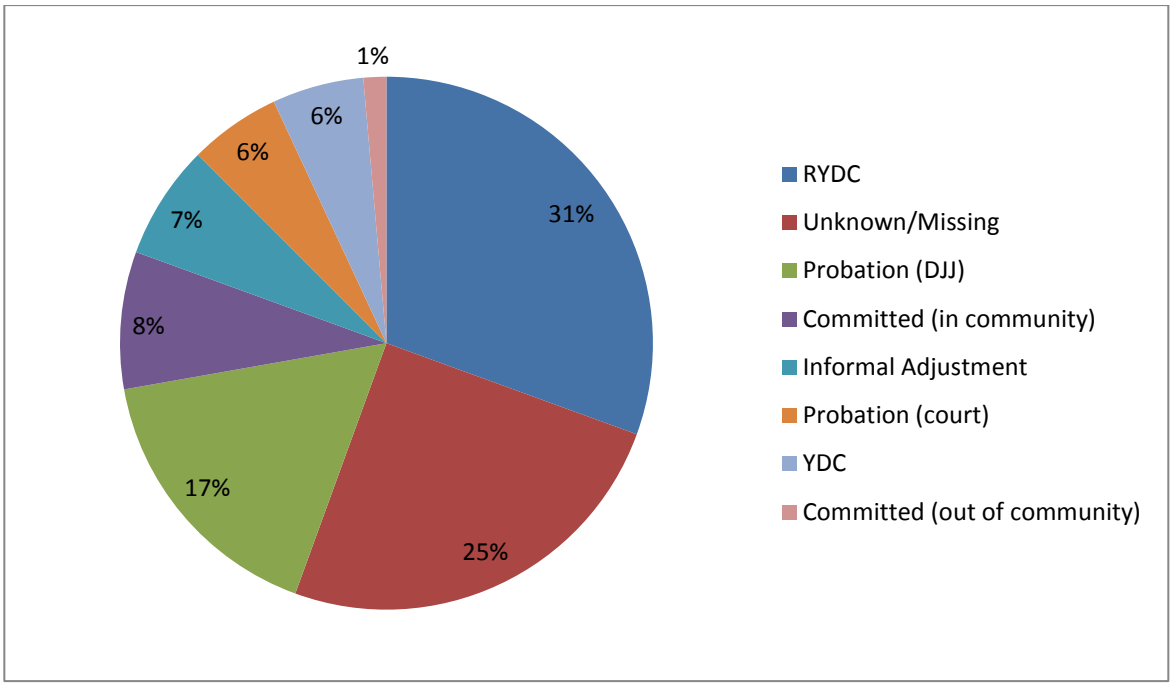
Juvenile Justice Outcomes for Youth with New Offenses while Enrolled in Wraparound



**Total may exceeds 100% due to rounding*

- 31% percent of youth were placed in an RYDC.
- Approximately 23% of youth were placed on probation by either the DJJ (17%) or the courts (6%) for the offenses committed.
- Eight percent of youth were committed in the community while one percent was committed out-of-community.
- Seven percent of youth received an informal adjustment and six percent were placed in an YDC.

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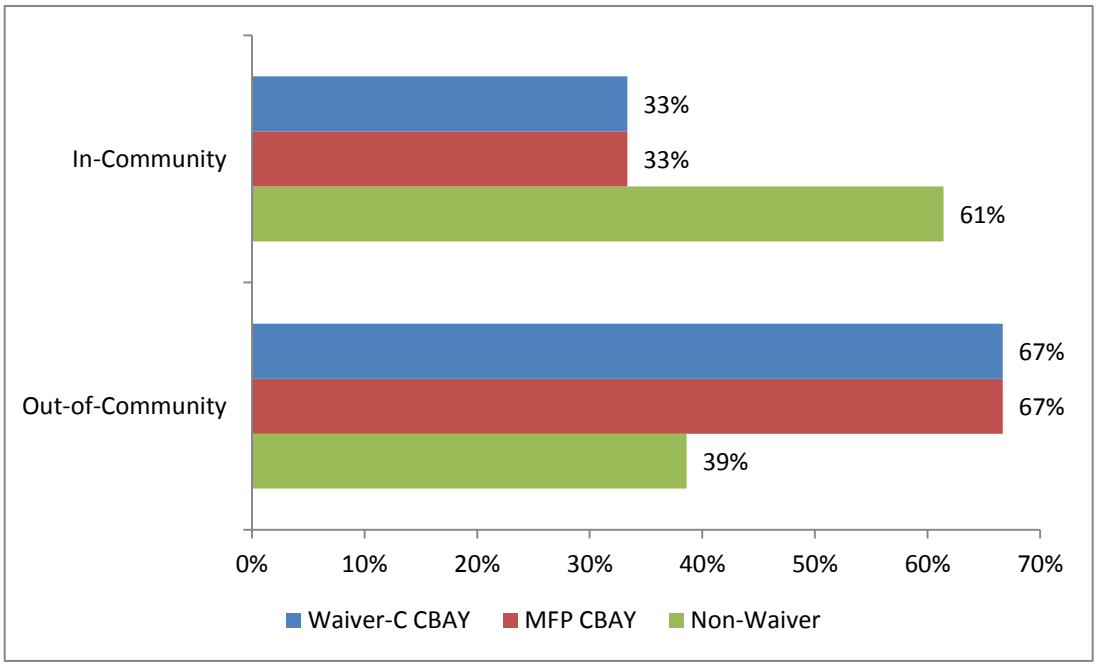
CME discharge outcomes for youth who incurred juvenile justice offenses while enrolled in a CME were examined.

CME Discharge Outcome for Youth with Offenses by Program



- A larger proportion of Non-Wavier youth with Juvenile Justice offenses had an in-community discharge from a CME compared to Waiver-C CBAY or MFP CBAY youth.
- Two-thirds of Waiver-C CBAY and MFP CBAY youth with offenses experienced an out-of-community discharge from a CME.

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School Attendance

Wraparound also seeks to improve youth functioning in an academic setting. To assess the potential influence of CME services on youth attendance at school, unexcused absences, suspensions and expulsions were reviewed. Attendance data was available for 594 of the 683 discharged youth (87%).

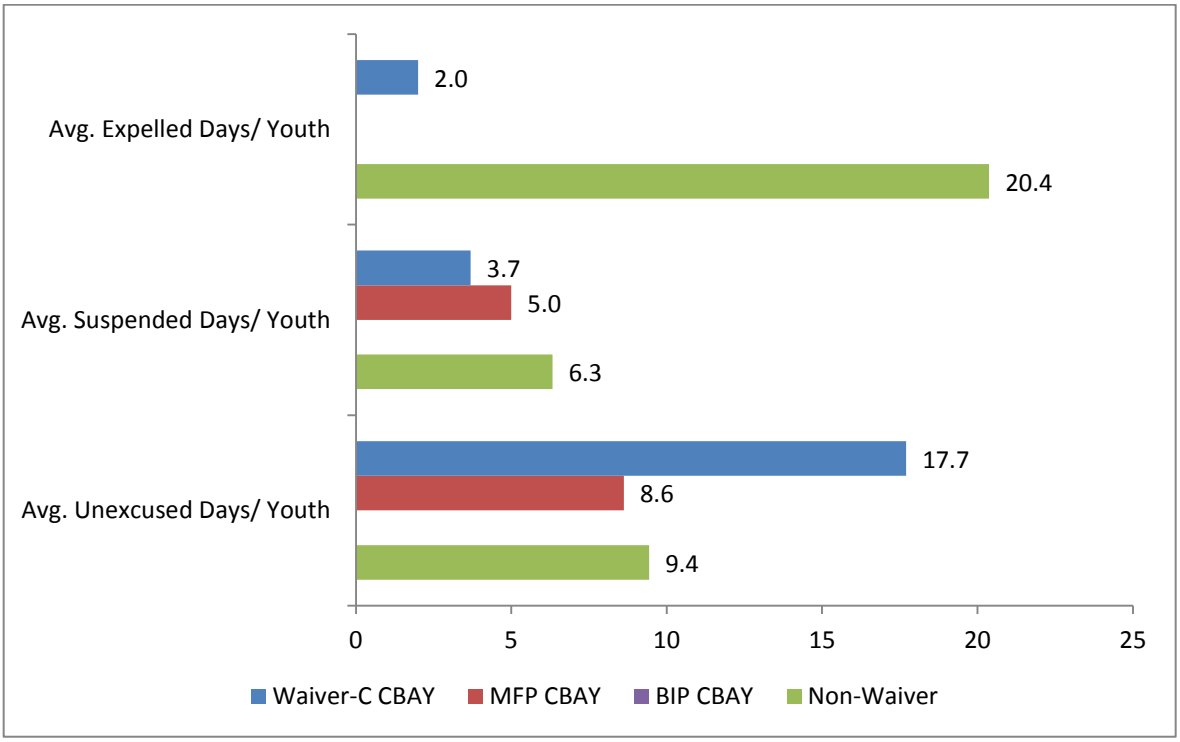
School Attendance for Discharged Youth

Program	Unique Youth with Unexcused Absence(s)	Unique Youth Suspended	Unique Youth Expelled	Discharged Youth with School Data
Waiver-C CBAY	20	13	1	44
MFP CBAY	8	7	0	40
Non-Waiver	130	89	8	510
Total	**158**	**109**	**9**	**594**
Percent of Discharged Youth	*26.6%*	*18.4%*	*1.5%*	*87.0%*

*Youth may be counted in >1 negative school attendance disposition.

- Approximately 27% of discharged youth experienced unexcused absence(s) while enrolled in a CME.
- 18% of discharged youth were suspended for one or more days.
- Almost 2% of youth experienced an expulsion while enrolled in Wraparound.

Average Days Missed from School by Program



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- On average, Waiver-C CBAY youth with unexcused absences missed 17.7 days of school, those with suspensions missed 3.7 days of school, and those with expulsions missed 2 days of school.
- On average, MFP CBAY youth with unexcused absences missed 8.6 days of school and those with suspensions missed 5.0 days of school. No MFP CBAY youth were expelled.
- On average, Non-Waiver youth with unexcused absences missed 9.4 days of school, those with suspensions missed 6.3 days of school, and those with expulsions missed 20.4 days of school.

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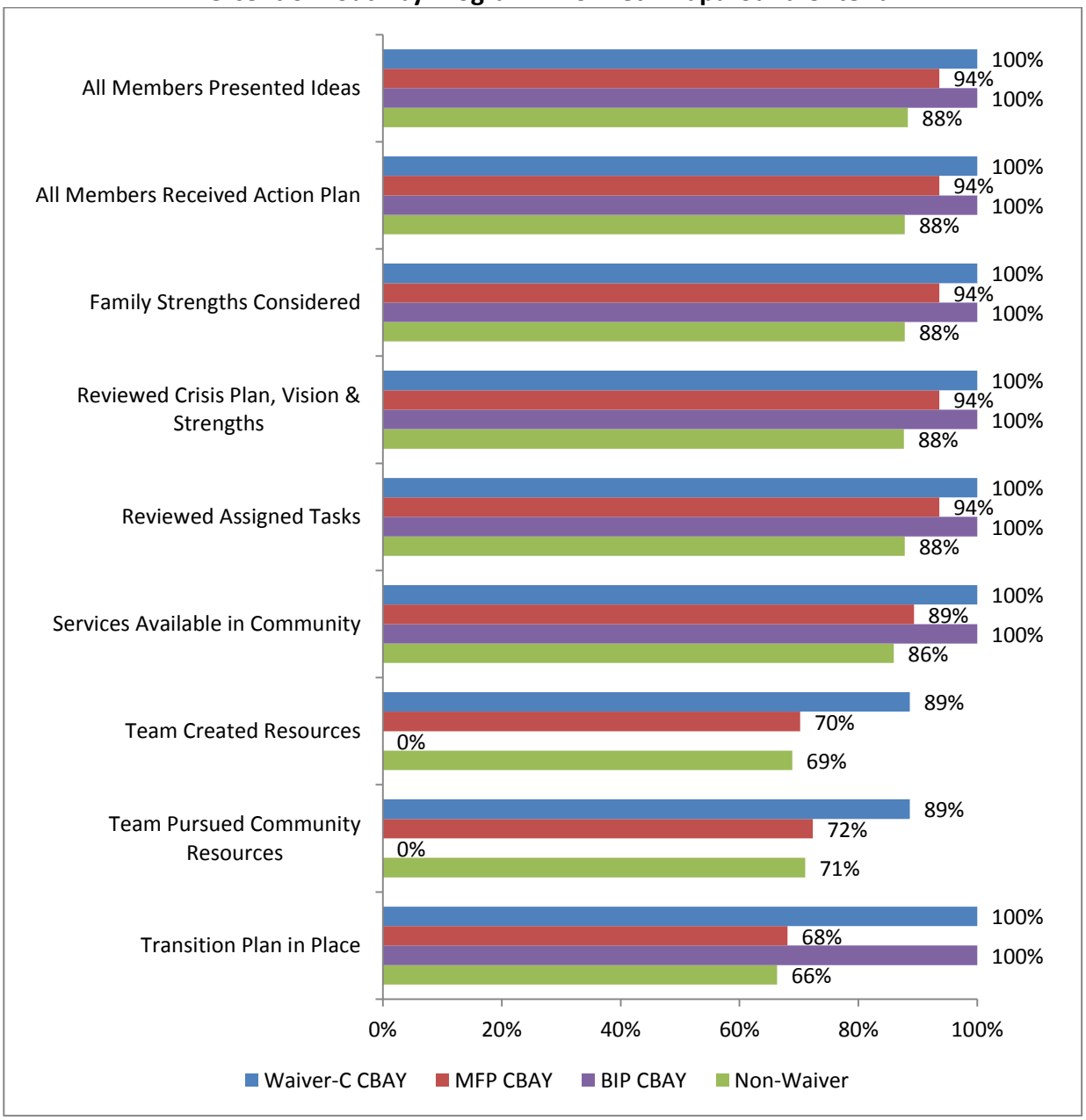
Fidelity to Wraparound Model

As part of the monthly Action Plan submitted through Synthesis, care coordinators report their adherence to the fundamental components of Wraparound care. The following table illustrates the percent of youth in each program where the Wraparound criteria were met.

Percent of Youth by Program who Met Wraparound Criteria



- Care coordinators working with Waiver-C CBAY youth routinely ensured (100%) that all members presented ideas, received actions plans, considered family strengths, reviewed crisis plans, visions, strengths, and assigned tasks, assured that services were

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available in the community and ensured a transition plan was in place. Care coordinators reported that, for 90% of discharged Waiver-C CBAY youth, teams created resources and pursued community resources.

- Similarly, care coordinators working with MFP CBAY youth routinely ensured (94%) that assigned tasks, crisis plan, vision, and strengths were reviewed, family strengths were considered, and all child and family team (CFT) members presented ideas and received a copy of the action plan. Resources were created by the team or community resources were pursued for 72% or less of discharged MFP CBAY youth. Transition plans were in place for 68% of MFP CBAY youth.
- For the single discharged BIP CBAY youth, care coordinators practiced with fidelity to the Wraparound model for all documented attributes with the exceptions of "team created resources" and "team pursued community resources."
- For 88% of Non-Waiver youth, care coordinators reported the completion of assigned tasks, crisis plan, vision, and strengths were reviewed, family strengths were considered, and ideas were presented by all CFT members who also received a copy of the action plan. 66% of Non-Waiver youth had a transition plan in place, 71% had a CFT who pursued community resources, and 69% created resources to support the youth.

Monthly Child and Family Team Meetings

Another important element of the Wraparound model is that youth have at least one monthly CFT meeting (CFTM), on average. The following figure provides a ratio of the number of CFTMs per youth compared to the number of complete months enrolled (LOE) in a CME by program.

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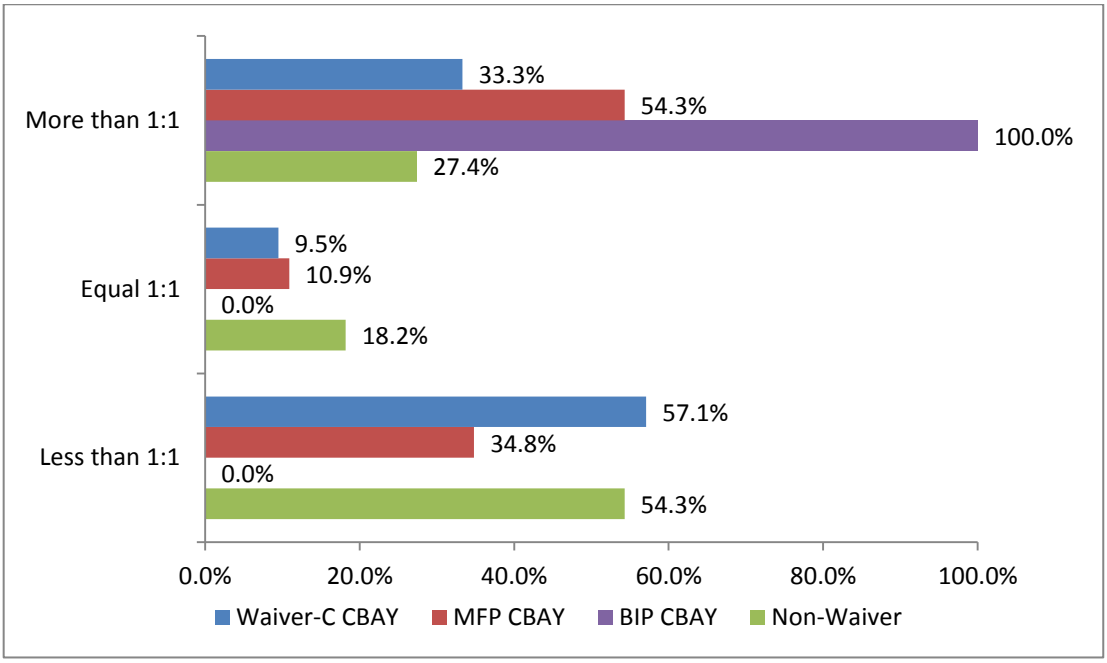
CFTM:CME Length of Enrollment Ratio



Note: Only youth who enrolled after the transition to Synthesis were included in this analysis as CFTM data were not transferred to Synthesis for youth enrolled prior to 6/30/2012.

- The sole BIP CBAY youth averaged more than one CFTM per month during CME enrollment.
- For other CBAY programs, approximately 33% (Waiver-C CBAY) to 54% (MFP CBAY) of discharged youth enrolled in a CME had more than one CFTM per month.
- 18% of Non-Waiver youth experienced on average one CFTM per month enrolled. Approximately 10% of MFP CBAY youth had a 1:1 CFTM to CME length of enrollment ratio.
- For more than half of Waiver-C CBAY and Non-Waiver discharged youth and 35% of MFP CBAY discharged youth, CFTMs occurred less than once per month.

Care coordinators submit exceptions to CFTM when a required or monthly meeting is missed. Exceptions were documented for 562 CFTMs for 223 unique youth who had less than a 1:1 monthly CFTM meeting to LOE ratio. Exceptions were attributable to a family's unavailability, a family member in the hospital, family relocation, the transition of youth to another care coordinator within the same CME, or the transition of a youth to another CME.

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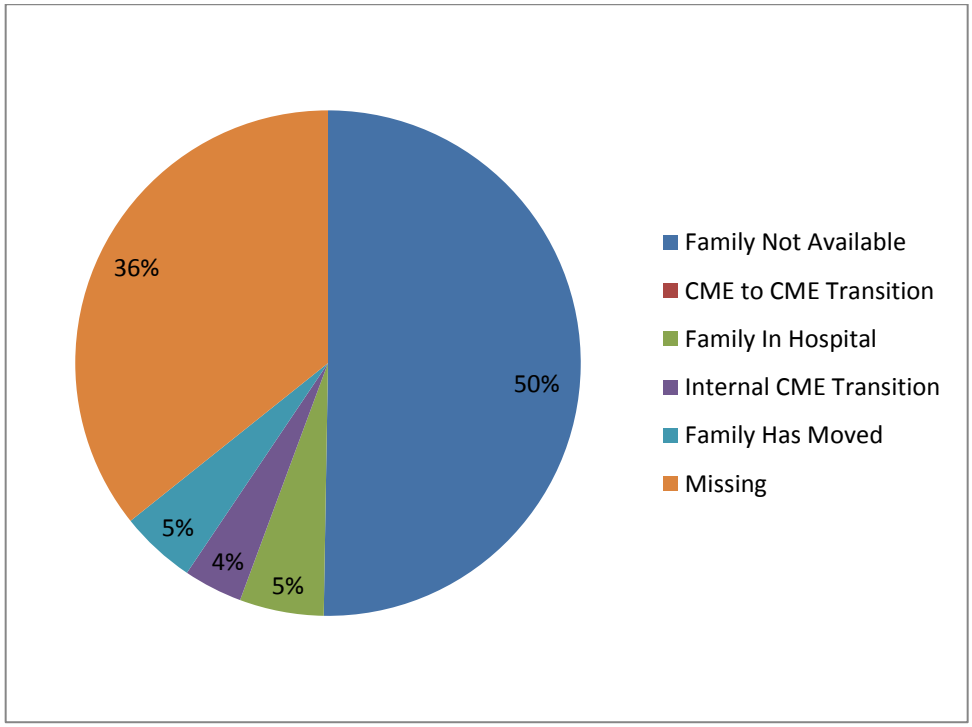
Frequency of CFTM Exceptions

Number of Exceptions	Number of Youth	Percent of Total
1	66	29.6%
2	68	30.5%
3	45	20.2%
4	23	10.3%
5	8	3.6%
6	8	3.6%
7	1	0.4%
8	1	0.4%
9	0	0.0%
10	3	1.3%
Total	**223**	**100.0%**

- Approximately 30% of youth required only one CFTM exception.
- Two to three exceptions were documented for 51% of youth.
- 14% of youth required four to five CFTM exceptions
- The remaining six percent of youth required six to ten CFTM exceptions.

The following figure illustrates the distribution of the documented exception reasons as a percent of total CFTM exceptions.

CFTM Exception Reasons as a Percent of Total CFTM Exceptions



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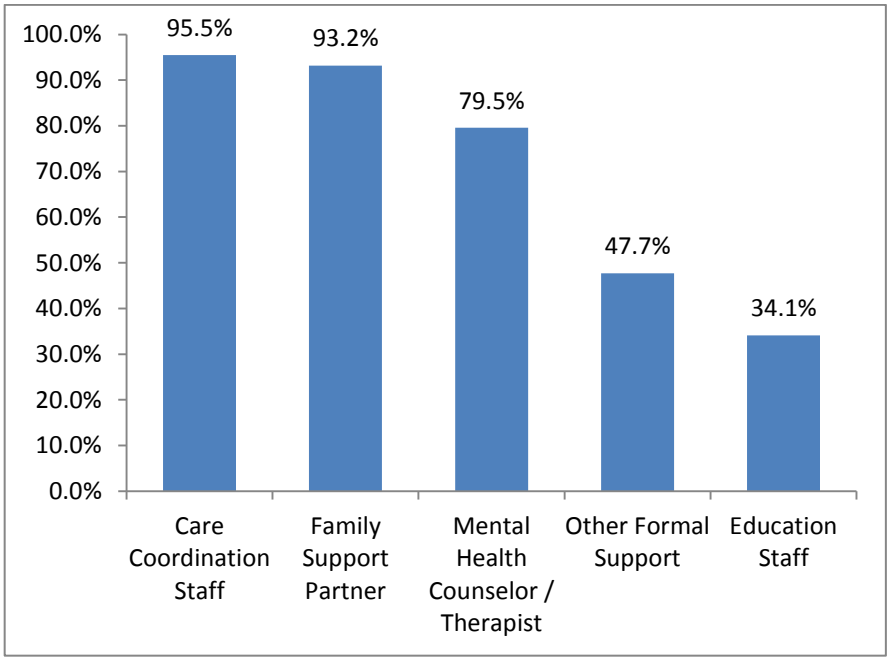
- Family unavailability (50%), family member in the hospital (5%), and family relocation (5%) accounted for the majority of all CFTM exceptions.
- No CFTM exception reason was documented for 36% of the meetings missed.
- Four percent of CFT meetings were missed due to change in care coordinator within a CME.

Formal and Informal/Natural Supports

Formal, informal and natural supports participating in CFTMs are also important elements to Wraparound. A large number of youth are referred to a CME from formal supports including the Department of Juvenile Justice (DJJ), the Division of Family and Children Services (DFCS) and the Department of Education (DOE), etc. The Wraparound model intends to identify and incorporate natural and informal supports during a youth's time in a CME that can help provide long-term support to the youth once discharged from the program. The following tables demonstrate the frequency of supports who participate on a youth's CFT.

Waiver-C CBAY Top 5 Formal Supports



- Care coordination staff and FSPs were present as formal supports on 96% and 93% of Waiver-C CBAY youth CFTs.
- Approximately 80% of Waiver-C CBAY youth had a mental health counselor/therapist as formal supports on the CFT.
- Less than half of Waiver-C CBAY youth had other formal supports or education staff on the CFT (48% and 34%, respectively).

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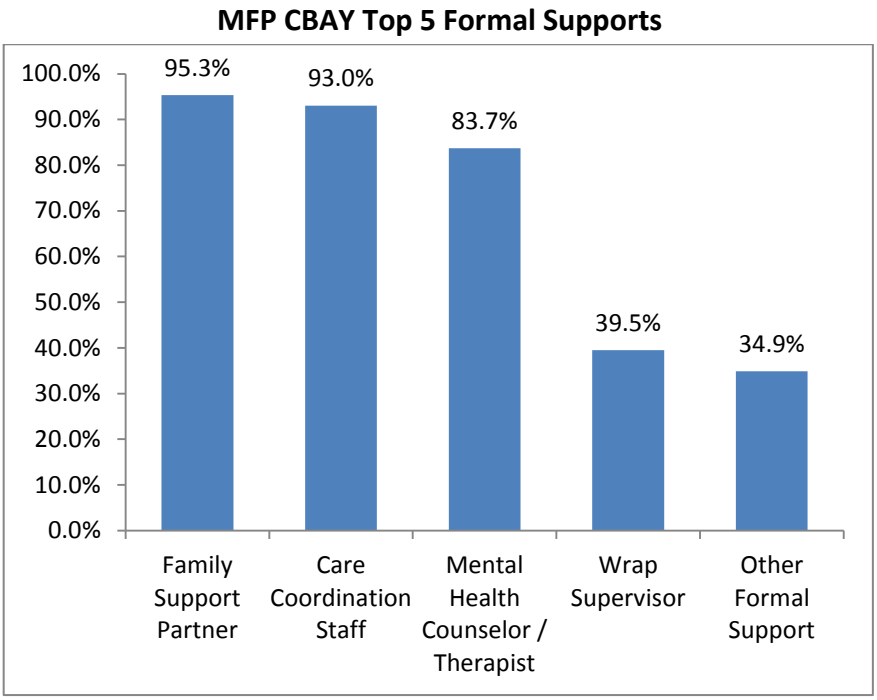

- FSPs and CME care coordinators were present as formal supports on 95% and 93% of MFP CBAY youth CFTs, respectively.
- Mental health counselors/therapists were formal supports on 84% of MFP CBAY youth CFTs.
- Wraparound supervisors and other formal supports participated in less than 40% of MFP CBAY youth child and family teams.

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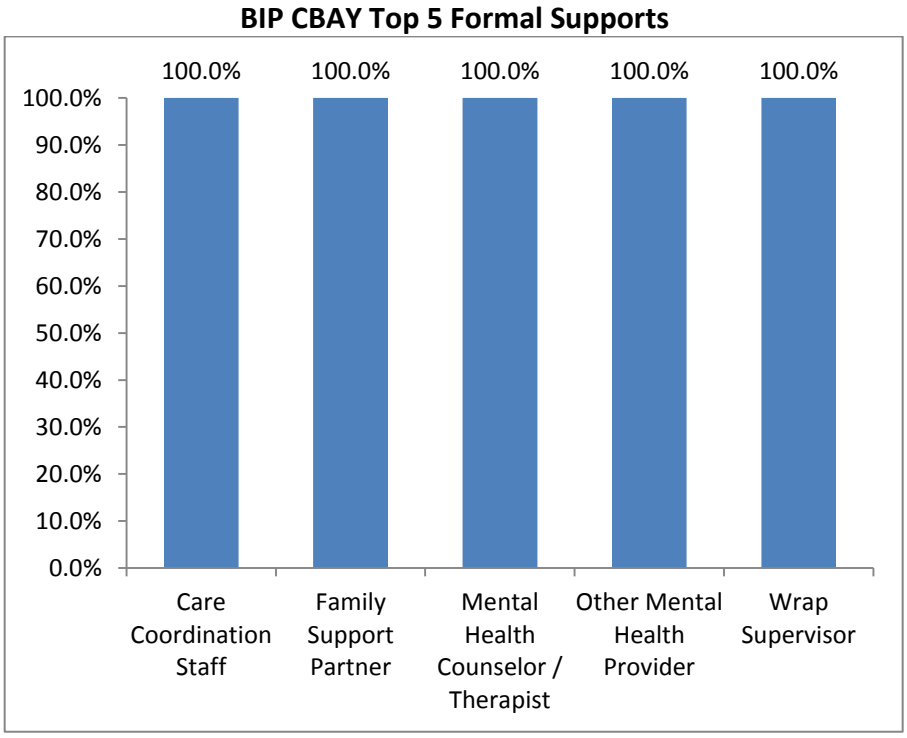

- For the single BIP CBAY youth discharged during the evaluation period, care coordination staff, FSP, mental health counselor/therapist, other mental health providers, and wraparound supervisors comprised the formal supports participating on the youths CFT.

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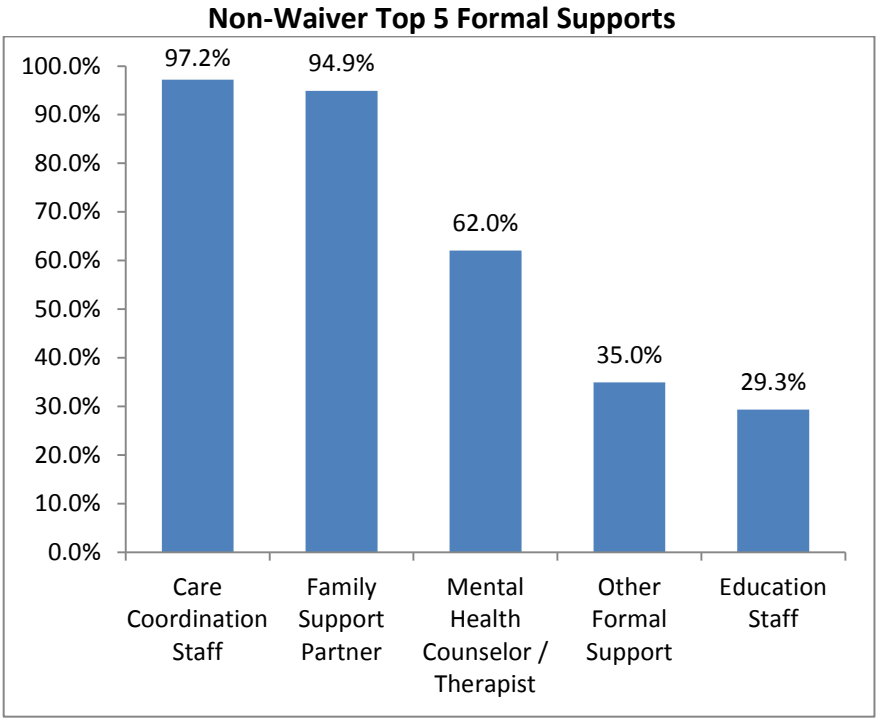

- CME care coordination staff and FSPs participated as formal supports for 97% and 95% of discharged youth CFTs, respectively.
- Mental health counselor/therapists served as formal support for 62% of Non-Waiver youth.
- Other formal supports and education staff participated on 35% or less of Non-Waiver youth child and family teams.

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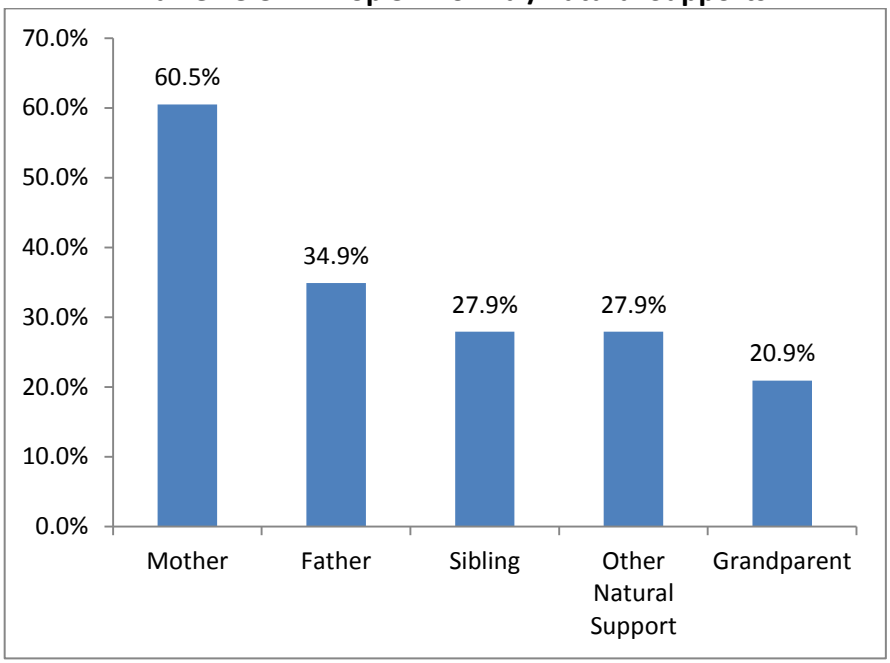
Waiver-C CBAY Top 5 Informal/Natural Supports



- Family members represented four of the top five informal/natural support types for Waiver-C CBAY youth discharged during the evaluation period.
- Parents represented the most common informal/natural supports participating on the Waiver-C CBAY youth CFTs, with mothers identified on 61% of CFTs and fathers identified on 35% of CFTs).
- Siblings served as informal/natural supports for 28% of Waiver-C CBAY youth.
- Similarly, other natural supports participated on CFTs for 28% of Waiver-C CBAY youth.
- Grandparents were included as informal/natural supports for 21% of Waiver-C CBAY youth.

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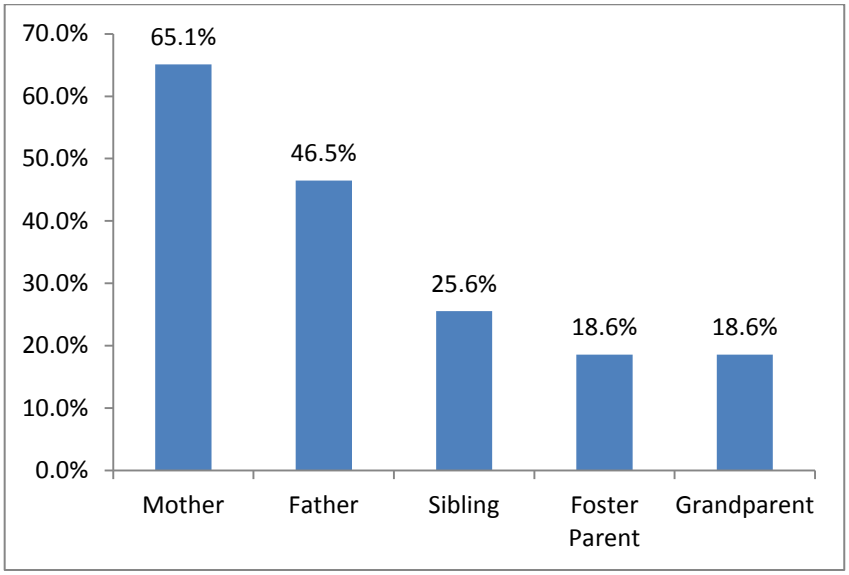
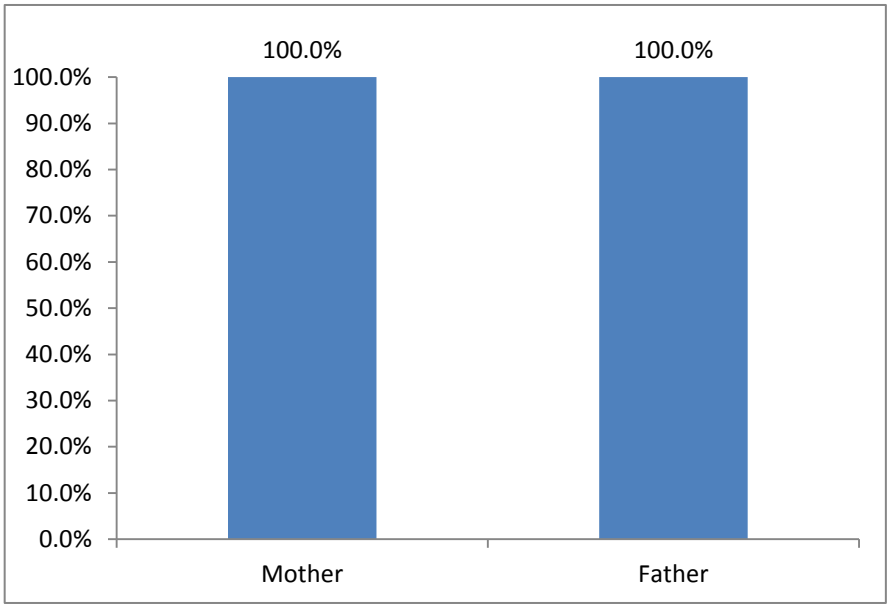
MFP CBAY Top 5 Informal/Natural Supports



- Family members including mothers (65%), fathers (47%), siblings, (26%) and grandparents (19%) accounted for four of the top five informal/natural supports for discharged MFP CBAY youth.
- Foster parents served as informal/natural supports for 19% of discharged youth.

BIP CBAY Top Informal/Natural Supports



- For the sole discharged BIP CBAY youth, parents were the only informal/natural supports included on the youth's CFT.

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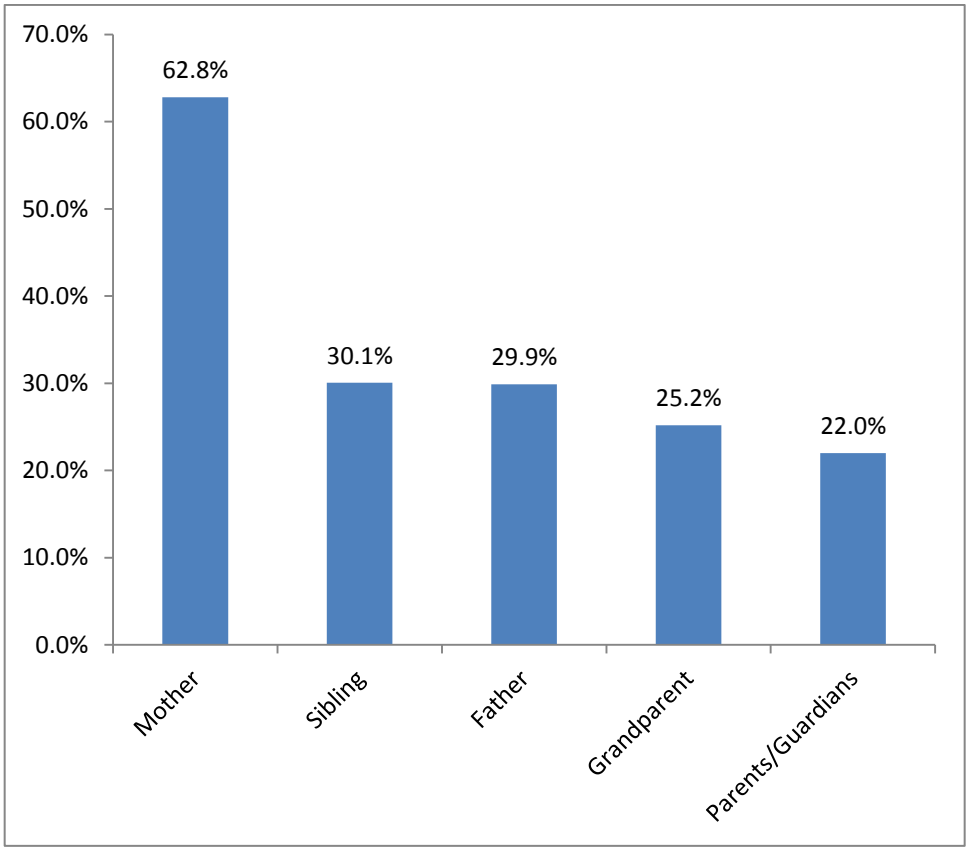
Non-Waiver Top 5 Informal/Natural Support



- Immediate family members constituted the top five informal/natural supports for Non-Waiver youth discharged during SFY2014.

In addition to the type of supports listed on the CFT, the number of supports was also examined.

Frequency of Formal Supports on CFT

Frequency of Formal Supports	Waiver-C CBAY	MFP CBAY	BIP CBAY	Non-Waiver	Total
1-2	0.0%	7.0%	0.0%	10.9%	10.3%
3-5	70.5%	60.5%	100.0%	63.7%	66.0%
6-8	29.5%	32.6%	0.0%	24.2%	28.5%
9+	0.0%	0.0%	0.0%	1.1%	8.7%
Percent with Total Discharged Youth with Formal Support	**100.0%**	**91.5%**	**100.0%**	**90.0%**	**90.8%**

- 90% or more youth had one or more formal supports on the CFT.

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- The number of formal supports ranged between three and five for the majority of youth.
- Approximately 8% of MFP CBAY youth and 10% of Non-Waiver youth had no formal supports listed on the CFT.

As families become better equipped through Informal and Natural supports, a goal of the Wraparound model is to minimize the need for Formal Supports.

Frequency of Informal and Natural Supports on CFT

Frequency of Informal/ Natural Supports	Waiver-C CBAY	MFP CBAY	BIP CBAY	Non-Waiver	Total
1-2	53.5%	48.8%	100.0%	58.1%	57.2%
3-5	39.5%	48.8%	0.0%	38.2%	38.9%
6-8	7.0%	2.3%	0.0%	3.4%	3.6%
9+	0.0%	0.0%	0.0%	0.4%	0.3%
Percent of Discharged Youth with Informal/Natural Supports	**97.7%**	**91.5%**	**100.0%**	**90.0%**	**90.6%**

- 90% or more youth discharged during SFY2014 had one or more Informal or Natural supports on the CFT.
- More than 50% of Waiver-C CBAY and Non-Waiver youth had one to two informal/natural supports on the CFT. The sole BIP CBAY youth had two informal/natural supports on the CFT.
- Approximately 39% of Waiver-C CBAY and Non-Waiver youth had 3-5 informal/natural supports on the CFT.
- An equal percent of MFP CBAY youth (49%) had 1-2 or 3-5 informal/natural supports on the CFT with the residual total of 2% having six or more.
- Approximately 8% of MFP CBAY youth and 10% of Non-Waiver youth had no informal or natural supports included on the CFT.

Family Support Services

Family Support Partners (FSPs) are adult peers who have experience with caring for a youth with behavioral health needs. FSPs participate in CFTMs and work closely with the youth and their families/caregivers to help achieve their desired goals.

641 of 683 discharged youth (73%) received family support services while enrolled in a CME. Length of enrollment (LOE) in the CME affects the number of contacts and time an FSP may interact with a family. The following graphs illustrate the average FSP encounters measured in days, average contact time measured in hours, and the average LOE for youth who

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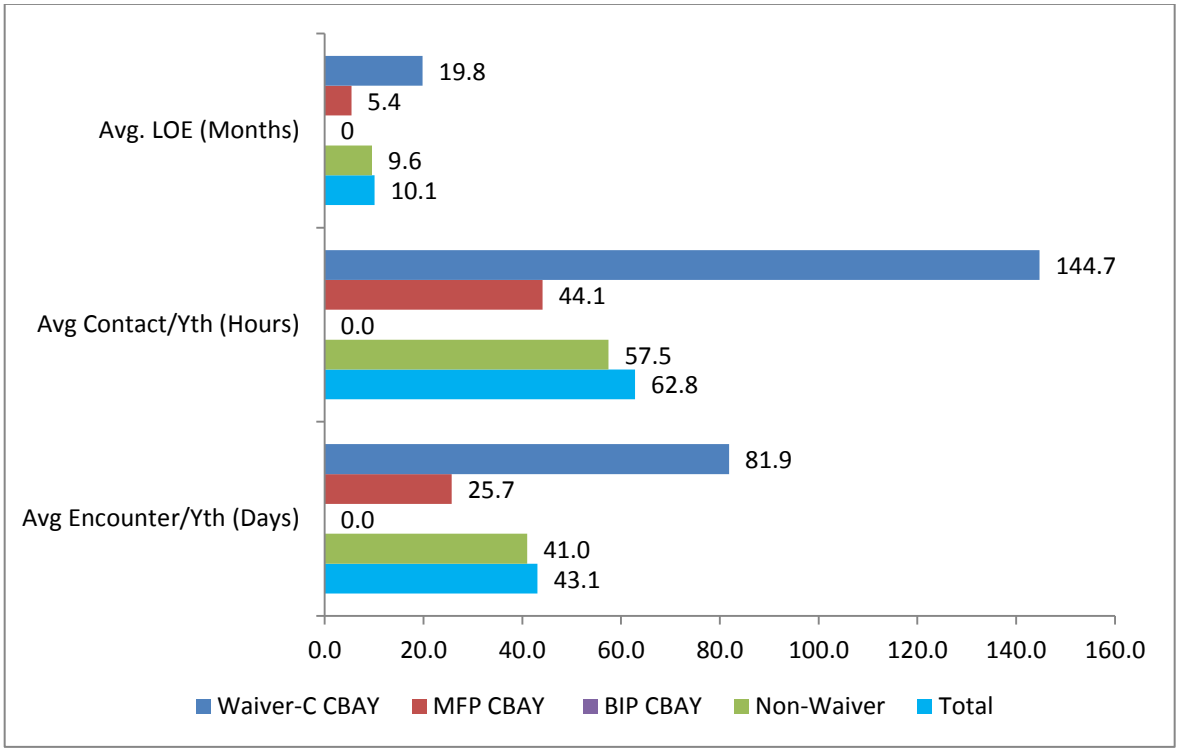
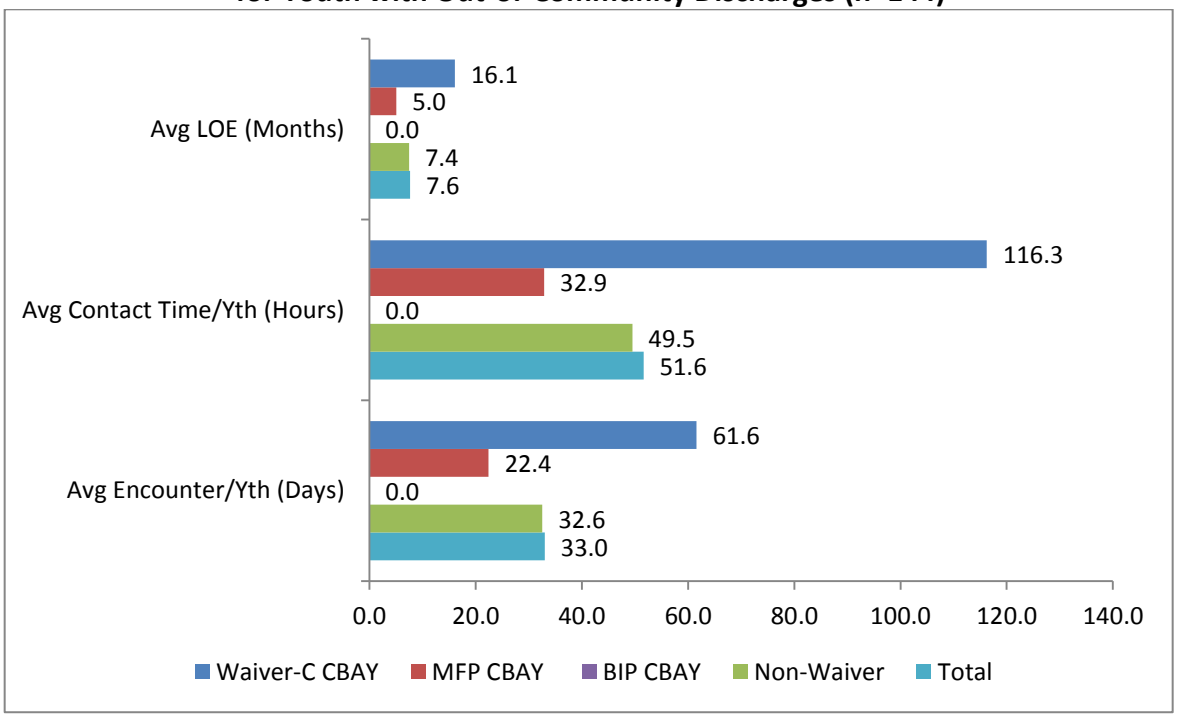
experienced in-community and out of community discharges from a CME. No FSP encounters or contact time were documented for the single BIP CBAY youth discharged during SFY2014.

FSP Average Encounters and Contact Time for Youth with In-Community Discharges (n=497)



- On average, Waiver-C CBAY youth averaged 81.9 FSP encounters during their 19.8 month average LOE. On average, FSPs spent almost 145 hours of contact with youth who experienced an in-community discharge from a CME.
- MFP CBAY youth who received FSP services averaged 25.7 FSP encounters during their 5.6 month average LOE. FSP contact hours with MFP CBAY youth averaged 44.1 hours.
- Non-Waiver youth averaged 41.0 encounters during their 9.6 month average LOE. FSP contact time spent with youth averaged approximately 58 hours.

FSP Average Encounters and Contact Time
for Youth with Out-of-Community Discharges (n=144)



- Youth who experienced an out-of-community discharge from Wraparound experienced shorter average lengths of enrollment (7.6 months), fewer encounters (33.0 days) and less contact time (51.6 hours) compared to youth who experienced an in-community CME discharge.
- Waiver-C CBAY youth experienced lengths of enrollment that were more than twice as long as MFP CBAY or Non-Waiver youth (16.1 compared to 5.0 and 7.4 respectively).
- Similarly, Waiver-C CBAY youth experienced almost three times as many encounters as MFP CBAY (61.2 versus 22.4, respectively) and twice as many encounters as Non-Waiver youth (32.6).
- Average FSP contact time with Waiver-C CBAY youth (116.3 hours) also exceeded time spent with MFP CBAY and Non-Waiver youth (32.9 and 49.5 hours, respectively).

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Workforce Development and Training

The COE has been charged with implementing and developing the Wraparound Training continuum to ensure quality practice. In an effort to support and sustain the workforce DBHDD has identified several consultants embedded in the CME's. The local coaches are supported by the COE and complete the Wraparound Practitioner Certificate Program via Innovations Institute in order to provide adequate technical assistance to Wraparound practitioners and community partners. Innovations Institute, located at the University of Maryland, provides technical assistance and training to help ensure that states implement and practice fidelity to the Wraparound model. The coaches conduct all training's, assess practice trends within the CME's, develop additional curriculums and provide technical assistance to Wraparound supervisors. The trainings developed by Innovations Institute include introduction to Wraparound, Engagement in the Wraparound Process, Intermediate Wraparound and Advancing Wraparound Practice. In an effort to grow the training continuum, in 2012 the COE collaborated with DBHDD to develop and disseminate a needs assessment to Wraparound facilitators and supervisors. The results were used to identify areas for skill development and training topics. A series of trainings were introduced in 2013which were created by the COE coaches. Those trainings included Needs and Outcomes in Wraparound, Strengths, Creative Styles of Safety & Crisis Planning, Transitions to Hope and Family Support Partners in Wraparound.

Wraparound Training

The COE provides Wraparound training to CME and FSO staff and other direct service providers. During SFY2014, 13 trainings were conducted by the COE. This summary report includes 9 of 13 trainings from July 1, 2013 until June 30, 2014. Training topics include:

- Introduction to Wraparound
- Intermediate Wraparound
- Family Support Partner Training
- Strengths Training
- Engagement Training
- Needs and Outcomes Training
- Safety and Crisis Planning

The training content consists of lectures and interactive group activities that build and strengthen the skills needed to implement High Fidelity Wraparound. The surveys are administered at the end of each training.

Direct Wraparound staff represented three-fourths of all training participants. This includes both CME Care Coordinators and FSPs.

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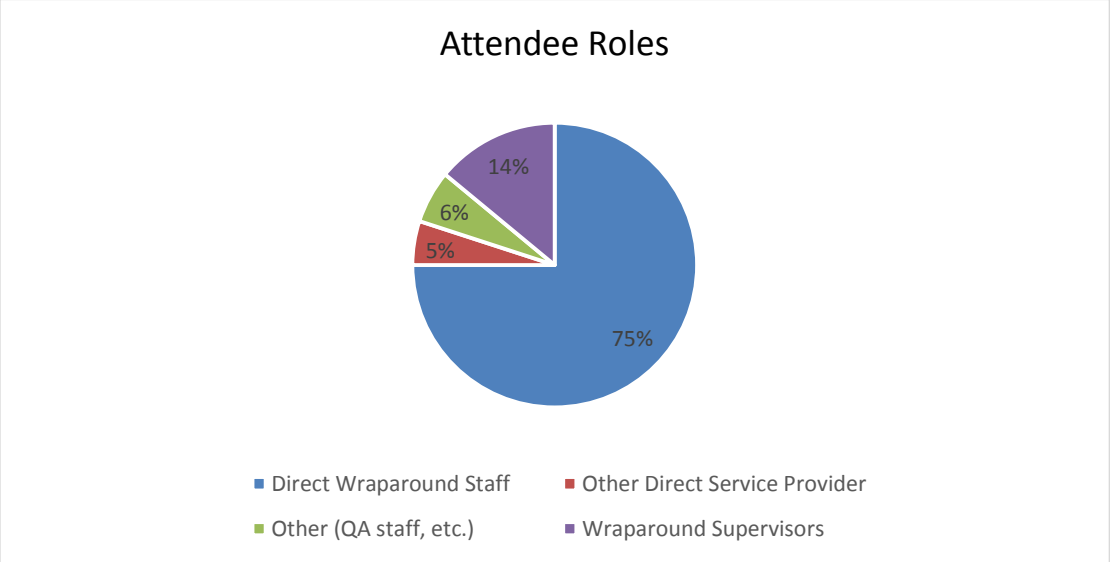
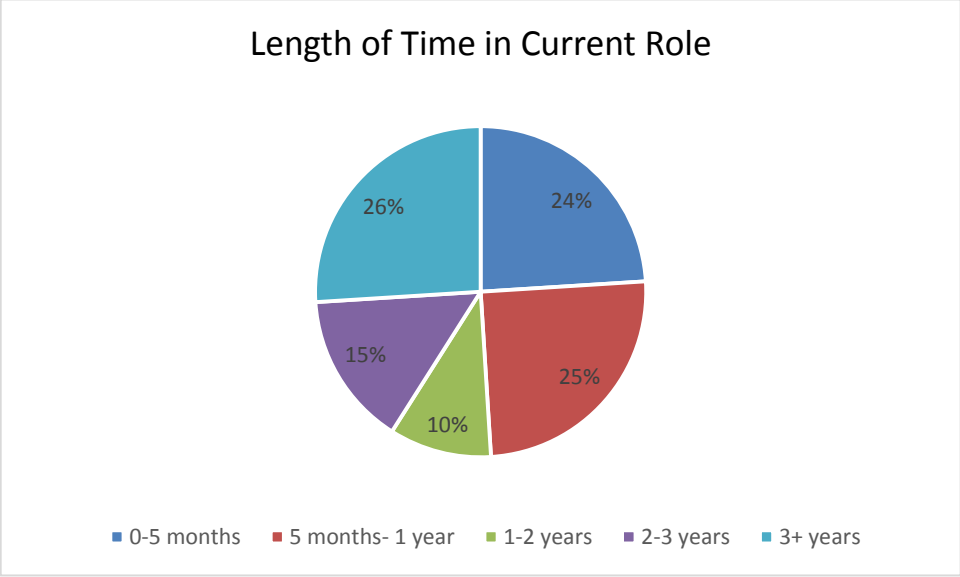


- CME Wraparound Supervisors and Quality Assurance (QA) staff accounted for 20% of participants.
- An additional five percent of participants represented direct service providers (i.e. therapists).

New and veteran providers attended trainings.



- Approximately half (49%) of training participants were in their role for one year or less.

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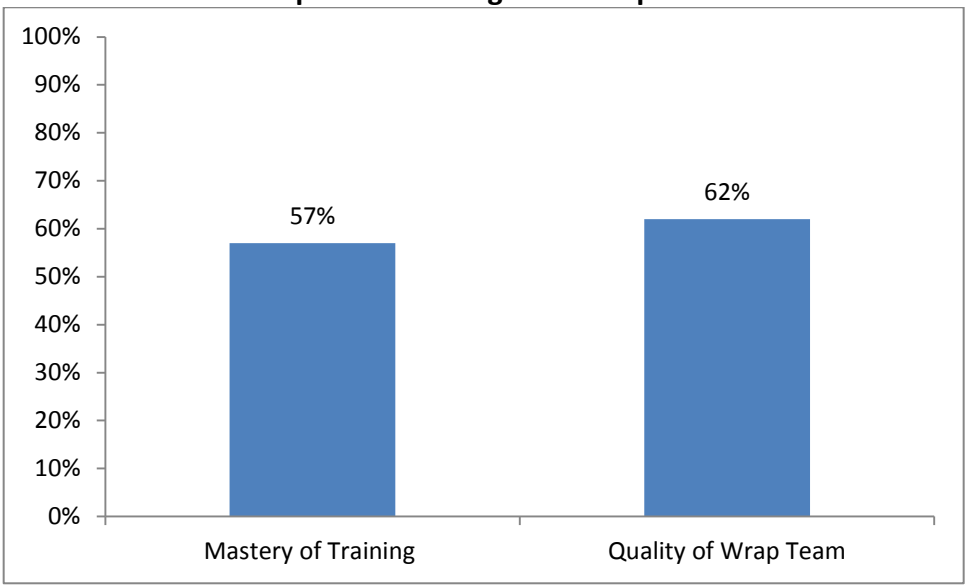
- One-quarter of training participants reported serving in their current role for 1-3 years.
- Similarly, an additional quarter of participants served in their role for 3 or more years at the time of the training.

Upon completion of the training participants are asked to rate on a scale of 0 to 10, with 0 representing “None” 5 representing “Moderate” and 10 representing “Profound/Enduring” of the training on knowledge and skills.

Impact of Training on Participants



- 57% of training participants reported a profound mastery of training/competency after the training compared to pre-training scores.
- 63% reported that they believe the training profoundly improved the quality of wraparound teams, programs or system supports.

Coaching Observation Measure for Effective Teams (COMET)

The Coaching Observation Measure for Effective Teams (COMET) is an evaluation instrument utilized to access a Care Coordinator’s skill level throughout the four phases of the Wraparound process. The four phases are Engagement & Team Preparation, Initial Plan Development, Implementation, and Transition. The 46-item measure is utilized through the observation of supervisions, Family Team Meetings, and plan of care document reviews. The purpose of the tool is to provide a framework to ensure mastery of skills in the four Key Elements of Wraparound (Grounded in a Strength Perspective, Driven by Underlying Needs, Supported by an Effective Team Process, and Determined by Families). The COMET is scored by local master coaches on a monthly basis to determine whether or not the identified skill is present. The tool is scored on a binary scale; the skill is either evident or not evident.

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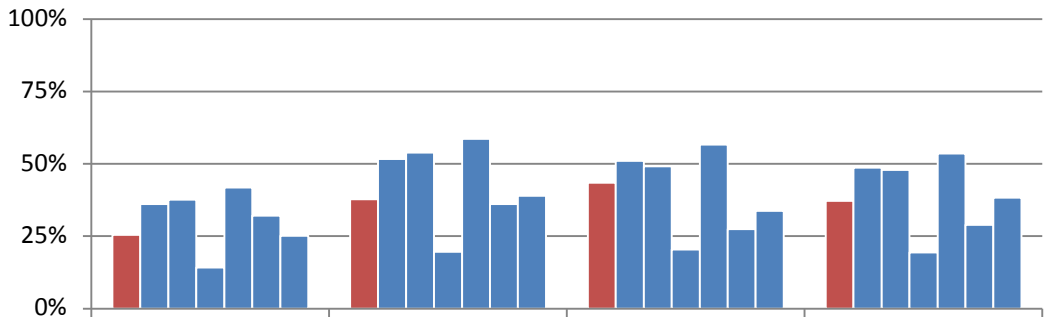
The unit of measure when scoring a COMET is the Wraparound facilitator. After observing a facilitator or conducting a document review a local coach will score the COMET. Georgia Wraparound facilitators are most often demonstrating skills in the areas of Supported by an Effective Team Process and Determined by Families.

Georgia COMET Results

- Relative to other states, Georgia's COMET scores are moderate. Some states are lower and some are higher.
- The items most often demonstrated in Georgia involved skills around communicating and demonstrating respect, managing conflict, and adopting a non-judgmental attitude, among others.
- The items least often demonstrated included the facilitators' ability to turn the information around the family's story into needs statements across several domains, the ability to generate needs statements that support families' decision making, and the ability to seek understanding about underlying needs and conditions.

Percent of Facilitators Demonstrating Skills for each Phase of Wraparound



	Engagement	Initial Plan Dev.	Implementation	Transition
Georgia	25.49%	37.76%	43.52%	37.23%
State A	36.12%	51.70%	50.95%	48.70%
State B	37.66%	53.88%	49.08%	47.92%
State C	14.15%	19.57%	20.44%	19.36%
State D	41.88%	58.62%	56.64%	53.58%
State E	32.09%	36.04%	27.43%	28.95%
State F	25.10%	38.91%	33.80%	38.24%

Items Most Often Demonstrated by Facilitators

Skill	Percent Demonstrated
Ability to communicate and establish respect for each family member and her/his choices (F3)	89.47%
Ability to effectively manage conflict and build team member consensus (T10)	84.21%
Ability to inspire others to adopt a strong, non-judgmental, family-friendly approach (F8)	84.21%
Ability to lead the team in holding each team member accountable for follow through on their commitments (T11)	78.95%
Ability to empower, train and support other team members to understand & incorporate the family's opinion into strategy adaptation (F9)	78.95%

Hensley, S. and Mudd, R. (2014). Georgia IOTTA and COMET Results. Division of Behavioral Health and Justice Policy University of Washington.

A complete copy of the report produced by WERT is available in Appendix H.

Qualitative Stakeholder Interviews

Qualitative interviews with key stakeholders were introduced as a component of the CME Annual Evaluation to better understand programmatic strengths, challenges and opportunities for improvement as perceived by a broad variety of internal and external stakeholders. Representatives from the CMEs (including care coordinators, supervisors and quality assurance staff), Family Support Organizations (FSOs) and Family Support Partners (FSPs), family advocacy organizations, DBHDD and other child serving agencies (Department of Juvenile Justice (DJJ), Department of Community Health (DCH) and Division of Family and Children Services (DFCS)) were identified by DBHDD and COE staff and invited to participate. Fourteen of sixteen identified individuals participated in the semi-structured interviews. Interviews were conducted over the telephone or in person and lasted approximately 60 minutes. Interview transcripts were reviewed by the evaluation team, who identified key thematic findings, which are presented in summary format below. A copy of the Qualitative Stakeholder Interview Guide is provided in Appendix I.

Across the board, stakeholders indicated that CMEs, functioning as care coordinators of services for youth and their families, ***are highly committed and effective in giving the families a voice***. In addition, it was noted that CME staff ***do a good job relating to and engaging with families, helping them identify and address their strengths and needs, connecting them to community partners and resources, and coordinating services***. CME staff are highly dedicated to and adaptive in helping the families get the services they need.

Limited community partners, resources and DBHDD-contracted core providers in rural communities are barriers to coordinating services for youth and their families. In addition to fewer resources being available, stakeholders reported that community cultural beliefs can minimize interest by community partners and organizations to work with SED youth and their families who have experienced troubled events. There are perceptions among community organizations that youth enrolled in CMEs are delinquents and should not partake in organization activities. Others may feel that these youth belong in the Juvenile Justice system, rather than in the community. However, increasing the knowledge of communities around SED youth and CMEs may help dispel these views.

Geographic decentralization of services was commonly voiced by stakeholders as a significant challenge for CMEs to effectively coordinate services for SED youth and families. The large geographic regions that CME staff serve pose an obstacle to effectively serving families. It was noted that CME staff may spend as much as 2 to 3 hours driving to a child and family team meeting. As a result, it is difficult for CME staff to foster relationships with local community partners and organizations in areas that are so far removed from their own communities.

Participants were asked to share their perspective, according to their scope of work, on what the CMEs are doing well and what could be improved upon in working with other stakeholders, including DBHDD, FSOs /FSPs, youth and families, and other child servicing agencies.

Working with DBHDD: Stakeholders recognize the ***commitment of DBHDD to ensuring that SED youth receive community-based care and to implementing quality improvement plans and other reporting mechanisms to ensure that community-based services meet both fidelity and quality standards***. The open lines of communication, regular meetings, and opportunities for collaborative decision making among CMEs and DBHDD are also beneficial. However, stakeholders noted that the ***ongoing changes in DBHDD policies and procedures are overwhelming and are not always communicated clearly or in a timely manner within the CMEs or to their contractors, making it difficult for CME staff to serve families effectively***.

Working with FSOs/FSPs: Stakeholders noted that FSOs/FSPs provide a valuable service to the family in helping them become better advocates for their youth and for engaging them in the Wraparound process. In addition, ***CMEs are working collaboratively with FSOs and FSPs to better understand the roles and responsibilities of each in serving SED youth and their families***. Stakeholders noted past confusion of roles and responsibilities on behalf of the FSOs. Further, collaboration between CME staff members and FSPs can be challenging due to incongruence in who is assigned to serve families. For example, one CME staff member may be working with multiple FSPs in a single service area. ***The inconsistent pairing of CME staff and FSPs can inhibit the development of a working relationship and consistent communications, both of which are beneficial to serving families.*** Opportunities for improvement suggested by stakeholders include additional training of FSOs/FSPs regarding their role and responsibilities within the Wraparound team, co-locating the CME staff and FSOs/FSPs to help increase opportunities for coordination and communication, and developing CME Care Coordinator - FSP teams.

Working with families: ***CME staff and FSPs do a very good job of working with the families to help them identify and obtain resources, develop a family voice and become empowered.*** Some families are initially untrusting of the Wraparound process but, through the relationships developed by the CME staff and FSPs, later feel empowered by their accomplishments. However, there are some challenges for family success. Families may become emotionally attached to the CME staff or FSPs, diminishing their motivation to transition out of the program. Alternatively, securing resources that are not readily available, such as transportation, may limit a family's ability to utilize community resources identified by the CMEs.

Working with other child serving agencies: According to stakeholders, ***it is commonly recognized by leadership in child serving agencies that CME services provided under the Wraparound model are important to helping the youth remain in the community.*** However, agency workers vary by county in their belief in the success of Wraparound, indicating a need for ongoing training on CME services and the Wraparound model. Each county's culture may also influence county-level workers' interest in participating in the Wraparound process, making it difficult for CMEs to coordinate services. For counties that embrace the Wraparound model, agency staff are often supportive of and willing to work collaboratively with CMEs to improve the lives of the youth and their families.

Stakeholders were also asked to describe the Wraparound model, to share their perceptions on whether CMEs and FSPs effectively practice to the model, what works well or not well, and what improvements could be made to address challenges.

Understanding the Wraparound Model: While stakeholders describe the Wraparound model as an individualized process to help SED youth remain in the community by building on family strengths, a distinct bifurcation emerged in discussions of family choice. ***Approximately half of the stakeholders believed that CMEs should honor family choice to participate in or include particular components of the Wraparound model, rather than adhere to the model itself.*** Other stakeholders voiced that it is the CME staff's responsibility to help educate and engage the family to follow *all* components of the model to achieve optimum outcomes.

Effectively practicing to the Wraparound Model: There is consensus among stakeholders ***that CMEs and FSPs are trying to effectively practice to the model, but that limited community partners and resources in certain geographic regions of the state make it difficult to find the support services needed for the families.*** In addition, stipulations on how flex funding can be allocated and used to help support the families in resource scarce areas makes it difficult for CME staff to secure resources.

Specific attributes discussed with stakeholders include the following:

> Family Engagement: Stakeholders shared that CMEs effectively engage families to identify strengths, develop goals, recognize accomplishments, and adapt when goals are not achieved. Stakeholders noted it is easier to engage families who are familiar with the CMEs and the services they provide, rather than families who are new to the CME system. Stakeholders also noted that it is easier to engage families who are not mandated to participate in Wraparound rather than families who are mandated, either via Juvenile Courts or DFCS. ***Areas for improvement include ensuring that CME staff and FSPs are culturally and ethnically diverse and competent.*** As minority populations are overrepresented in the DJJ and DFCS systems, CME and FSO staff must have the

cultural diversity and competency to maximize their engagement in the Wraparound model.

Incorporating Natural and Informal Supports: According to stakeholders***, identifying and incorporating natural and informal supports on the child and family team is challenging.*** It is time-consuming and requires the CME staff and FSPs to "meet the families where they are." Families may be hesitant to include others on their team because they feel embarrassed or ashamed of the issues their family faces. Alternatively, families may feel they have alienated friends and family members in the past. Because informal and natural supports are unpaid, many are not willing to consistently participate in team meetings. Community partners and agencies may not be willing to serve in this role because of the troubled history of the family***. To be effective, stakeholders noted that it is important to help the family recognize the supports they have in their everyday life. Families must learn skills to keep natural and informal supports involved in the life of the youth and sustain the connections they make with community partners.***

Transition Planning: Only a small proportion of stakeholders reported that CME staff were effectively practicing transition planning. Most felt ***transition planning needs to begin earlier in the process and should be continuously discussed as a goal to prepare families for transitioning out of Wraparound.*** This can be a difficult balance, as families may be initially hesitant to participate in Wraparound for fear of being released from the program or they may become emotionally attached to CME staff and don't want to transition from the program.

Training and Resources***: Additional training is needed to address the confusion many internal and external stakeholders have regarding the different programs that finance Wraparound.*** It was noted that youth may be enrolled to receive Wraparound through Non-Waiver funding though they may qualify for CBAY because providers don't understand the eligibility criteria or process for applying for CBAY programs. Best practices need to be identified on how CME staff and other mental health providers coordinate enrollment for youth into Wraparound. Stakeholders shared that additional training of child serving agencies on the Wraparound model would be helpful to CME staff as they work to develop family teams. Other suggested trainings include Wraparound and documentation refresher courses, and ensuring that CME staff know what data elements need to be collected and entered into data systems for evaluation and practice management.

Administrative Requirements and Reporting: Stakeholders reported administrative challenges to effectively adhering to the model. Several stakeholders noted that

inclusion of all team members at the required 14-day planning meetings is very difficult.

Obtaining flex fund approval in a timely manner to support the needs of families transitioning to the community is an opportunity for improvement identified by many stakeholders. Conversely, ***forms and data to support flex fund approval are often incomplete and greater data quality checks are necessary by CME staff***. It was also noted that CMEs should collect data to demonstrate that the ways in which flex funds are used result in improved youth and family outcomes.

While a recognized necessity, ***data entry and reporting is duplicative and detracts from the time spent with families.*** According to many stakeholders who are responsible for collecting and using the data for quality improvement initiatives, data required for reporting is constantly changing and is difficult to track. ***CME staff could benefit from having access to the data in a user friendly format that allows them to more easily assess what is and is not working well for families.***

Impact of Wraparound Model on Outcomes: ***All stakeholders reported that participation in care coordination services under the Wraparound model results in family empowerment***. In addition, ***stakeholders reported that, in general, participation in care coordination services under the Wraparound model results in improved youth and family resiliency and functioning***. Stakeholders also reported that youth and families who participate in the Wraparound model ***have fewer admissions to and shorter tenures in restrictive residential settings*** (e.g. Crisis Stabilization Units, Psychiatric Residential Treatment Facilities and DJJ secure facilities). Exceptions were noted based on the youth's mental health diagnosis and the family environment.

Opportunities for improvement identified by stakeholders include ***wider dissemination of the Wraparound outcome data that may be of interest to other child serving agencies,*** such as increased stability of the youth and their family, fewer higher intensive services, improved youth performance in school, and decreased recidivism to DJJ. Additional areas for future research include longitudinal post-discharge studies of family level independence, use of medical services, ***increased understanding of illness and use of psychotropic medications***, and family knowledge of navigating the child service system. With the rising use of psychotropic medication among SED youth, CMEs and FSPs can help to ***empower families to ask physicians about the medications prescribed for their youth and alternative forms of treatment.***

For Whom Does the Model Work Best: ***Stakeholders uniformly reported that the model works best for families, including caregivers*** **and** ***youth, who want to engage in the model and improve their lives***. However, there were qualifiers offered by many stakeholders. Some felt

the model worked best for families who wanted to participate and were not mandated to do so. Others felt that the model worked best for families who could be stabilized quickly, as Georgia's Wraparound model is not designed to assist with long-term problems. In particular, stakeholders identified difficulties to effectively helping youth with dual mental health and developmental delay diagnoses. Conversely, it was also voiced that Wraparound works best for the highest need youth. Several stakeholders noted that ***a challenge of the current model is that it is not designed to meet the needs of Transition Aged Youth (TAY). CMEs, in conjunction with DBHDD, must identify solutions to better meet the needs of this population***.

Summary of Findings

Youth Served

In SFY2014, 980 youth were enrolled in Wraparound through the Care Management Entities (CMEs). Lookout Mountain CME served 53% of the enrolled population, while View Point Health CME served the remaining 47%. Eighty-four percent of youth active in Wraparound were enrolled in either fee-for-service Medicaid (50%) or Medicaid managed care (34%) within six months of CME enrollment.

The majority of the youth were enrolled as Non-Waiver (83%), 61% were male, 50% were Caucasian and 39% were black. Over 60% of youth served were between the ages of 13 and 17 years. Forty-three percent of youth resided in Region 1 (i.e. Northwest Georgia) and a quarter resided in Region 3 (i.e. Metro Atlanta). Fifty-three counties in the state had no youth enrolled in Wraparound. An additional 72 counties had ten or less youth enrolled in Wraparound.

The majority of youth referred for CME services were referred from other child serving agencies (e.g., Division of Family and Children Services, Department of Juvenile Justice). Three-quarters of all referred youth were involved with one to three agencies upon enrollment.

The most common two diagnoses among active youth in the Waiver-C CBAY, MFP CBAY, and Non-Waiver categories are oppositional defiant disorder and combined attention-deficit/hyperactivity disorder. For youth enrolled in BIP CBAY, 42% of diagnoses were attributable to attention deficit/hyperactivity disorder and bipolar disorder. The majority of Waiver-C CBAY and MFP CBAY youth had severe risk CAFAS scores (($\geq$140) at intake (85% and 71%, respectively). The majority of BIP CBAY and Non-Waiver youth had moderate risk CAFAS (100-130) scores at intake (50% and 64%, respectively).
Approximately 80% of youth experienced Emotional/Behavioral challenges at enrollment.

Youth Resiliency:
Biannually, active youth are asked to self-assess resiliency, protective factors, and risk behaviors using the California Healthy Kids Survey (CHKS). Youth are given a series of statements and asked to indicate how true each statement was for them, on a scale from “Not at all true” (1) to “Very much true” (4). Results from the May 2014 administration cycle of the California Health Kids Survey (CHKS) showed that youth reported the highest average scores regarding their goals and aspirations, comfort in their home environment, and self-awareness. Youth reported the lowest average scores for self-efficacy, cooperation and communication, and problem solving. Though the CHKS test-retest reliability is low, longitudinal comparison of responses for youth also enrolled in May 2013, showed consistent responses with only slight

reductions in mean scores across all composite categories, and none were statistically significant.

Caregiver Satisfaction & Family Empowerment:

Biannually, caregivers of active youth are asked to complete two surveys: (1) the Youth Satisfaction Survey (YSS-F) and (2) the Family Empowerment Scale (FES).

Results from the May 2014 administration of the YSSF found that slightly more than half of caregivers agreed or strongly agreed with statements their child was doing well in areas of daily life, school/work, getting along with family, friends and others, and doing things he/she wanted. A majority of caregivers agreed or strongly agreed that they were satisfied with the services the youth has received. However, slightly less than half of caregivers agreed or strongly agreed that their child had improved symptoms and coping skills.

YSS-F results were compared for youth who were also enrolled during the November 2013 administration cycle. In comparing the two time periods, most of the differences between the two cycles were marginal. However, from November 2013 to May 2014, there was a seven percentage point increase in caregivers agreeing or strongly agreeing with statements that their child had improved symptoms, a seven percentage point increase in caregivers agreeing or strongly agreeing with statements that they were satisfied with family life, and an eight percentage point increase in caregivers agreeing or strongly agreeing with statements that their child was getting along better with family members. None of these differences were statistically significant.

Within the May 2014 administration of the FES survey tool, caregivers reported a fairly high level of family and service systems empowerment, particularly related to their confidence in navigating their child's behavioral health system. In comparing FES scores for caregivers who completed the FES during the November 2013 administration cycle and the May 2014 cycle, the total empowerment level of these caregivers improved by 4.2 points between November 2013 and May 2014. None of the observed differences were statistically significant.

Within the WFI fidelity monitoring tool used to assess the extent to which a CFT is adhering to the principles of Wraparound, the 83 care coordinator interviews had an average score of 87.8%, the 56 team member interviews had an average score of 86.9%, the 47 caregiver interviews had an average score of 80.6%, and the 21 youth interviews had an average score of 72.5%.

CME Discharged Youth:

Over 85% of the 683 youth discharged from Wraparound during SFY2014 were Non-Waiver youth. Similar to active youth, discharged youth primarily resided in Regions 1 and 3. Seventy counties across the state had no youth discharged from Wraparound, and 58 counties had ten or less youth discharged from Wraparound.

Time Spent in Wraparound: Length of enrollment (LOE) in a CME for discharged youth varied widely, ranging from two months to 45 months, with an average of 8.7 months. Youth in the Waiver-C CBAY program experienced the longest average LOE of 19 months. MFP CBAY youth and BIP CBAY youth had an average LOE of five months or less.

Wraparound Discharge Disposition: Slightly more than half of all youth discharged into the community upon completion of Wraparound (53%). Of those who experienced an out-of-community discharge, 26% returned to a RYDC/YDC/Jail for 30 days or more, 25% returned to a PRTF for 60 days or more and 16% returned to a PRTF for 30 days or more. Approximately one-quarter of youth "unsuccessfully opted out" of CME services. MFP CBAY had the highest proportion of youth who experienced an out-of-community discharge (49%). Only five percent of youth who discharged from a CME during SFY2014 re-enrolled and discharged within the evaluation period. The majority of re-enrolled youth experienced a neutral final discharge outcome (61%).

Youth Impairment: More than 56% of discharged youth demonstrated lower levels of impairments at the completion of Wraparound services as assessed by the caregiver using the Columbia Impairment Scale (CIS). Approximately 64% of Waiver-C CBAY, 27% of MFP CBAY, and 59% of Non-Waiver youth demonstrated an improvement in functioning. Approximately 40% of caregivers reported that youth experienced deterioration in functional impairment. Approximately three-fourths of MFP CBAY youth demonstrated higher levels of impairment at discharge compared to baseline. One-third of the Waiver-C CBAY and Non-Waiver youth demonstrated a deteriorated CIS score at discharge. However, one limitation of this analysis is the small sample size. CIS baseline and discharge scores were available for comparison for only just over half of discharged youth. Exclusion criteria include lack of baseline data for youth enrolled prior to the installation of Synthesis, missing CIS assessments and missing CIS scores.

Crisis Events: Fourteen percent of discharged youth experienced a crisis event while enrolled in a CME. No BIP CBAY youth experienced a crisis event. Collectively, 85% of all crisis events were classified as risk management. Waiver-C CBAY and MFP CBAY youth experienced the greatest percent of crisis events that were considered critical incidents (24% and 20%, respectively). The majority of crisis events resulted in an out-of-home placement (70%).

Out of Home Placements: Over 40% of discharged youth enrollments experienced an out-of-home placement (OHP). Youth who experienced an OHP were, on average, enrolled in a CME longer than all discharged youth (9.7 months vs. 8.7 months, respectively). Almost 30% of youth who experienced an OHP while enrolled in a CME were placed in a Crisis Stabilization Unit (CSU). Approximately one-fifth of youth had a DJJ or Corrections placement in a Regional Youth Detention Center (16%), Jail (3%) or Youth Development Center (1%). An additional 21% of placements included intensive treatment in either a PRTF (13%) or an inpatient hospital (8%) due to mental health needs.

School Attendance: 73% of youth who discharged from a CME had no unexcused absences, 82% had no suspensions and 98% experienced no expulsions while enrolled in Wraparound.

Child Welfare Involvement: Approximately 20% of discharged youth were involved with the child welfare system, the Division of Family and Children Services (DFCS), upon enrollment in a CME. Three-quarters of discharged youth experienced no new involvement with DFCS while enrolled in Wraparound. For the remaining quarter of youth with new DFCS involvement, the majority discharged in-community upon completion of Wraparound (78%).

Juvenile Justice Involvement: Just over 40% of all discharged youth experienced involvement with the Juvenile Justice System (JJS) during their enrollment. While only 13% of discharged youth were referred to a CME from either DJJ or the Juvenile Court System, 34% of youth experienced new involvement with JJS while enrolled in Wraparound. Six percent of youth incurred new JJS offenses, with battery, theft and runaway offenses accounting for 30% of documented offenses. One-third of youth with new offenses were placed in a RYDC. Approximately 23% of youth were placed on probation by either DJJ or the courts for the committed offenses (17% and 6%, respectively). A larger proportion of Non-Wavier youth with Juvenile Justice offenses had an in-community discharge from a CME compared to Waiver-C CBAY or MFP CBAY youth. Two-thirds of Waiver-C CBAY and MFP CBAY youth with offenses experienced an out-of-community discharge from a CME. One-quarter of youth with offenses had unknown or missing DJJ outcome data.

Wrapround Fidelity: Fidelity to Wraparound is assessed using multiple assessment tools including WFI 4 Interviews, Care Coordinator documentation in Synthesis, and IOTTA and COMET assessments. In reviewing documentation from Synthesis, essential elements of the Wraparound model are actively included during the child and family team meetings. For exmple, 86% of Care Coordinators reported that they review crisis plans, family vision and strengths, and availability of services in the community with the families. In addition, the Care Coordinators indicate that child and family team (CFT) members present ideas to help develop

and update the action plan based on family strengths and that tasks are assigned and reviewed. Action plans are reviewed with and disseminated to team members. Challenge areas include team-created resources and team-pursued community resources. More than 25% of MFP CBAY and Non-Waiver youth have no transition plan in place at discharge.

Completion of the required monthly CFTM can be challenging for Care Coordinators. For more than half of Waiver-C CBAY and Non-Waiver discharged youth and 35% of MFP CBAY discharged youth, CFTMs occurred less than once per month. Exceptions were documented for 562 CFTMs. Approximately 30% of youth required only one CFTM exception. Two to three exceptions were documented for 51% of youth. Family unavailability (50%), family member in the hospital (5%), and family relocation (5%) accounted for the majority of all CFTM exceptions. No CFTM exception reason was documented for 36% of the excepted meetings.

FSP Services: Approximately three-quarters of discharged youth received family support services while enrolled in a CME. Youth who discharged into the community experienced more frequent and longer FSP encounters than those who discharged out of the community. An overwhelming majority of discharged youth had both formal and informal/natural supports on the CFT (90%). For the majority of youth, the number of formal supports ranged between three and five. Care Coordinators and FSPs were the most common formal supports on the CFT for discharged youth, followed by Mental Health Provider/Therapist. Fifty-seven percent of youth had one to two informal or natural supports on their CFT, and an additional 39% had three to five informal or natural supports on their team. Immediate family members (i.e. mother, father or siblings) constituted the top five informal/natural supports for discharged youth.

COE Wraparound Training: The COE provides Wraparound training to CME staff, FSO staff and other direct service providers. Nine of the 13 trainings provided during SFY2014 were evaluated by participants. CME Wraparound Supervisors and Quality Assurance (QA) staff accounted for 20% of participants. Approximately half of training participants were in their role for one year or less. As a result of participating in Wraparound training, 57% of participants reported a profound mastery of training/competency after the training compared to pre-training scores. Over 60% of participants reported that they believe the training profoundly improved the quality of Wraparound teams, programs or system supports.

Georgia also participates in Master Coaching training in conjunction with other states and territories who have implemented Wraparound. The purpose of the Coaching Observation Measure for Effective Teams (COMET) analysis is to help determine if practitioners are adhering to the Wraparound model. Relative to other states, Georgia's COMET scores are moderate, falling approximately in the middle of all state scores. Items most demonstrated by CME staff involve skills around communicating and demonstrating respect, managing conflict, and

adopting a non-judgmental attitude. COMET scores suggest that care coordinators face challenges in their ability to gather sufficient information about the family's situation to appropriate facilitate the meetings and develop an individualized plan of care.

Qualitative Stakeholder Interviews

Qualitative interviews with key stakeholders were introduced as a component of the CME Annual Evaluation to better understand programmatic strengths, challenges and opportunities for improvement as perceived by a broad variety of internal and external stakeholders. Representatives from the CMEs (including care coordinators, supervisors and quality assurance staff), Family Support Organizations (FSOs) and Family Support Partners (FSPs), family advocacy organizations, DBHDD and other child serving agencies (Department of Juvenile Justice (DJJ), Department of Community Health (DCH) and Division of Family and Children Services (DFCS)) were identified by DBHDD and COE staff and invited to participate.

Stakeholders commented that CMEs are highly committed to and effective in giving families a voice. In addition, it was noted that CME staff do well relating to and engaging with families, helping them identify and address their strengths and needs, connecting them to community partners and resources, and coordinating services. Interviewers recognize that DBHDD has a strong commitment to ensuring that SED youth receive community-based care that is continuously monitored for quality improvement. Stakeholders also noted that CMEs are working collaboratively with FSOs and FSPs to better understand the roles and responsibilities of each in serving SED youth and their families.

CME staff and FSPs succeed in working with the families to help them identify and obtain resources, develop a family voice and become empowered. All stakeholders reported that participation in care coordination services under the Wraparound model promotes family empowerment. In addition, stakeholders reported that, in general, participation in care coordination services under the Wraparound model results in improved youth and family resiliency and functioning. Stakeholders uniformly reported that the model works best for families who want to engage in the model and improve their lives.

Stakeholders noted several challenges to practicing fidelity to the Wraparound model. There is a clear delineation among practitioners regarding the role of family choice in guiding the Wraparound process. Approximately half of the stakeholders believed that CMEs should honor family choice to participate in or include particular components of the Wraparound model, rather than adhere to the model itself. The COE and DBHDD continue to work with the Innovations Institute (the national technical assistance and training center for implementation and practice fidelity to the Wraparound model) to certify current Wraparound Master Trainers

to help coach providers and support ongoing fidelity to the Wraparound model. Ongoing training and coaching may help address challenges such as ensuring that CME staff and FSPs are culturally and ethnically diverse and competent and better identifying and incorporating natural and informal supports on the child and family team.

Organizational operations and system of care (SOC) infrastructure were also identified as barriers by stakeholders. Geographic decentralization of services was commonly voiced by stakeholders as a significant challenge for CMEs to effectively coordinate services for SED youth and families. The inconsistent pairing of CME staff and FSPs can inhibit the development of a working relationship and consistent communications, both of which are beneficial to serving families. Limited community partners, resources and DBHDD-contracted core providers in rural communities are other infrastructure barriers to coordinating services for youth and their families. Along this vein, stakeholders noted that additional awareness and education is needed to address the confusion many internal and external stakeholders have regarding the different programs that finance Wraparound. Finally, stakeholders reported that the current Wraparound model does not meet all of the needs of Transition Aged Youth (TAY). Stakeholders suggested that CMEs, in conjunction with DBHDD, explore additional service models that better meet the needs of this population.

As a "promising practice," High Fidelity Wraparound is currently under review for inclusion in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP). Many studies have been published evaluating Wraparound and its efficacy; however, very few of these studies have been recognized as rigorous and strong methodologically (Suter & Bruns, 2009). Due to the lack of rigorously-controlled trials, the Wraparound model maintains a "promising practice" status, rather than an "Evidence-Based Practice" (EBP) status (Suter & Bruns, 2009). It is therefore important that adopters of the model continue to monitor fidelity and evaluate outcomes.