NEW YORK STATE SYSTEMS OF CARE YEAR FOUR REPORT

November 2020

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Executive Summary

BACKGROUND

This report describes the implementation and outcomes of the New York State System of Care (NYS SOC) initiative. This four-year project, funded through a Substance Abuse and Mental Health Services Administration (SAMHSA) System of Care (SOC) Expansion grant, was awarded to the New York State Office of Mental Health (OMH) in October 2016. The grant focus was in two areas:

- Strengthening NYS child-serving systems using the SOC framework through state-wide and county-specific efforts, and

- Implementing the NYS SOC High Fidelity Wraparound (HFW) Pilot within Health Homes Serving Children (HHSC) for youth and young adults with severe mental health needs and their families.

Evaluation findings are organized into four focus areas: 1) SOC Development, 2) Training and Workforce Development, 3) HFW Practice, and 4) Family Success.

KEY FINDINGS:

SOC Development
- Service system representatives across 57 upstate counties and NYC responded to a survey about the level of System of Care implementation in their county. Knowledge of SOC was high, with 75% of respondents indicating they had a firm understanding of SOC philosophy and goals.

- The findings indicated further efforts would be helpful in strategic planning; cultural and linguistic competence approaches; youth-guided practice, SOC system infrastructure development, and the expansion and coordination of services.

Training and Workforce Development
- Care manager and peer advocates found trainings effective, relevant, and enjoyable.

- Trainees particularly appreciated interactive and hands-on activities.

- Trainees requested additional coaching and training opportunities, particularly around documenting HFW practice.

HFW Practice
- The NYS SOC pilot served 246 youths. Care managers identified the team-based approach was most helpful for families progressing through HFW.

- Overall, HFW practice in team meetings was delivered with fidelity to the model, an important component in achieving outcomes when providing a standardized practice model.

- Team meetings were particularly strong in emphasizing strengths and facilitating a family-driven and teamwork approach.

- The incorporation of natural/community supports into HFW was a challenge in many communities.

- Care managers identified some implementation challenges including maintaining full caseloads, convening regular CFTMS, and completing all four phases of the model.

Family Success
- Medicaid data analyses using propensity score matching demonstrated a positive outcome for HFW participants compared with a matched comparison group.

- Specifically, HFW participants demonstrated decreased residential treatment-related spending after enrollment, while comparison participants showed an increase over the same period. This finding suggests a reduction in residential placement following enrollment in HFW.

- HFW participants also had lower overall costs in the six months after enrollment in HFW than in the six months prior. A similar cost change was observed for a comparison group of only-HHSC-enrolled youth, suggesting that general reductions in Medicaid spending may be related to receipt of any care coordination, whether HHSC or HFW.

- Care managers reported family improvements in CANS-NY areas of trauma, behavioral health, child and caregiver needs and functioning, and child strengths.

- Caregivers reported statistically significant improvements in youth impairment and symptomology, and caregivers had a significant reduction in strain over the course of HFW enrollment. Youth empowerment and hope also improved, though not significantly.

INTRODUCTION

Introduction to New York State Systems of Care

This report focuses on the evaluation of the implementation of the New York State System of Care (NYS SOC) expansion project with emphasis on the final year of the grant. The report includes current data and evaluation findings across the project and potential next steps and conclusions.

The Substance Abuse and Mental Health Services Administration (SAMHSA) funds the System of Care expansion grant. This grant supported the implementation, expansion, and integration of the SOC approach through the creation of infrastructure and services, with the goal of improving mental health outcomes for children and youth with mental health challenges. The System of Care theoretical concept includes a definition, a framework, and core values and principles (Stroul, Blau, and Friedman, 2010).

A System of Care is defined as:

> a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life. (Stroul, Blau, and Friedman, 2010)

The current SOC expansion grant was awarded to the New York State Office of Mental Health (OMH) and began in October 2016, focusing the majority of its activities in two areas: 1) the strengthening of the NYS children's system using the SOC framework through broad efforts as well as county-specific attention, and (2) creating and operating a NYS SOC High Fidelity Wraparound (HFW) Pilot within Health Homes Serving Children (HHSC) for youth and young adults with severe mental health needs.

CHSR EVALUATION FRAMEWORK

The evaluation aims to explore both major activity areas of the grant. An organizing framework guides the evaluation activities of the Center for Human Services Research (CHSR) on the NYS SOC project. It is organized around NYS SOC's ultimate aim of identifying resources and strategies that improve the lives of families with complex needs. This framework emerged through an evaluation discussion between CHSR researchers, Nathan Kline Institute for Psychiatric Research (NKI), and OMH SOC leaders.

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

1. **Systems of Care Development:** Identify organizational strategies that lead to the successful adoption of SOC and HFW philosophies and practices.

2. **Training and Workforce Development:** Identify resources and strategies that support the development of an effective workforce.

3. **High Fidelity Wraparound Practice:** Identify the most effective HFW practices that lead to improvement of families' lives.

4. **Family Success:** Identify family/youth characteristics that are associated with attaining particular markers of success.

This report describes evaluation findings within each focus area. Each section will note major changes within the focus area over the implementation period; current findings; and potential next steps.

NYS SOC PROJECT ACTIVITIES

The following sections describe the NYS SOC project activities in the areas of statewide SOC development and the NYS SOC HFW pilot project.

Improving SOC Statewide: Changes in Implementation over Grant Period

Efforts around improving the children's system statewide have used the SOC framework to focus on the dissemination of SOC information, local SOC assessment and capacity building, and direct systems change efforts.

Concurrently with the grant, children's care coordination also shifted to an HHSC model. This model delivers tiered care coordination based on the youth's level of physical and behavioral health needs. Some of the changes that have come with the shift to the HHSC model include: peer support services becoming Medicaid-reimbursable and Home and Community Based (HCBS) Waiver being incorporated into HHSC. During the spring of 2020, requirements for in-person meetings were waived to allow for compliance with social distancing directives during the COVID-19 pandemic.

SOC Information Dissemination

Because the availability of information about collaborative cross-systems work is an important resource for local SOC development, the project used multiple methods to distribute information to child-serving providers across the state. Beginning in November 2017, the NYS Systems of Care Pilot & Wraparound Training Institute Monthly Update e-mail was distributed to relay current information on the NYS SOC project, including updates on the SOC Affinity group, the SOC Virtual Learning Collaborative, social marketing, evaluation, and the Wraparound Training and Implementation Institute. Additionally, the SOC Virtual Learning Collaborative began presenting quarterly webinars to the NYS SOC community in January 2019. These webinars highlight topics such as "Family and Youth Voice in System of Care Governance" and "County activities since the SOC Summit." Development of an informational and promotional NYS SOC HFW video began in 2020.

Local SOC Assessment & Capacity Building

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

The first NYS SOC Summit was held in September of 2018 and focused on sharing information on SOC while serving as a venue for county-level SOC development and planning. The Summit also provided a forum for representatives across the state to make recommendations to enhance the statewide SOC.

These recommendations informed several grant activities. First, a state-level Cross-Systems SOC Subcommittee was formed in December 2018 and was designed to work collaboratively to respond to the county/regional recommendations resulting from the NYS SOC Summit to strengthen the statewide SOC. Throughout the grant, NYS SOC has also focused on facilitating collaborations of other NYS System of Care Expansion grantee sites (i.e., Cayuga County, Chautauqua County, Herkimer County, Otsego Country, Rockland County) in order to share resources, grant project learning and collaborate on common project components.

Further, in January 2019, baseline SOC implementation was assessed statewide through a survey. The subsequent report helped counties to determine their level of SOC implementation both in an absolute sense and as compared to other counties in NYS. A follow-up assessment occurred in January 2020, so that changes in SOC implementation over time could be explored.

Another activity resulting from the Summit was the creation of a standardized SOC 101 training in February 2019. The NYS SOC Project Director delivered this training to six groups. An additional standardized SOC 201 training, targeted at county governance's efforts to assess SOC implementation and sustainability, was released in March 2019. A facilitator guide and a slide deck were made available for both SOC 101 and SOC 201 so that staff could hold local SOC presentations and conversations. Presentations of these materials are sometimes led by the state team as well, as was the case for Madison County in October 2019.

In summer 2019, Policy Research Associates, Inc. designed a curriculum for facilitators to plan and implement SOC workshops in nearby communities. The curriculum was based on the Sequential Intercept Model, originally developed to help communities map the flow of children, services, and supports within the juvenile justice system. Within the SOC framework, the goals of these workshops are to bring together high-level system stakeholders in order to understand the flow of children through various child-serving systems in their community, while also identifying gaps and needs in the systems and network. Two cohorts completed training to learn how to facilitate these workshops in the final year of the project. The first training was conducted in person in November 2019 with 25 facilitators. In the spring 2020, the training was converted into a virtual format due to the pandemic, and was conducted with an additional 35 facilitators, who completed the training over five sessions from June to July 2020.

The ideas gathered at the Summit also led to the delivery of local SOC technical assistance by the Project Director. This assistance became available in April 2019 and was delivered to Essex, Rockland, and Yates counties, with the goal of supporting them as they built local SOC capacity. Continued efforts to build local SOCs has been incorporated into the next SOC expansion grant workplan.

An additional NYS SOC Summit had been planned for September 2020 but had to be canceled due to COVID-19.

Direct Systems Change Efforts

Many efforts of the NYS SOC project were directed towards building partners who could serve as advocates of the NYS SOC initiative, in particular Children's Single Point of Access (C-SPOA), schools, Community Schools Technical Assistance Centers and Regional Interagency Technical Assistance Teams (RiTATs).

As of September 2019, C-SPOAs role shifted to act as coordinators of their local SOCs with enhanced funding from NYS OMH. The role of counties' C-SPOAs shifted away from assessments/level of care determinations and towards coordinating, development, and maintenance of the local SOCs. This shift facilitated the creation of a consistent point of contact and local lead for SOC opportunities throughout the state.

There were also efforts to integrate the SOC framework within schools as evidenced by collaborations at both the state and county level. NYS OMH partnered with NYS Department of Education, under a separate SAMHSA grant, to work on Project AWARE (Advancing Wellness and Resilience in Education), a program aimed at promoting the healthy development of school-aged youth and increasing access to mental health services by focusing on building partnerships and expanding collaboration between state and local systems. School districts in one county focused on integrating the SOC framework by adding policies on "how to use SOC" to their district handbooks. The Project Director also delivered the SOC 101 presentation to the Project AWARE sites, thus strengthening SOC knowledge in schools. In 2020, efforts began to assist in the completion of SHAPE (School Health Assessment and Performance Evaluation System) assessments to a sample of school districts. SHAPE is designed "to support mental health quality improvement."[1]

NYS OMH further facilitated partner development and collaboration through the internal management of RiTAT activities and financial resources, which allowed them to be tied more closely to SOC efforts statewide. RiTATs act as liaisons between stakeholders, identify and address regional barriers, provide cross-systems training and technical assistance on local and regional levels, and promote services that are reflective of SOC values.

In addition to the larger state-level partnerships, policies were established over the four years of the grant between counties, providers, and community organizations to better facilitate cross-systems collaboration and to strengthen SOC work at the local level. These formal arrangements included streamlining referral and enrollment processes, facilitating workflows, guiding service provision, and establishing regular meetings with SOC stakeholders. These efforts help to promote and ensure that local systems work collaboratively and remain aligned with SOC values.

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[1] See https://www.theshapesystem.com/

NYS SOC High Fidelity Wraparound Pilot

OMH's second major grant activity area was creating and operating a NYS SOC High Fidelity Wraparound (HFW) Pilot within Health Homes Serving Children (HHSC) for youth and young adults with severe mental health needs. HFW is a specialized care coordination practice model as described below.

> Wraparound is a planning process that follows a series of steps to help children and their families realize their hopes and dreams. The Wraparound process also helps make sure children and youth grow up in their homes and communities. It is a planning process that brings people together from different parts of the whole family's life. With help from one or more care coordinators, people from the family's life work together, coordinate their activities, and blend their perspectives of the family's situation. Wraparound is an intense form of team-based care coordination that is designed for the youth with complex mental health needs and their families and represents an individualized way a community can implement SOC values in their care coordination. (Miles, Bruns, Osher, Walker, & National Wraparound Initiative Advisory Group, 2006/2019)

NYS SOC HFW is guided by the National Wraparound Initiative's (NWI) HFW model. Initially, NYS SOC HFW was facilitated by a triad of a care manager, a youth peer advocate, and a family peer advocate. Grant activities focused on HFW scope, practice, training, and information dissemination.

Scope

The NYS SOC pilot has expanded rapidly over the duration of the grant. HFW was initially implemented in four agencies. Over the course of the grant, it expanded to 18 agencies across the state. At the end of the third quarter of Year Four, HFW is being implemented in 14 agencies. The first youth and family was enrolled in HFW in April 2017, with a total of 246 families being served by the end of the third quarter of Year Four. The following table displays the distribution of youths enrolled per participating region and agency.

Table 1. Youths Enrolled by Agency and Region, Total and Current

County/Region	Agency(ies)	Total # Enrolled	% of Total Enrolled	Current # Enrolled	% of Current Enrolled
Westchester County*	Mental Health Assoc. & Westchester Jewish Community Services	49	20%	17	16%
Rensselaer County*	County Mental Health	34	14%	16	15%
Erie County*	New Directions	34	14%	0	0%
Cayuga County	Cayuga Counseling	21	9%	7	6%
Oneida County	Integrated Community Alternatives Network	16	7%	10	9%
Bronx County**	Astor Services for Children & Families	14	6%	10	9%
Kings County**	SCO Family of Services	13	5%	10	9%
Rockland County	Mental Health Assoc.	12	5%	11	10%
Broome County	Catholic Charities	12	5%	7	6%
Chenango County	Catholic Charities	10	4%	5	5%
Orange County	Rehabilitation Support Services	9	4%	5	5%
Suffolk County	Family Service League	5	2%	5	5%
Otsego County	Rehabilitation Support Services	5	2%	3	3%

County/Region	Agency(ies)	Total # Enrolled	% of Total Enrolled	Current # Enrolled	% of Current Enrolled
Waiver Sites					
Franklin County	Citizen Advocates, Inc.	7	3%	2	2%
Essex County	Families First of Essex County, Inc.	2	1%	0	0%
Steuben County	Pathways, Inc	2	1%	0	0%
Kings County	JCCA	1	0%	0	0%
Total		**246**	**100%**	**108**	**100%**

Note: Data as of 6/30/20. * indicates original pilot site. **Indicates that NYC DOHMH has a self-funded demonstration project that is collaborating with the NYS SOC project.

HFW delivery was initially restricted to those not already served through the HCBS Waiver but was expanded in July 2018 to include families that were eligible for Waiver services. In June 2019, the population served by HFW was further expanded to include youth in Residential Treatment Facilities (RTFs)[2]. At the end of Year Four quarter three, HFW is currently delivered in agencies in the Central, Hudson River, Long Island, and New York City regions (NYS OMH regions).

Practice
Several practice changes were integral to the delivery of HFW. Original pilot sites were provided an initial monitoring tool in the winter of 2018 to help guide practice changes. This tool was completed by the state project team members and provided feedback on early HFW implementation. In September 2018, the HFW delivery method formally shifted away from a "triad" facilitation model, with shared facilitation between the care manager, youth peer advocate, and family peer advocate, to a model where the care manager serves as the team facilitator and peer support service providers serve as facilitation team members.

In November 2018, care managers also shifted from using an excel-based documentation system to a website-based documentation system (Wrap-NY) to document their wraparound work. This system helps service providers organize information needed to carry out the HFW process. Having all HFW documentation in one location also allows for the streamlining of evaluation and coaching activities; Now, coaches and evaluators only have to look in one location to review all HFW-relevant documentation related to an enrollee. In June 2020, Wrap-NY based report cards were finalized and will be introduced to sites to provide valuable feedback on documentation completeness and fidelity attainment to support continuous quality improvement of practice.

The COVID-19 pandemic beginning in March 2020 necessitated shifts in focus for HFW implementation. Providers shifted much support to ensuring family safety and that basic needs were met, while shifting the practice model to virtual delivery.

Training
In April 2017, the Wraparound Training and Implementation Institute (WTII) created the six-month comprehensive NYS SOC HFW Certification Training for care managers and supervisors. The HFW training process was designed to be delivered through two-day in-person monthly classroom training sessions, with the topics of: Supporting Wraparound Implementation, Foundations of Wraparound Part 1 and 2, Deeper Towards Fidelity, Enhanced Child and Family Team Meetings (CFTMs), and Transition Begins at Hello. Supervisors were encouraged to attend the training as well, so that they have the knowledge and skills needed to support care managers.

Delivery of the training for the first cohort began in November 2017, and since then, six cohorts from five OMH regions have completed the HFW training. OMH Certification requirements (e.g., coaching and webinars) were created to accompany this training to help care managers further develop HFW skills. In 2020, coaching was enhanced by

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[2] Please note that RTF youths are not included as part of the evaluation.

increased use of the Practice Review Tool, which is used by both supervisors and coaches to monitor HFW at the family level. With the emergence of restrictions discouraging close in-person contact and encouraging social distancing due to COVID-19, the training was rapidly adapted to a virtual format, using primarily video lecture, video conferencing activities, and assignments. The virtual training is slated for delivery in summer 2020.

WTII, along with the Family Engagement Specialist and Youth Wraparound Implementation Coordinator, also created and piloted an additional training to help support peers in serving families involved with HFW. The three-session Peer Participation in Wraparound Training began in February 2019 and was completely piloted with four cohorts. In 2020, Regional Parent Advisors and Regional Youth Partners were trained to teach the material and deliver the peer training across the state. Since then, one cohort has completed this training. The transfer of training responsibilities to the Regional Peer Advocates increases the reach and the sustainability of the training. This training was also adapted to a virtual format in summer 2020. These trainings are supplemented with regular group coaching calls which cover topics such as "Peer Service delivery in Wraparound using the CFTSS services" and "Wraparound and Engagement." These calls are interactive and allow advocates to learn from each other's experiences.

In addition, ten Cultural and Structural Competence and Health Habitus Integration (CSC/HHI) trainings were conducted by the Center for Research on Cultural and Structural Equity in Behavioral Health (C-CASE) at the Nathan Kline Institute for Psychiatric Research. The first three were two-day trainings; the remaining trainings consisted of a one day in-person training and a one-hour webinar refresher. In summer 2020, the curriculum was converted to a virtual format.

HFW Information Dissemination

A couple activities were focused on disseminating information about HFW. The Wrapaganza event was held in August 2019 and served as a celebration of SOC and HFW practices, as well as a learning and networking opportunity for the NYS SOC HFW providers. Additionally, an informational and marketing video about HFW is in production by Overit at the time of this report.

TIMELINE

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

Table 2. Timeline of SOC expansion and the HFW pilot

Year 1	
Quarter 1 (Oct. 2016 – Dec. 2016)	• SOC Expansion grant received
Quarter 2 (Jan. 2017 – March 2017)	• Initial meetings with sites, partners, and cross-systems committees held • Enrollment and evaluation protocols finalized
Quarter 3 (April 2017 – June 2017)	• Youth enrollment initiated
Quarter 4 (July 2017 – Sept. 2017)	• Wraparound Training and Implementation Institute established
Year 2	
Quarter 1 (Oct. 2017 – Dec. 2017)	• HFW Certification Training started • NYS SOC Pilot and Wraparound Training Institute monthly update started
Quarter 2 (Jan. 2018 – March 2018)	• Monitoring tool for the initial pilot sites released
Quarter 3 (April 2018 – June 2018)	• Service population expanded to HCBS Waiver enrollees
Quarter 4 (July 2018 – Sept. 2018)	• NYS SOC Summit held • SOC Social Marketing Toolkits delivered • Team structure shifted (Peer support service providers as team members)

Year 3	
Quarter 1 (Oct. 2018 – Dec. 2018)	• Collaboration with Project AWARE began • Wrap-NY system website introduced • State level Cross Systems SOC Subcommittee formed
Quarter 2 (Jan. 2019 – March 2019)	• NYS SOC baseline assessments conducted • Wraparound Readiness Training for Peers started • SOC 101 and SOC 201 created
Quarter 3 (April 2019 – June 2019)	• Service population expanded to RTFs • Local SOC technical assistance provision from SOC Project Director began
Quarter 4 (July 2019 – Sept. 2019)	• Wrapaganza held • C-SPOA coordinating role in SOC introduced
Year 4	
Quarter 1 (Oct. 2019 – Dec. 2019)	• First SOC TOT facilitator training held
Quarter 2 (Jan. 2020 – March 2020)	• Practice Review Tool use expanded
Quarter 3 (April 2020 – June 2020)	• NYS SOC Report Cards developed in Wrap-NY • Virtual SOC TOT facilitator training delivered
Quarter 4 (July 2020 – September 2020)	• New SAMHSA SOC expansion grant awarded • NYS SOC Promotional/Informational video created

REPORT DATA SOURCES

This report incorporates data from many different sources to explore data findings in the major focus areas of the evaluation framework: *Systems of Care Development, Training and Workforce Development, High Fidelity Wraparound Practice, and Family Success*. A more detailed description is available in Appendix A. Data sources include data collected through Year Four of the project, unless otherwise specified. The follow data sources are examined in this report.

- **Infrastructure, Development, Prevention and Mental Health Promotion (IPP) data collection:** Data is collected quarterly from project leads and monthly from county leads to document SOC infrastructure changes, including policy changes and formal collaborations.

- **SOC implementation survey:** The SOC Implementation Survey provided a baseline and a follow-up assessment of current SOC implementation at the local level. The survey was completed by individuals identified as important to the local SOC by the SPOA and/or local lead contact.

- **NYS SOC Wraparound Certification Training surveys:** Training surveys are collected from attendees following each session. This survey solicits feedback on training style/format, segment specific impression, knowledge acquisition, and overall impression.

- **Peer Participation in Wrapround Training surveys:** Training surveys are collected from attendees following each session. This survey solicits feedback on basic impressions of the training.

- **Cultural and Structural Competence and Health Habitus Integration training qualitative interviews:** Follow-up in-depth qualitative interviews were conducted at least three months after training to explore trainees' familiarity with the information imparted in the training, but more importantly, reveal whether and how trainees integrate the strategies and tools they acquired in the training into their HFW practice.

- **Administrative records:** Administrative records collect demographic and service data on every family. They were completed by the HFW team at baseline, six-month reassessment intervals, and discharge.

- **CANS-NY:** The CANS-NY is an assessment tool completed by the care manager with the family. It identifies needs and strengths of the youth (primarily) and caregiver in various health and functioning domains. This tool is completed at baseline, reassessments, and discharge, so changes over time can be reviewed.

- **Interviews with youth and family:** The opportunity to participate in evaluation interviews is offered to each participating family (youth and caregiver, or young adult) at baseline, six-month reassessment intervals, and discharge. These interviews include assessments of functioning, social support, empowerment, hope, and satisfaction. The SAMHSA-required National Outcome Measures (NOMS) are part of these interviews.

- **Medicaid data:** Medicaid data for HFW participants enrolled as of June 2019 and a matched comparison group, including number of claims/visits, length of visits, and cost of care for the period prior to, during, and post HFW/care coordination.

- **Fidelity assessments – observation and surveys:** Observation (TOM 2.0) and survey (WFI-EZ) fidelity assessments were conducted between the third through the seventh team meeting. These tools measure the extent to which practice reflects the HFW model.

- **Fidelity assessments – documentation review:** Document review was conducted using the documentation available in the Wrap-NY system website. Two review types are currently in use: the 45-Day Review and the Second CFTM Review. These tools measure the extent to which practice reflects the HFW model.

- **Project reflection survey:** This survey solicited feedback from care managers on HFW implementation and feedback on the pilot project, including HFW during COVID-19 social distancing restrictions.

SECTION 1:

System of Care Development

Section I:
System of Care Development

INTRODUCTION

The concept of SOC provides a framework with values and principles to guide the field in reforming child serving systems, services, and supports to better meet the needs of children and youth with or at risk for mental health challenges and their families (Stroul, Blau, & Friedman, 2010). The SOC philosophy supports the development of SOC infrastructure to best guide services and supports for children (Stroul, 2002). In addition, there is evidence that SOC infrastructure impacts HFW implementation. For instance, studies suggest that system factors, such as greater support, lead to higher fidelity (e.g., Bruns, Suter, & Leverentz-Brady, 2006).

Although individual communities across the state have received support from SAMHSA to build and expand SOCs for many years, this grant represents the first time this support has been awarded at the for statewide intervention. The development of extensive infrastructure and ongoing support is necessary to expand and sustain the use of SOC philosophy over the course of the grant and beyond. This opportunity allows OMH to be the leader in SOC and deliver a consistent message that can guide local SOC development throughout the state.

The goal of this section is to identify organizational strategies that lead to the successful adoption of SOC philosophy and values in NYS. The following sections outline: 1) activities that have impacted SOC development over the past several years, 2) evaluation findings relevant to SOC development, and 3) potential next steps.

ACTIVITIES RELEVANT TO SOC DEVELOPMENT

Below is a list of SOC development related events and activities that have taken place during this grant.

- **Shift to the HHSC model:** Children's care coordination shifted to an HHSC model, which provides tiered care coordination based on level of need and increases the availability of services for Medicaid youth.

- **Change in role of C-SPOA:** C-SPOAs now coordinate development and maintenance of the local SOCs.

- **Collaboration with Project AWARE:** This project builds school participation with local SOCs.

- **SOC workshops:** These workshops build within-county collaboration and develop local goals around children's services.

- **Shift in RiTAT management:** OMH began managing these regional groups that meet regularly and are important for SOC information dissemination.

- **SOC 101 & 201:** These curricula were developed for counties to deliver local SOC training.

- **Social marketing toolkits:** These toolkits were developed for counties to market the local SOC and HHSC.

FINDINGS

SOC Implementation

In Years Three and Four, a survey was distributed statewide to understand more about SOC implementation at the county-level. This section reviews the overall findings (for additional information, see full System of Care Implementation in New York State 2020 Report).

County representatives from child-serving systems received the SOC Implementation survey (adapted from Stroul, Dodge, Goldman, Rider, & Friedman, 2015) which is designed to "...assess progress in a community or region implementing

the SOC approach…" The Year Four survey was administered from February 5 to March 2, 2020, with a response rate of 51% (578 out of a possible 1071), with responses from 57 upstate counties and NYC (94% of all counties).

Findings between 2019 and 2020 were similar among many components of the survey. Several areas, including strategic planning for the SOC approach and subscales of the service delivery guided by SOC values and principles (i.e., youth-guided, evidence-informed, service array, and data and accountability), showed statistically lower scores in 2020. Even in these cases, mean differences between 2019 and 2020 were small.

Table 3. Mean Scores on Survey Areas and Subscales in 2019 and 2020

	2019	2020
Strategic planning*	2.28	2.01
Principles*	2.58	2.44
Individualized Wraparound Approach	2.70	2.63
Family-Driven Approach	2.80	2.71
Youth-Guided Approach*	2.38	2.23
Coordinated Approach	2.68	2.61
Culturally and Linguistically Competent Approach	2.17	2.07
Evidence-Informed Approach*	2.55	2.39
Least Restrictive Approach	2.76	2.64
Service Array*	2.32	2.11
Data and Accountability*	2.68	2.54
Services	2.24	2.13
Home- and Community-Based Treatment	2.27	2.18
Out-of-Home Treatment	2.10	2.04
Infrastructure	2.15	2.10
Commitment	2.47	2.41
Child-Serving Systems	2.43	2.34
Policy and Decision Makers	2.39	2.35
Providers	2.79	2.73
Family and Youth Leaders	2.65	2.63
Managed Care Organizations	2.36	2.31
Overall Assessment	2.26	2.17

*Note. * indicates a significant difference, p < .05.*

Results of the 2020 survey indicated that knowledge of SOC was high, with 75% of respondents indicating they had a firm understanding of SOC philosophy and goals. In contrast, just over one-third of respondents reported that the SOC approach was being implemented "substantially" or "extensively" in their community.

Figure 1. 2020 Responses to the item "To what extent do you believe that the system of care approach is being implemented in your community or region?"
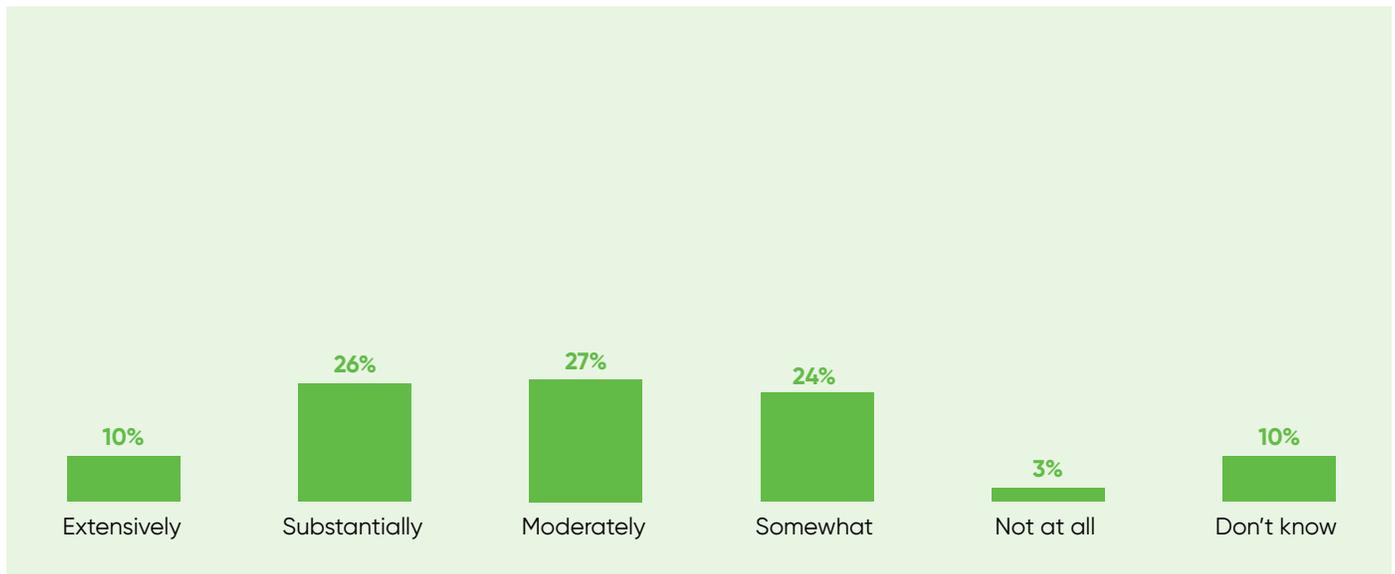
In addition to overall findings, results can be reviewed by several breakout groupings, such as: service system, region, counties with/without an NYS SOC pilot site, and recent receipt or no receipt of SOC training/TA. These breakouts revealed some interesting findings, detailed in the following table:

Table 4. Findings by breakouts

By service system	Respondents from schools consistently reported lower SOC implementation compared to respondents from other service systems.
By region	The Long Island, Mid-Hudson and Western regions had consistently higher average scores compared to NYS averages in nearly all domains of the survey, reflecting stronger SOC implementation in these regions.
By county with a pilot site	Respondents from counties with NYS SOC pilot sites consistently scored higher than respondents from counties without NYS SOC pilot sites on all domains of the survey.
By receipt of SOC training/TA	Respondents who reported receiving SOC training or technical assistance (TA) also reported stronger SOC implementation than those who had not received such support[3].

There was little evidence of regional SOC development. Notably, the county-level breakouts within the regional profiles demonstrated that there was often variation within a region, with most regions having some counties with mostly high and others with mostly low average responses compared to state averages. The Long Island region was an exception, such that both Suffolk and Nassau counties scored similarly.

The following scatterplot maps 2019 and 2020 scores per county (for those with adequate data for both years). Those in the bottom left quadrant score consistently lower, whereas those in the upper right quadrant scored consistently higher. Those in the lower right quadrant scored lower in 2019 and higher in 2020, thus showing improvement. Those in the upper left quadrant scored higher in 2019 and lower in 2020, displaying a reduction in SOC implementation. Counties with high SOC implementation in both years were, in general, either connected to the NYS SOC project by having a pilot site or were a county located in the Long Island region.

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[3] However, these patterns were not generalizable to the county level, as often some respondents within a county reported receiving such assistance but others within the same county did not. In addition, individuals requesting training and TA may be more knowledgeable of SOC or more engaged in SOC in the first place, which leads them to seek additional learning opportunities.

Figure 2. Scatterplot of 2019 and 2020 county averages
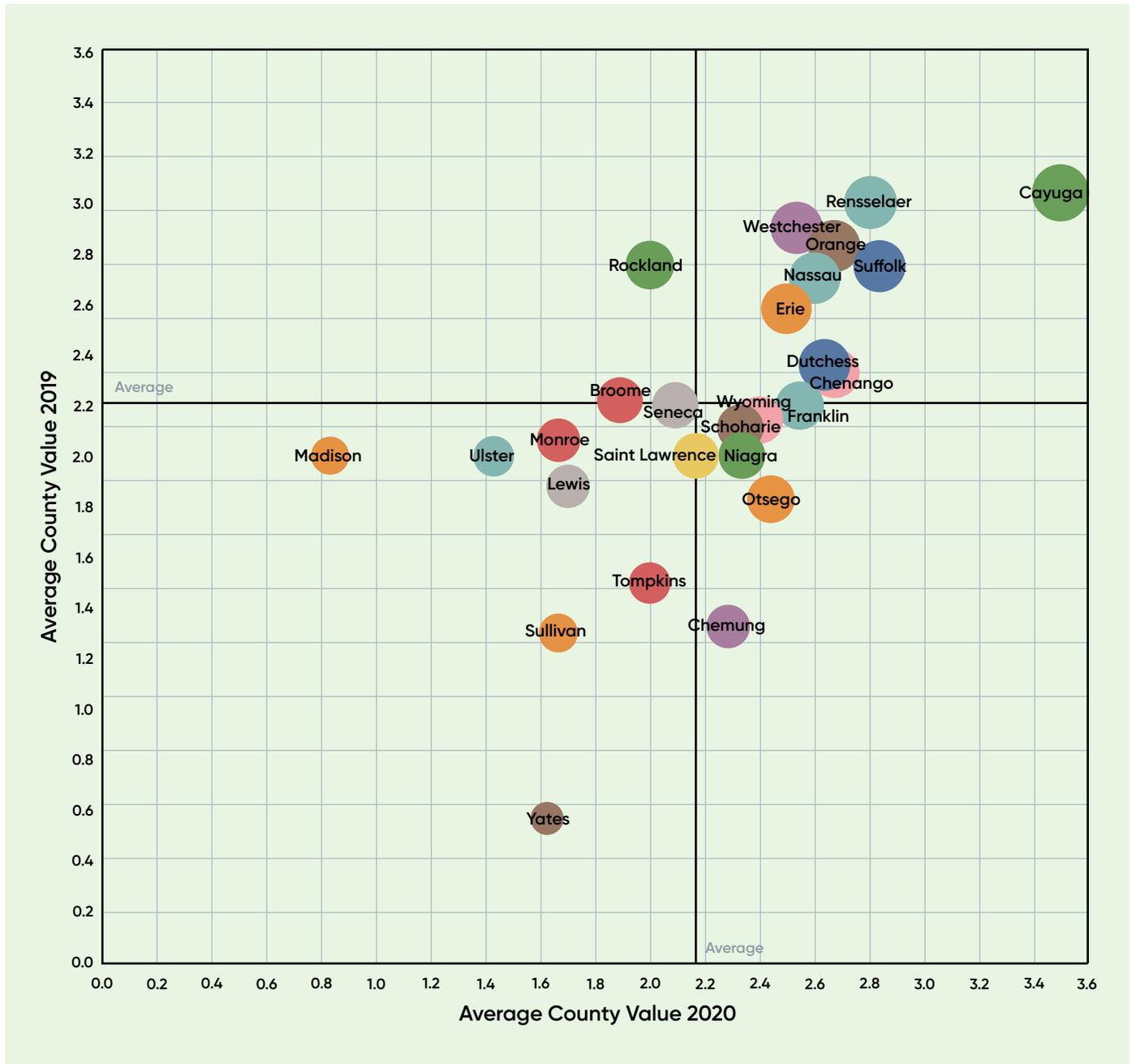
Relative to sampling and survey distribution procedures in 2019, 2020 procedures focused on only the most relevant stakeholders serving children and youth in each county. However, there were still high proportions of "don't know" responses throughout the survey, potentially indicating that some partners identified as important to the SOC were not aware of SOC-relevant activities. This pattern indicates there could be a benefit to increased local communication around SOC. The items that exhibited the highest percentages of "don't know" responses were regarding the existence of strategic plans (51%) as well as for current and planned HFW implementation (52% and 61% respectively). The items with the lowest percentages of "don't know" responses were regarding receipt of SOC training and TA in the past year (6%) and availability of the home- and community-based service of outpatient individual therapy (8%).

The results suggest little change in the implementation of SOC across NYS in the past year; in general, average scores remained in the "moderate" implementation range. In areas that significantly decreased between 2019 and 2020 (i.e., strategic plans, and service delivery guided by SOC values for: youth-guided, evidence-informed, service array, and

data and accountability), the average difference in means was quite small. However, respondents reported a greater understanding of SOC in 2020 compared to 2019 (75% compared to 66%). Improving implementation can be challenging, but expanding knowledge of SOC is an important first step to develop an SOC.

SOC Implementation Survey: Key Qualitative Findings

Several respondents (N=108; 19% of total) on the System of Care Implementation survey responded to a final open-ended question asking whether they had anything else they would like to share. Responses were qualitatively coded using a grounded theory approach in which categories and themes were developed inductively. Two coders analyzed responses, first by developing categories independently, then developing a single list of categories through discussion. These categories were then independently assigned to sets of 10% of responses until coders agreed on 80% of assignments, revising the categories throughout. Coders then recoded the rest of the responses independently and reconciled differences through discussion. Categories were then grouped into themes. For more description of themes, categories, and category definitions, please see Appendix B. The following narrative identifies categories in bold and italics.

Many responses were substantial and specific about issues within the respondents' local System of Care. Most comments were critical, often describing a ***shortage of available services*** and service providers needed to meet the complex challenges of families within their communities. Many of these descriptions pointed to Medicaid Redesign Team (MRT), the New York State initiative to improve quality and efficiency of healthcare, as a cause of their current challenges. The most consistently and clearly articulated ***negative effects of MRT*** was its influence on service eligibility criteria and reimbursement rates. Respondents related that under MRT fewer families are eligible for services and that rates are not commensurate with the level of effort required to meet families' needs. Some suggested that low reimbursement rates disincentivizes employment within the service provider profession, another factor constraining the supply of services. Some also said MRT has created a competitive, reimbursement-focused environment that detracts from the needs of families. Specific services or resources identified as lacking included outpatient mental health services, peer services, crisis services, and psychiatric hospitals.

Another service-reimbursement issue several respondents described was the development of "two systems of care" (respondent's words): a ***private and a Medicaid*** system of care. These respondents posited that privately-insured youth lacked access to residential care and crisis stabilization services and often fell into eligibility gaps, while services for Medicaid recipients were ample because of Medicaid's higher reimbursement rate and more comprehensive array of reimbursable services. Thus, while some respondents found Medicaid reimbursement to be insufficient, others said private insurance supported even fewer service options.

Some respondents also described the downstream negative effects of unmet family mental health needs. They said that unmet needs drove some families to seek more intensive inpatient services, only to be released back into an inadequate network of outpatient services, followed by a return to inpatient services. A couple of respondents provided a very clear description of this phenomenon of cycling in and out of out-of-home placements due to "watered down" (respondent's words) services. Thus, the net effect of insufficient services described by respondents was outstanding mental health challenges, which for some families escalated to crisis.

Respondents identified other factors that created service gaps, including barriers to access due to service system ***navigation difficulties*** and longstanding ***service coordination issues***. These are the issues that SOCs were designed to address. Their mention indicates the fundamental need for a System of Care framework remains. However, several respondents expressed a lack of confidence in the System of Care movement. Some pointed out that they are often presented with ***excessive changes to SOC*** in the form of new plans or informed of structural changes before they have had enough time to allow current plans or structures to succeed. Others said that the System of Care movement proposes admirable values, but that it is ***difficult to actualize SOC*** in concrete policies, infrastructure, and service provision, at least not with the current ***inadequate funding***.

Others expressed more hope in the System of Care movement, suggesting specific improvements including creating ***better strategic or sustainability plans*** and ***increasing representation***, particularly among members of the peer advocacy community, in mental health administrative and decision-making bodies. Thus, while the work of SOC remains unfinished, trust in its promise among stakeholders is inconsistent.

Other features of the System of Care respondents identified as positive or negative depending on the respondent included the **commitment to their SOC among leadership** and the level of SOC knowledge needed to advance the SOC aims. Some said their local leaders were committed while others found leadership commitment lacking. Some said key stakeholders (e.g., providers) **lacked knowledge of SOC** values, principles, infrastructure, or practices to carry out their work, while others described stakeholders as engaged in **efforts to increase knowledge about SOC** components (e.g., through workshops).

In addition to responses about specific challenges or possible improvements to the local and state level SOCs, some respondents commented on the general state of their local SOC. Some said their **SOC was strong**; others said their **SOC was in development** or they were acting on opportunities to enhance their SOC; while others described that their local **SOC was deteriorating**. Notably, two respondents said the decline they observed in their communities was related to difficulties sustaining the improvements they were able to make because of past SAMHSA funding for a System of Care grant.

Thus, responses to the SOC implementation survey were primarily critical, focusing on unmet mental health needs stemming from insufficient services, with some respondents suggesting Medicaid Redesign was driving these insufficiencies. Less commonly identified but noteworthy SOC challenges were service system complexity and a lack of coordination, excessive changes to SOC, and difficulties in actualizing the ideals of SOC. Some respondents offered solutions to current challenges, such as creating better strategic or sustainability plans and increasing representation of key SOC stakeholders, particularly peer advocates, in decision-making bodies. Responses also highlighted the variation across localities in current SOC functioning. Some described generally strong local SOCs, leadership commitment, and stakeholder knowledge of SOC, while others described inadequacies in these areas or said their SOC was in general decline.

Strategic Plan Research Brief

The data gathered from the 2020 SOC Implementation Survey also led to some interesting findings specific to strategic plan development and implementation. The current report contains a summary of the findings; for more information please see the System of Care Development Research Brief: Examining Implementation of Strategic Plans across New York State Research Brief.

Facilitating strategic plans is the first step towards SOC development and implementation. A strategic plan is described as "the blueprint for expanding the system of care approach" (Dodge, 2014) and is therefore critical to implementing an SOC that comprehensively and holistically serves children and youth in the community. Due to the statewide focus on coordinated care and cross-systems collaboration, one would expect most NYS counties to have a plan in place. However, developing and using a strategic plan can be difficult, especially in the absence of external funding, staff time, and/or targeted guidance. One way such resources may be available is through a connection to a Substance Abuse and Mental Health Services Administration's (SAMHSA) System of Care expansion grant (SOC grant), either through receiving a grant directly or connecting with NYS SOC (the state level SOC grant). Thus, counties with access to an SOC grant would be expected to have more developed strategic plans compared to counties without this resource.

The following sections describe: the importance of the strategic plan in overall SOC implementation, the extent to which NYS counties have implemented a strategic plan and if it is an area of need, and whether counties without access to an SOC grant have less developed strategic plans. Results are intended to identify where to target future strategic plan development efforts.

Results from a regression model showed scores on having an existing plan for the SOC approach was a significant predictor of overall SOC implementation even after controlling for the implementation scores of each of the other major areas, $b = .094$, $t(154) = 2.81$, $p < .01$., suggesting that efforts towards advancing a strategic plan are beneficial towards SOC implementation as a whole. Open-ended responses also reflected the perceived benefit of creating and using a strategic plan. In particular, several respondents tied creation of a plan to addressing some of the challenges introduced by MRT. As one respondent noted, "It is very disheartening that the financial state of the SOC is causing regions and agencies across the state to not be able to support [our] wonderful services. I hope that we can come up with a plan to continue to provide these services to the youth in our care." Another respondent wrote, "...the communication, collaboration, accountability, genuine care, outcome driven approaches, and inclusive approach among and between systems is lacking. Perhaps an appointment of a lead agency to create an SOC oversight plan is in need and could

be part of the solution." Thus, some stakeholders are suggesting the development of a plan as a first step toward addressing children's service needs, particularly to address difficulties stemming from Medicaid Redesign.

Despite recognizing that importance of SOC plans, creating and using such a plan was a challenge for counties. Of the five major areas of implementation, the area with the lowest average implementation score was the extent to which there was an operating strategic plan for SOC implementation (see Figure 3). Further, only 15% of respondents indicated that a formal written plan was used extensively in their county. These data suggest that communities tended to struggle with creating and implementing this critical aspect of SOC development. In addition, responses to the item asking about the existence of a strategic plan yielded a very high proportion of "don't know" responses; the majority of respondents (51%) reported that they did not know the extent to which their community had developed or used a strategic plan. This could indicate that either a plan does not exist, or that it does exist but is not widely disseminated to all the vital child-serving partners in the county; either way, communication around a strategic plan seems to be an area of need. The lower implementation score coupled with the importance of this implementation area indicates this is an area to focus improvement efforts.

Figure 3. Mean implementation scores for five major SOC focus areas[4] (N=261–361)
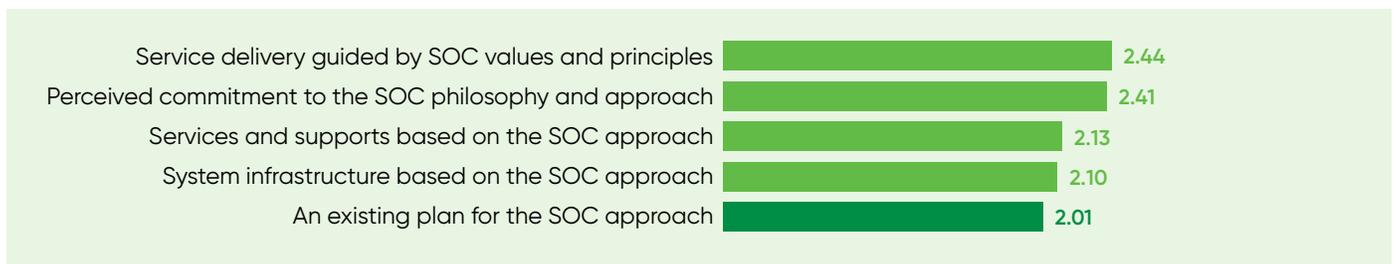
As shown in Figure 4, strategic plan awareness and use were impacted by involvement in either statewide or local SOC efforts, such that those counties who either had a NYS SOC pilot site or were recently awarded a SAMHSA SOC grant were more likely than other counties to have and operate a strategic plan, $t(258) = 4.39$, $p < .001$ and $t(258) = 6.24$, $p < .001$, respectively. Figure 5 shows that extensive use of a formal written strategic plan was more prevalent among respondents from counties with pilot sites (X^2 (1, N = 542) = 30.38, $p < .001$) and SOC grants (X^2 (1, N = 542) = 45.04, $p < .001$) compared to those without. Lower rates of reporting "don't know" of the existence of a strategic plan were observed among respondents from counties with pilot sites (X^2 (1, N = 542) = 10.71, $p < .001$) and SOC grants ($X2$ (1, N = 542) = 17.03, $p < .001$) compared to those without, which may indicate better communication and dissemination of strategic plans among relevant partners. Taken together, this information suggests that assistance to create strategic plans should be targeted to counties not currently involved in the NYS SOC pilot and who do not have an SOC grant.

Figure 4. Mean implementation scores on strategic plan focus area, for counties with (N=103) and without (N=157) a pilot site and counties with (N=35) and without (N=225) a recent SOC grant
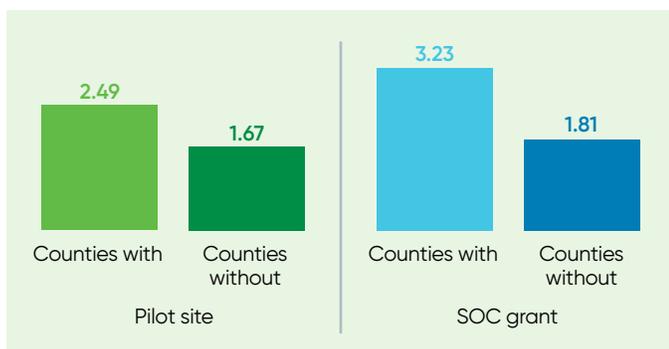
Figure 5. Percentage indicating plan used extensively and don't know if strategic plan exists, for counties with (N=103) and without (N=157) a pilot site and counties with (N=35) and without (N=225) a recent SOC grant
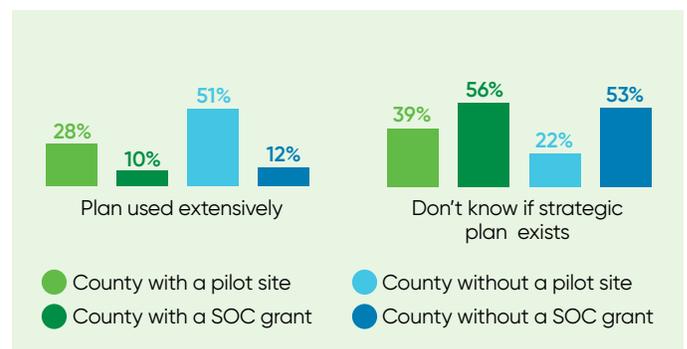
[4] Ns for the different SOC implementation areas ranged from 261–361: an existing plan for the SOC (N=261), system infrastructure based on the SOC approach (N=354), services and supports based on the SOC approach (N=338), perceived commitment to the SOC philosophy and approach (N=304), and service delivery guided by SOC (N=361). Most variation in Ns is due to variation in proportion of "don't know" responses.

Policy Changes and Formal Written Agreements

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

Building and sustaining an SOC requires certain key components to be in place. Policy development and formal organizational partnerships within the community support the SOC approach. Throughout the grant, NYS set goals for each of the IPP indicators below and tracked SOC infrastructure development by regularly comparing their progress on indicators with their goals. Table 5 describes the key infrastructure areas:

Table 5. Definitions of IPP indicators

| Focus Area	Indicator ID	Definition
Policy Development	PD1	The number of policy changes completed as a result of the grant.
Partnership/ Collaborations	PC1	The number of organizations that entered into formal written inter/intra-organizational agreements (e.g., MOUs/MOAs) to improve mental health-related practices/activities that are consistent with the goals of the grant.

NYS met or exceeded the policy development goals they originally set each year (see Figure 6). As described in the NYS SOC Project Activities section, policies generally focused on establishing processes to streamline and guide service provision and facilitate better cross-systems collaboration. While the goals for partnership/collaborations fell short the first two years, NYS exceeded those goals in Years Three and Four (see Figure 7). However, the goals for partnership/collaborations were also lowered for later years. Collaborations were generally made at the state and local levels, with efforts focused on strengthening partnerships with C-SPOAs, schools, RiTATs, county providers, and community organizations.

Figure 6. Number of reported PD1 indicators (policies) and goals, by year
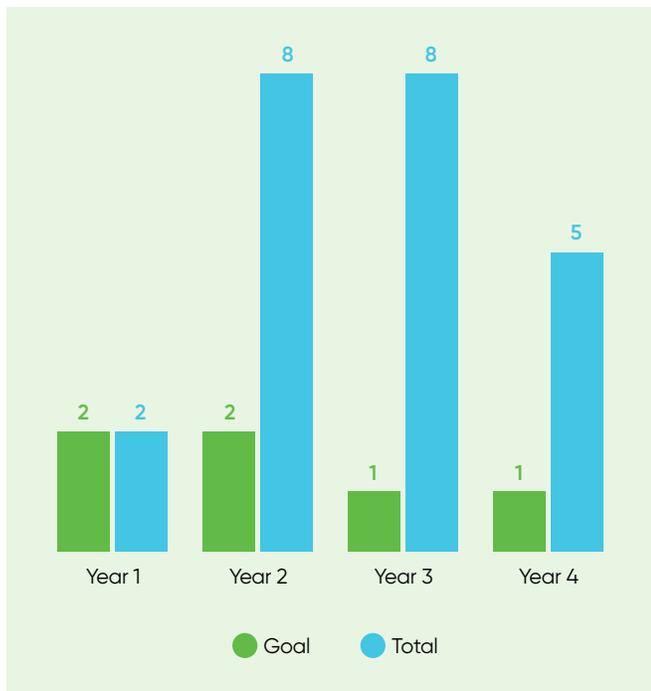
Goal   Total

Figure 7. Number of reported PC1 indicators (formal agreements with partners) and goals, by year
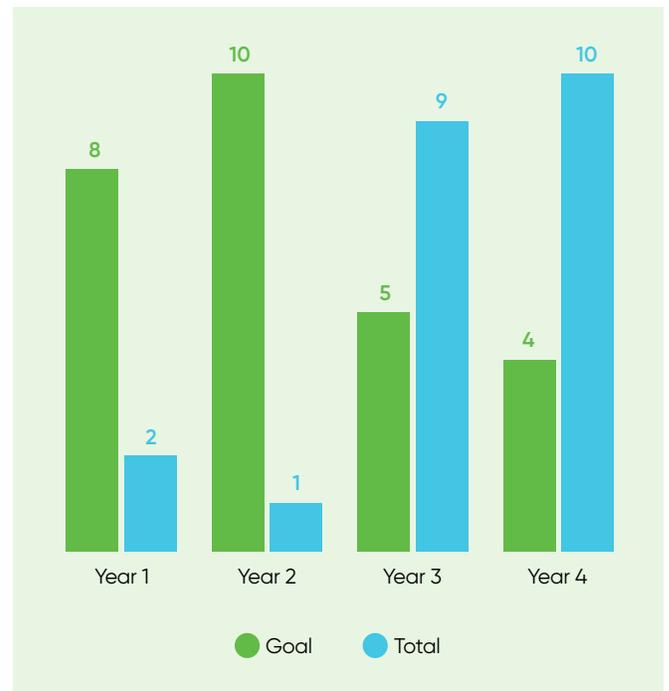
Goal   Total

*Note. *Numbers reflect goal and total reported indicators for three-fourths of the year (through Year 4, Quarter 3).*

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SUMMARY

The goal of the SOC development portion of this report is to identify organizational strategies that lead to the successful adoption of SOC philosophy and values in NYS.

In general, findings suggest:

- Child serving system leaders report high understanding of SOC philosophy and values and moderate implementation of SOC statewide. SOC implementation is higher in the Long Island, Mid-Hudson, and Western regions and among those connected to the NYS SOC project.

- System of Care development and implementation showed little change between 2019 and 2020. Small but significant decreases were observed in strategic plan development, youth-guided approach, data and accountability, and service array.

- The following survey topic areas exhibited lower average scores: information dissemination of HFW and supporting development of HFW practice; development and use of a strategic plan; service delivery guided by SOC values and principles of cultural and linguistic competence, service array, and youth-guided approach; SOC system infrastructure (specifically financing and processes for strategic communications and managing care and costs); and availability and use of home- and community-based services and out-of-home services, specifically behavioral management skills training, therapeutic behavioral aide services, tele-behavioral health services, and medical detoxification.

- There was little evidence of regional SOC development, with most regions having some counties with mostly high and others with mostly low average responses compared to state averages.

- School systems exhibited lower SOC implementation than other systems. Because schools are a system that reaches nearly all youth and are often a frequent referral source, it is very important to develop SOC values and principles in schools.

- Strategic planning was the area least implemented across the state, and in the highest need of support. Strategic plans are also important, as they contribute to overall SOC implementation. If a community wants to improve their SOC, especially in the wake of recent major changes to children's mental health (e.g., Medicaid redesign), creating a strategic plan is a concrete first step.

- Qualitative responses to the SOC implementation survey were primarily critical, focusing on unmet mental health needs stemming from insufficient services, with some respondents suggesting Medicaid Redesign was driving these insufficiencies.

- Whereas NYS SOC met or exceeded goals on policy development, practice fell short on goals for partnerships/collaborations earlier but exceeded their goals later in the grant.

These findings suggest that statewide SOC development is moderate on average, so continued efforts towards building SOCs is warranted. Building local SOCs throughout the state should focus on the areas of lower implementation described above. Because there was little evidence of consistent regional SOC development, region-wide SOC learning opportunities may be less useful. A better approach may be to use technology to present different "grade" levels of SOC information. That way beginner, as well as advanced, counties can find the appropriate level of information to build their SOC. Tools developed by OMH (e.g., SOC 101 and 201 materials as well as SOC workshops) will likely be helpful in this endeavor. There may also be an opportunity in county variation within a region such that the county with the most developed SOC could serve as a mentor to neighboring counties in the region. These mentors could be leveraged as local leaders to assist less developed SOCs. RiTATs may provide a means to build these mentoring relationships. County leaders also suggested SOC implementation could be improved by creating better strategic or sustainability plans and increasing representation of key SOC stakeholders, particularly peer advocates, in decision-making bodies. The next SAMHSA grant allows for continued implementation of these tools/opportunities created in the first SAMHSA SOC expansion grant.
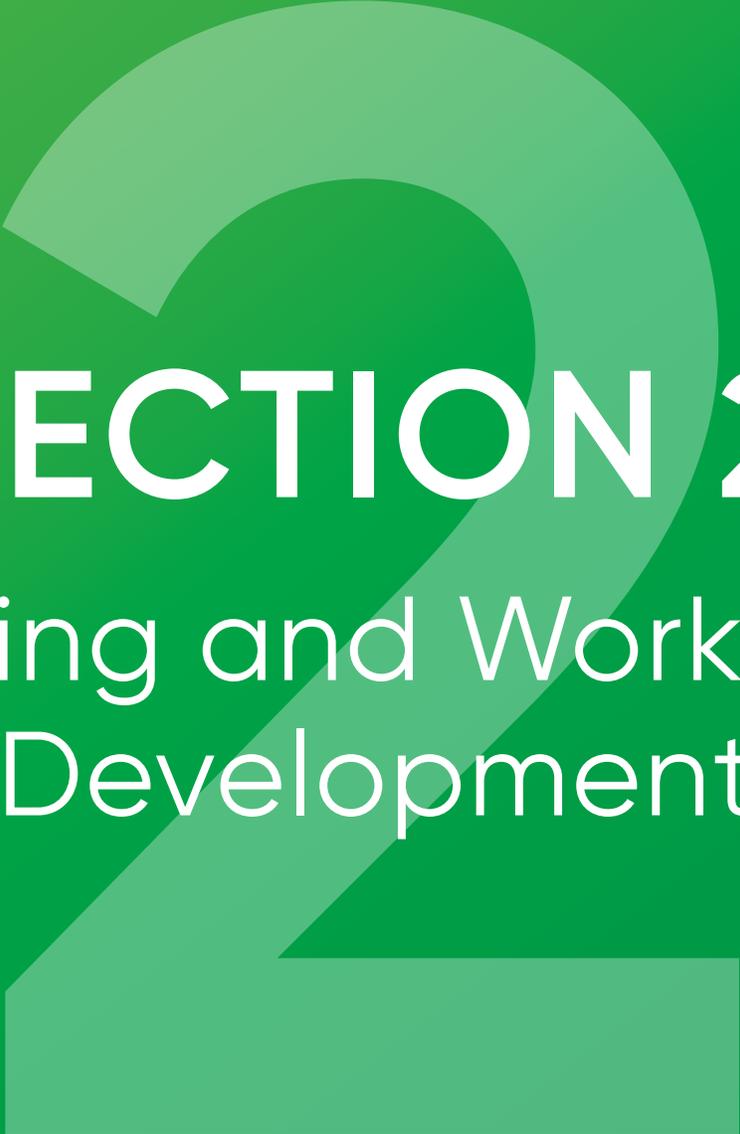
SECTION 2:
Training and Workforce Development

Section II:
Training and Workforce Development

INTRODUCTION

Many efforts of the NYS SOC project have focused on the creation and delivery of trainings to help build staff competencies in delivering HFW and related services, with the ultimate goal of providing better services to youth and families so that the most benefits from HFW can be realized. Three types of trainings were developed as part of the NYS SOC grant: HFW Certification Training for Care Managers (HFW Certification Training), and two trainings for peers: Peer Participation in Wraparound Training (Peer training) and Cultural and Structural Competence and Health Habitus Training (CSC/HHI).

These trainings aim to prepare the staff to implement HFW. Research has illuminated the importance of well-prepared staff. The National Implementation Research Network's (NIRN) Implementation Drivers Framework suggests that competent staff help to "develop, improve, and sustain one's ability to implement an intervention as intended in order to benefit youth, families, and communities" (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). The importance of an effective workforce is also recognized in the Wraparound Implementation and Practice Quality Standards[5] (Coldiron, Bruns, Hensley, and Paragoris, 2016), which further underscores the important role staff play in the implementation of HFW.

An effective workforce is expected to: a) understand their roles, b) have sufficient support and resources to do their work, c) know key features of the HFW model, d) evidence behavior consistent with HFW practice standards, and most importantly, e) facilitate families' progress in HFW. Identifying resources and strategies that result in an effective workforce will allow SOC grant leaders to target these areas to make efficient use of limited funds.

A major activity of the NYS SOC project was to develop a training and certification process for HFW delivery in NYS. The following graphic, from the WTII team, provides a visual representation of the case management certification process. As is shown, the certification process is designed to take 12 months to complete, and consists of classroom training, implementation meetings, and webinars. Webinars cover important topics such as Informal Supports and Motivational Interviewing in Wraparound. In addition, the supervisor provides support and guidance throughout the certification process. Certification is designed to occur concurrently with serving families.

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[5] These standards have a set of indicators focused on "competent staff," specifically highlighting the importance of a stable workforce with low turnover (<25%/year), qualified personnel (e.g., experienced and skilled), rigorous hiring processes, effective training, initial apprenticeship, ongoing skills-based coaching, and meaningful performance assessment.

Figure 8. Care manager certification process
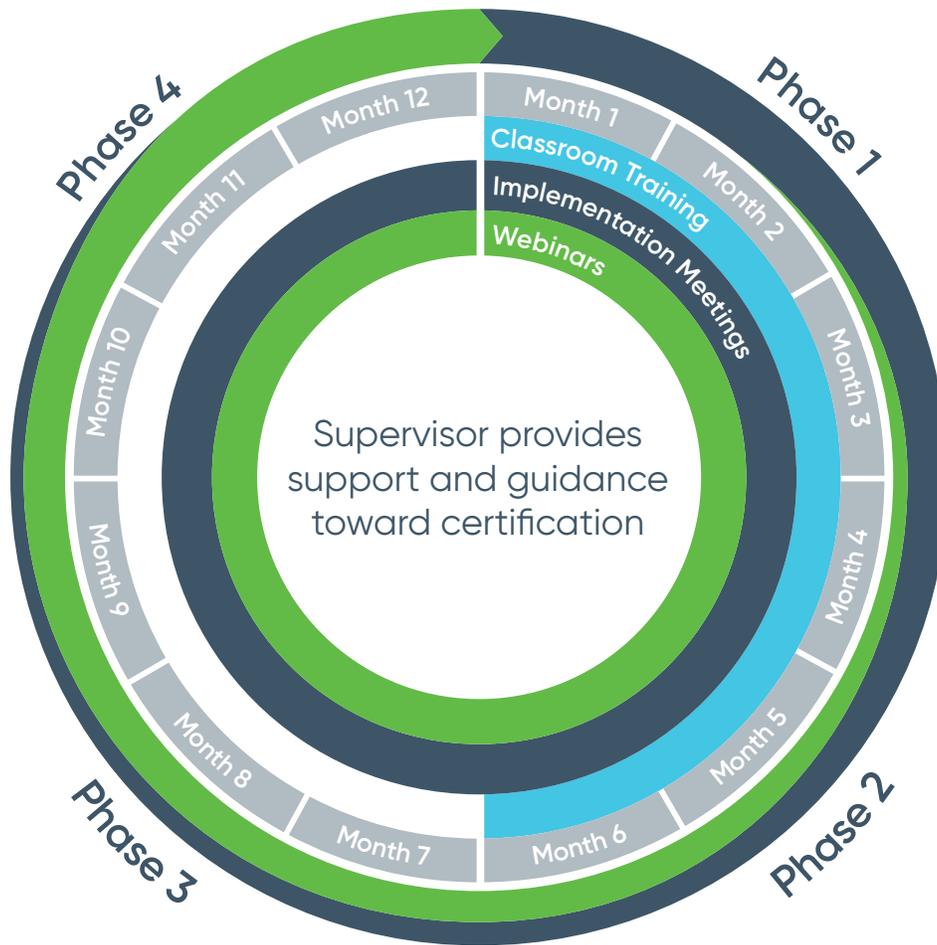
This certification process comports with the practice goals outlined in the Wraparound Implementation and Practice Quality Standards (Coldiron, Bruns, Hensley, and Paragoris, 2016, pg.12), specifically competent staff indicators as described below:

Table 6. Wraparound implementation and practice quality standards, competent staff indicators

1D	Effective Training	Wraparound care coordinators and supervisors are required to attend initial and booster trainings relevant to carrying out their job responsibilities. There is a written training protocol outlining the timing of required trainings, and staff are oriented to the requirements upon hiring. Training attendance is tracked.
1F	Ongoing Skills-based Coaching	Care Coordinators have at least bi-weekly contact with a coach or a supervisor who serves as a coach. Coaching activities are integrated into practice and aimed at improving the staff's skills in working with youth and caregivers. Coaching includes at least quarterly formal assessment of practice in multiple settings via observations, recordings, and/or review of documentation.

In addition to the certification process for care managers as wraparound facilitators, trainings were developed for peers regarding how peer advocates can best support their peers and the HFW process itself.

The evaluation of both care managers and peers aims to identify resources and strategies that support the development of an effective workforce. The following sections outline activities that have impacted workforce

development over the past several years, evaluation findings relevant to SOC development, and potential next steps. Because this is the final year of the grant, the findings presented are focused on information that will likely be helpful for planning and sustainability.

ACTIVITIES RELEVANT TO TRAINING AND WORKFORCE DEVELOPMENT

Below are the Training and Workforce Development related events and activities that have taken place during this grant.

- **Creation of NYS SOC Wraparound Certification:** WTII created the six-month comprehensive NYS SOC Wraparound Certification Training for care managers and supervisors.

- **Creation of the Peer Participation in Wraparound Training:** WTII and the Youth and Family Peer leads also created and piloted an additional training to help support peers in serving families involved with HFW.

- **Creation of the Cultural and Structural Competence and Health Habitus Integration (CSC/HHI) Training:** This training was aimed at encouraging cultural humility and are delivered to peers.

- **Conversion of trainings to virtual format:** Due to COVID-19, all trainings are now virtual.

- **Enhanced focus on use of the Practice Review Tool:** WTII created this tool for care manager supervisors to use to monitor and guide HFW practice with families.

FINDINGS

Training Overview

The following table indicates the number of training cohorts completed each year.

Table 7. Number of training cohorts completed each year

Year	HFW Certification	Peer Wrap	CSC/HHI
Year 2 (Oct. 2017 – Sept. 2018)	2	0	3
Year 3 (Oct. 2018 – Sept. 2019)	3	3	6
Year 4 (Oct. 2019 – Sept. 2020)	3*	1	1
Total	**8**	**4**	**10**

*Note: *One cohort completed by June 2020; two additional cohorts to be completed by the end of Year 4*

HFW Certification Training Survey Results

Between November 2017 and June 2020, WTII conducted 46 HFW Certification Training sessions with eight cohorts, for a total of 212 trainees. Of these 212 trainees, 82 were care managers and 22 were supervisors. Not all care managers who participated in training continued on to serve families with NYS SOC HFW. By the end of the third quarter of Year Four, 45 care managers had served families with HFW.

Trainings were held statewide in Central New York, the Capital Region, Downstate New York, NYC, and Long Island.

One week following each training session, attendees were e-mailed a link to an online training survey. Respondents included care managers, family peer support service providers, youth peer support service providers, administrators, supervisors, and RTF providers. The evaluation team compiled and analyzed data from each survey and completed 49 training briefs, including individual reports for 44 sessions and one combined report for each of the first five cohorts.[6] Findings from the briefs are summarized below.

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[6] Individual training briefs for two NYC sessions and one combined brief for NYC were not completed due to low survey response rates.

The average response rate across all individual surveys across all cohorts was 57%; ranging between 37% and 71%. Earlier and more recent trainings had higher response rates (see Table 8).

Table 8. Average CM HFW training survey response rates by cohort (N=10-43)

	Central NY (N=21)	Downstate 1 (N=32)	Capital 1 (N=43)	Downstate 2 (N=35)	Capital 2 (N=22)	NYC (N=10)	Capital 3* (N=22)	Long Island* (N=27)	Overall average
Average	71%	67%	60%	59%	42%	37%	49%	57%	57%

*Note: * Indicates training cohorts that did not complete all training sessions by June 2020*

Overall, attendees reported that all of the training styles (case study, group activities, video, hands-on by self, and lecture) helped them understand the training material. There was little variation among training styles, suggesting the style were similarly effective. Average scores for each training style were high, at least 75 out of 100, ranging from a low of 76/100 for lecture to a high of 82/100 for case study.

Attendees were also asked direct questions about specific concepts presented in the training. While changes to training material and associated surveys inhibits the ability to evaluate specific changes over time, some general themes emerged. In the earlier cohorts, attendees struggled most with questions related to health habitus and cultural humility, CFTM skills, the Transition phase, and documentation. Moving health habitus and cultural humility to a separate training may have aided trainees, as it allowed for more specific focus on these topics. While later cohorts demonstrated greater understanding on questions related to CFTM skills, suggesting a change in the curriculum or delivery of this topic, attendees indicated challenges with how to track and monitor progress on family goals. Transition and documentation persisted as challenges for attendees across most of the cohorts.

When asked to provide general feedback, attendees overall enjoyed the trainings and appreciated how knowledgeable, helpful, engaging, and prepared the training team was. They liked the interactive nature of the training (e.g., group, hands-on, and role-playing activities) but wanted more realistic cases and examples to work through. They also wanted additional - or earlier - training on specific topics, such as documentation, Health Habitus, and identification of certain Plan of Care elements (e.g., underlying needs). There was also a desire for more materials (e.g., templates, handouts) to help better guide and document HFW practice with families. When providing feedback regarding the length and location of the training, some thought the training was long and felt overwhelmed by the amount of information presented. Some also noted the location of trainings was not convenient. Generally, most appreciated the comprehensiveness of the trainings and felt that the information presented was useful in developing and improving skills for HFW practice.

Following the final training session for six cohorts, attendees were asked to reflect on their experiences in training as a whole and how training prepared them to participate in HFW. Attendees responded to 15 items along a 7-point scale ranging from 1 ("strongly disagree," indicating training prepared them poorly) to 7 ("strongly agree," indicating training prepared them well). Respondents were also offered the answer option of "skill mastered prior to training;" those responses were counted as missing.

The average score across all 15 items of the survey was 5.92, which indicates that, on average, respondents agreed that the training was effective in preparing them to support HFW in various domains (See Figure 9 for average scores on individual items). Trainings seemed to be effective at reinforcing many of the important facets of HFW, such as identifying strengths and building them into the Plan of Care. Trainees also felt they were prepared for engaging with families in ways consistent with SOC principles, such as being youth-guided (e.g., eliciting youths' contributions). Lower-rated items were related to documenting HFW practice, which is consistent with what attendees' reported as a persistent challenge throughout the trainings.

Figure 9. Average survey ratings of training skills across six cohorts (N=53)

Skill	Rating
Overall average	5.92
Identify strengths that are built into strategies	6.25
Ensure the plan of care reflects the family's/youth's wishes, interest, and needs	6.23
Elicit youth contributions to team meetings and the plan of care	6.19
Objectively monitor progress toward meeting the youth's and family's needs	6.17
Involve everyone who is integral to the family's and young person's plan of care in the wraparound process	6.13
Identify underlying needs	6.12
Use agendas in team meetings	6.10
Assess youth's and family's current level of connection to natural supports	6.10
Write and update wraparound crisis plans	6.08
Fulfill the responsibilities of my specific role	6.02
Create goals that are objective, measurable	5.92
Write a progress note	5.82
Document my services so they meet Medicaid requirements for reimbursement	5.63
Use the Wraparound Engagement Tracker/Fidelity EHR/online documentation system to document the wraparound process	5.46

Peer Participation in Wraparound Training Survey Results

Between February 2019 and June 2020, 13 Peer trainings were delivered to five cohorts, for a total of 119 trainees. Twelve trainings were led by WTII and one training was led by trained regional parent advisors and youth partners. Trainings were held statewide in Central New York, the Capital Region, Downstate, NYC, and Western New York.

Training attendees completed paper surveys immediately following each training session. Respondents included family peer support service providers, youth peer support service providers, administrators, and supervisors. The evaluation team compiled and analyzed data from each survey and completed 13 training briefs by the end of Year Four, quarter three. Findings from the individual briefs are summarized here.

Response rates were high across most cohorts with an overall average of 89% (see Figure 10).

Figure 10. Peer training survey response rates for each cohort (N=14–36)

Cohort	Response rate
All regions	89%
Downstate	97%
NYC	93%
Capital	87%
Central NY	87%
Western NY	71%

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

Attendees were also asked to provide a list of topics they would like to see in a webinar following the training. Most were interested in learning more about some of the topics already covered in the peer trainings (e.g., HFW phases and principles, Plan of Care components), indicating a need for training reinforcement and skill practice/development. Attendees also indicated interest in learning topics not reviewed during the training, such as: working with different types of youth, practicing HFW in various systems, and infrastructure issues.

Cultural and Structural Competence and Health Habitus Integration Training[7]

Under the auspices of the current grant, the Center for Research on Cultural and Structural Equity in Behavioral Health (C-CASE) at the Nathan S. Kline Institute for Psychiatric Research developed and implemented the Cultural and Structural Competence (CSC) training for providers (i.e., family and youth peer advocates, care managers, and supervisors) working with families with children and/or youth with serious emotional disturbances. Nine trainings were conducted in Years Two and Three. In Year Four, the team conducted one additional CSC training session, bringing the total trainings to ten. A total of 168 individuals were trained.

The CSC training is primarily designed to enhance the peer advocate's skill set by integrating the social and structural determinants of health perspective and the cultural humility approach into their practice. This theoretically guided training is based on the recognition that cultural and social factors shape the tendencies (i.e., habitus) and actions of families and youth to attend to their mental and physical health in certain ways. The training provides the communication strategies and tools to elicit the family's and youth's habitus and behavior and bring this information: (1) to the team meetings with care managers and supervisors; and (2) to their interactions with family and youth from the phase of engaging in HFW to transitioning out of HFW, always adopting a culturally humble approach.

Follow-up in-depth qualitative interviews are conducted at least three months after training to explore trainees' familiarity with the information imparted in the training, but more importantly, reveal whether and how trainees integrated the strategies and tools they acquired in the training in their HFW practice.

To date, 27 trainees have participated in qualitative interviews. Most of the qualitative interviews were conducted with peer advocates (n= 23, 85%); 16 were Family Peer Advocates (59%), seven were Youth Peer Advocates (26%), and four were Peer Advocate supervisors (15%). The average age of participants was 42.6 years of age (range: 22-76). All participants but one self-identified as female. Black/African Americans represented 15% of the sample, Hispanic/Latinx 7%, More than one race 4%, and 74% identified as non-Hispanic White.

The four main themes arising from these interviews are summarized below. A full version of the findings is available in Appendix C.

Theme 1.

Comprehension and Retention of Training Components: This theme referred to trainees' understanding and recollection of key components of CSC training. Trainees retained information about many key components of the training, including cultural humility, implicit bias, and health habitus. Trainees specifically noted the value of interacting with families with cultural humility and recognizing one's own biases, which included seeing the value of using the Implicit Association Test (Nosek, Greenwald, & Banaji, 2005). Trainees also noted the value of

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[7] Content for this section and the accompanying appendix was provided by the Center for Research on Cultural and Structural Equity in Behavioral Health (C-CASE) at the Nathan S. Kline Institute for Psychiatric Research.

understanding the cultural and structural origins of a family's health habitus and how health habitus impacts health-related decisions.

Theme 2.

Practice Informed by the Training: This theme referred to whether and how trainees included the strategies and tools shared in the training into their practice. Trainees recalled the use of many techniques acquired from the training, including: strategies for engaging families and youths, approaching families and youths with cultural humility, practicing active listening, applying the health habitus tools (i.e., interview guide, writing the health habitus note), writing one's own health habitus, applying understanding of families' and youths' health habitus in engaging, and supporting families to set and meet their goals. Data on experiences of writing about one's own personal health habitus under the theme of practice because this training exercise exemplifies strategies for eliciting health habitus, as well as writing a health habitus note. Trainees specifically noted writing about one's own health habitus enhanced health self-awareness and understanding of intergenerational health behaviors and illuminated how health habitus notes can be used to engage and support families.

Although many of the trainees indicated that they do not use the interviewing guide as a tool, most used the topics in the guide to organize their conversations with family and youth when they try to engage them in HFW, understand their strengths and needs, and develop a plan. Similarly, many indicated that they did not use the form to write a health habitus note, nor did they regularly indicate their notes as health habitus notes; however, when discussing their progress notes, it became obvious that they often included health habitus information and insights.

Interview responses indicated that trainees integrated multiple different strategies, tools, and insights from the training into their practice. This finding emerged when we examined how trainees described their overall practice, and the strengths and barriers confronting the families and youths they serve. Descriptions incorporated many of the key constructs and insights from the training (e.g., structural and cultural barriers, the significance of assessing habitus, the "why" behind families' behavior, and the cultural humility approach) when discussing the challenges facing the families.

Theme 3.

Implementation Support of CSC and HFW Training.[8] This theme is comprised of interpersonal implementation support (i.e., from other team members such as advocates, care managers, and supervisors) and institutional implementation support. Trainees reported training with other team members was beneficial because they could support each other in implementation. In addition, several advocates discussed the value of sharing insights from the training with their team members who were not included in the training to discuss health habitus insights and increase cultural humility. Supervisors also described how they support peer advocates with understanding and implementing health habitus, such as supporting recognition of health habitus information and assisting with incorporating health habitus insights into the family story. Trainees valued working in an agency that supported the implementation of health habitus and HFW.

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[8] Data that referred to both trainings are included under this heading because trainees often did not differentiate between the two and instead, perceived CSC as part of HFW.

Theme 4.

Recommendations for Improving the CSC Training. This theme included what to change, add, or eliminate to improve the CSC training. Trainees offered a plethora of suggestions about all aspects of the training from the style of the delivery of the information to the best time to offer the training, and how best to practice the skills. Specifically, they recommended offering CSC earlier in the HFW series, extending the duration of the training and/or providing refreshers/booster sessions. Most trainees raised the need to devote more time to practicing the health habitus interview and to writing the health habitus note. Specific suggestions referred to the role playing component of the training, with most trainees recognizing the value of this activity, but adding that it is challenging to engage in this exercise in a group setting, while others suggested doing the role playing only with members from their own agency/care team and practicing using the story of an actual family they serve. A few participants found the theoretical part of the training complex or tedious and asked for more interactive activities given the day-long length of the training session. Trainees made excellent suggestions regarding the training tools, including using the personal health habitus to elicit the family or youth's health habitus and using the series of health habitus notes to demonstrate to the family and/or youth their progress over time. These suggestions, where applicable, informed the development of the virtual version of the training currently underway.

The C-CASE trainers are in the process of finalizing a virtual version of the CSC training to be delivered remotely to peers in four New York State regions as a component of the Peer Participation in Wraparound training that has been scaled up throughout the state. The team intends to hold these virtual trainings between September and December 2020.

Additional SOC-relevant trainings

In addition to the HFW Certification, Peer, and CSC trainings provided by WTII and NKI, NYS and individual counties/sites offered and participated in other various grant-relevant trainings. Staff reported on training attendance as part of the IPP data collection for SAMHSA, and these trainings included classroom trainings, webinars, workshops, and learning events related to SOC, HFW, and children's mental health services. Providers received a total of 1901 trainings in mental health-related practices/activities that are consistent with the goals of the grant. Figure 11 shows the annual goals compared to the number of trainings attended. NYS exceeded the goals set each year for trained staff; this is expected as the project expanded to more sites statewide.

Turnover

Turnover can inhibit maintenance of an effective workforce. Staff turnover can sometimes be a challenge in human services work, especially with a model like HFW that works with families with complex needs and is typically a long process (averaging around 11 months and counting for currently enrolled youths, and 8 months for discharged

Figure 11. Number of reported workforce development (WD2) indicators (trained staff) and goals by year
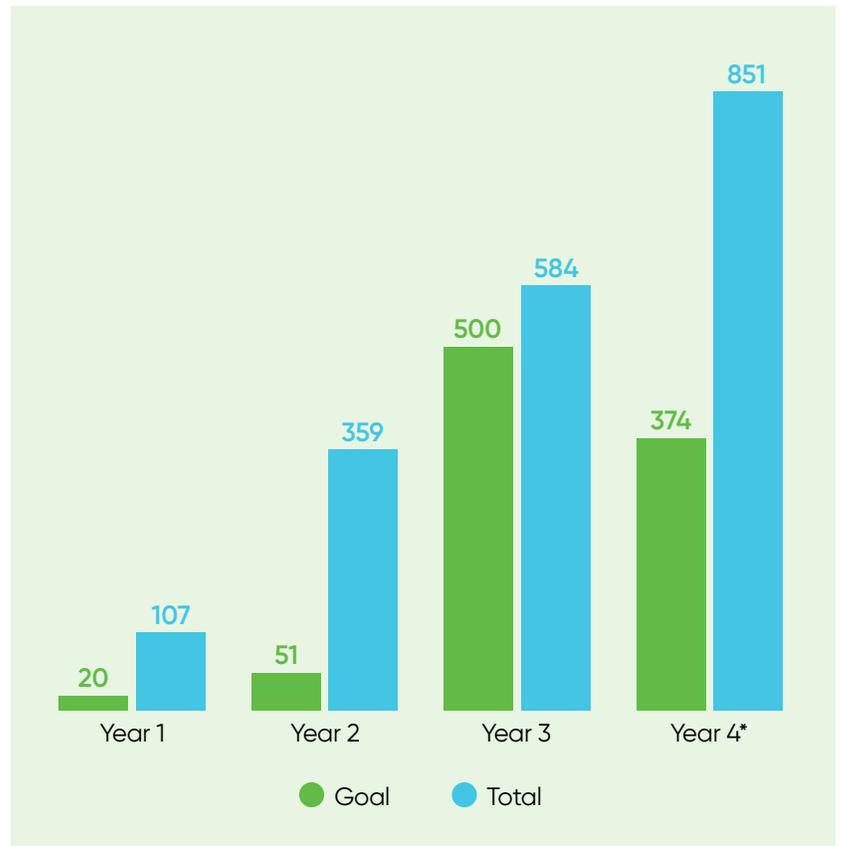
*Note. *Numbers reflect goal and total reported indicators for three-fourths of the year (through Year 4, Quarter 3).*

youths); therefore, turnover may be more likely to impact families to a greater extent than is experienced by families in less intensive care coordination processes. At the end of the third quarter of Year Four, 78% of families had a consistent care manager, whereas 22% experienced a change in care manager during their HFW participation. Most youths served in HFW were not impacted by care manager turnover.

SUMMARY

The goal of the Training and Workforce Development portion of this report is to identify resources and strategies that support the development of an effective workforce.

In general, findings suggest:

- Providers enjoyed the trainings and felt the trainers were knowledgeable and helpful; providers also valued the interactive elements of the process (e.g., role-playing, group activities).

- Providers desired more concrete and realistic case scenarios/examples to work through, and additional materials, resources, and trainings to better implement and support HFW.

- Providers thought the training was effective overall and gave them the necessary skills to practice HFW.

- Documentation continued to be a challenge throughout the training sessions, indicating that more training and coaching in this area would be helpful.

- Training survey response rates were higher when completed in-person at the end of the training session (i.e., for the peer trainings), rather than online the following week (i.e., for the care manager trainings).

- NYS and individual counties/sites had a great focus on developing a strong and effective workforce, as evident by the large number of staff trained by the end of Year Four, quarter three. They also exceeded the original goals set for workforce development.

- Turnover was a workforce challenge for NYS SOC HFW, as it typically is with human services work. However, fewer than a quarter of families experienced a change in care manager.

NYS SOC devoted a lot of time and effort to the development and implementation of trainings and supports for care managers and peers to be able to effectively carry out the HFW process. In general, participants enjoyed trainings and felt they prepared them well for their work. Some areas requiring additional assistance may be documentation and transition from HFW. Future work can be devoted to evaluating trainings in conjunction with staff behavior (e.g., fidelity instruments) to identify additional areas of focus for future training and TA opportunities.
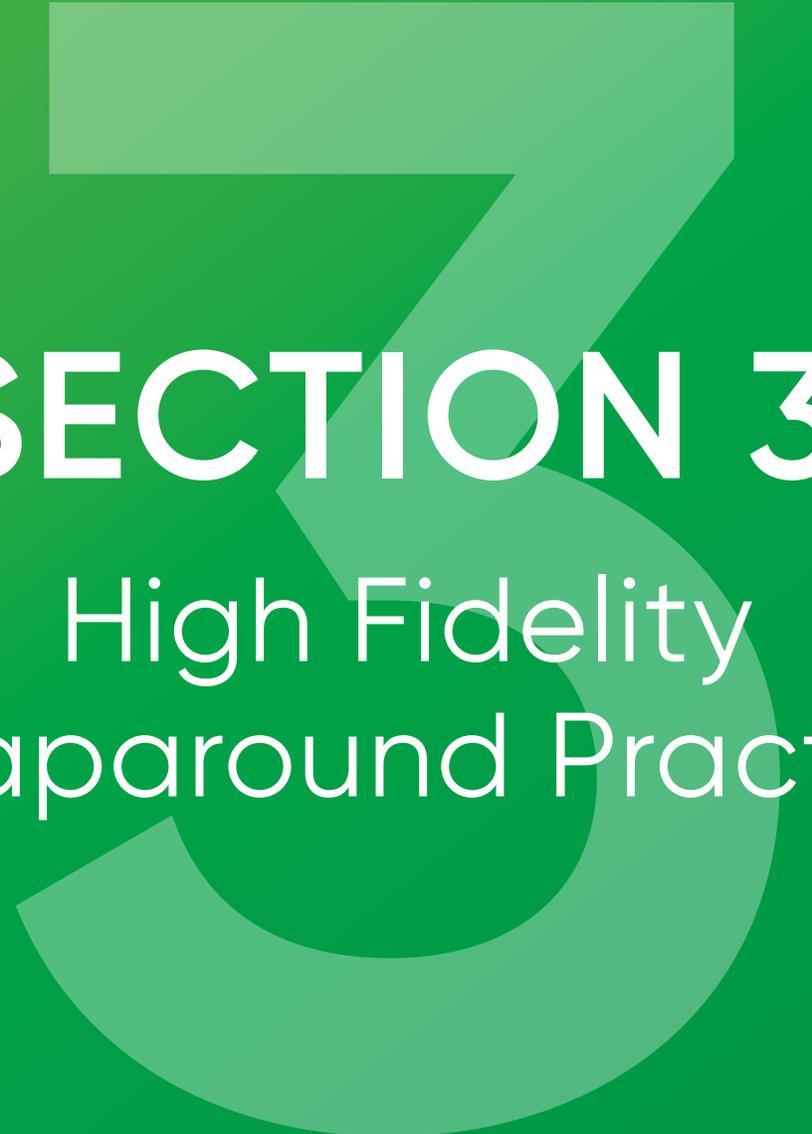
SECTION 3:

High Fidelity Wraparound Practice

Section III:
High Fidelity Wraparound Practice

INTRODUCTION

It is important to explore HFW practice to ensure the process is operating as intended and to identify where practice is going well and what areas may need improvement. Understanding how HFW operates in NYS is essential in order to have effective care coordination and in turn maximize family improvements. This section explores overall HFW operation and timelines, care manager input on program operation, impacts of COVID-19 on practice, peer advocates' practice, and practice fidelity compared to HFW standards.

Research has shown HFW is effective to the extent practitioners adhere to model standards (Bruns, Suter, Force, & Burchard, 2005). Practitioner fidelity to the HFW model is critical for ensuring high-quality implementation and positive family outcomes. Identifying standards practitioners tend to meet, and areas where they need further support, could provide valuable insights toward boosting model adherence. The goal of this section is to identify how NYS SOC HFW is implemented compared to model standards to ensure NYS SOC is using effective practices that lead to improvement of families' lives. In addition to assessing fidelity, descriptive information on program operation is presented, to help inform future planning.

ACTIVITIES RELEVANT TO HIGH FIDELITY HFW PRACTICE

Below are High Fidelity HFW practice related events and activities that have taken place over the course of this grant.

- **Introduction of Wrap-NY for documentation:** Wrap-NY was introduced in the beginning of Year Three as an online hub for all documentation related to HFW.
- **Introduction of the Practice Review Tool:** The practice review tool was introduced to aid in coaching and supervision as a tool to provide feedback and improve practice.
- **Introduction of Report Cards:** Report Cards were introduced in Year Four, to provide feedback for continuous quality improvement on HFW documentation and fidelity of practices.

FINDINGS

HFW Operation and Timelines

The following section describes the operation of NYS SOC, including number of youths served, flow of youths through the program, lengths of stay (LOS), and CFTM patterns.

A strength of NYS SOC is that nearly all referrals to HFW end up enrolling in the program (91%). In the beginning of the project, the total number of open cases rose gradually, whereas over the past year, the number of open cases has remained somewhat constant around 100. A total of 246 youths were served with HFW through Year Four, quarter three. At the end of the third quarter of Year Four, there were 119 youths referred to HFW and active, with 108 having completed the full enrollment process. The current state of enrollments put the program at about 63% of the maximum capacity. Most sites have struggled to maintain a full caseload at maximum capacity throughout the project.

Figure 12. Total open cases, by quarter
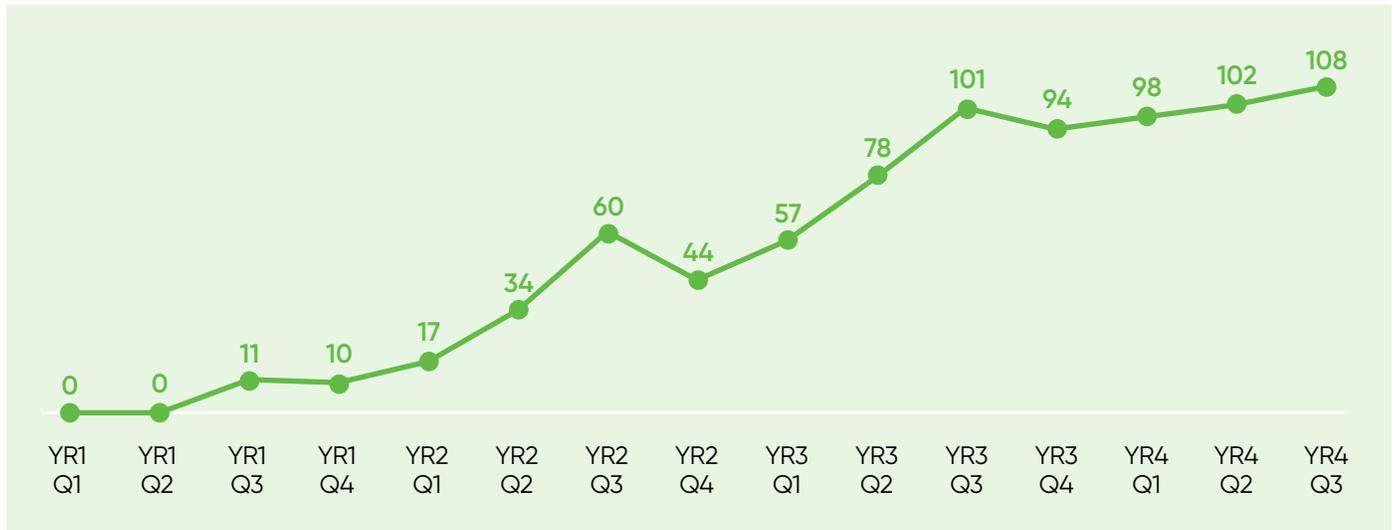
*Note. Graph shows full timeline of the grant, the first youth was enrolled 4/1/2017.*

Early on in the project, enrollments typically outpaced discharges, as most sites built up their caseloads (see Figure 13 for total enrollments and discharges by quarter). There were two spikes in enrollment: the first spike in Year Two, quarter three reflects high enrollments from Cayuga, Erie and Rensselaer counties; and the second spike in Year Three, quarter three reflects a wave of new sites (e.g., ICAN, Chenango, NYC, waiver sites) that started enrolling youths as well as high enrollments in Westchester county. The spike in discharges in the fourth quarter of Year Two is due to Erie ending its program with NYS SOC and discharging all of their cases. Over the past year, enrollments and discharges have been consistent at around 15–20 per quarter. This consistency would suggest that sites are likely no longer building caseloads and have moved on to maintaining current caseloads. During the third quarter of Year Four when COVID-19 restrictions were prevalent, activity went down a bit with 14 enrollments and eight discharges.

Figure 13. Enrollments and discharges, by quarter

HFW serves high needs youth and young adults and is a process that requires a lot of effort from all team members. Because of these challenges, it can be difficult for teams to complete all four phases of the process (i.e., Engagement, Plan Development, Plan Implementation, and Transition). The following figure displays discharges by quarter, separated by discharges during the Transition phase compared to those prior to the Transition phase. Discharge during the Transition phase is the goal but was only accomplished by about a fifth (21%) of discharged families. Over the course of the grant, no consistent pattern of disposition at discharge was observed beyond discharges prior to the Transition phase being more prevalent than discharges in the Transition phase (with the exception of Year Two, quarter two).

Figure 14. Discharge type, by quarter
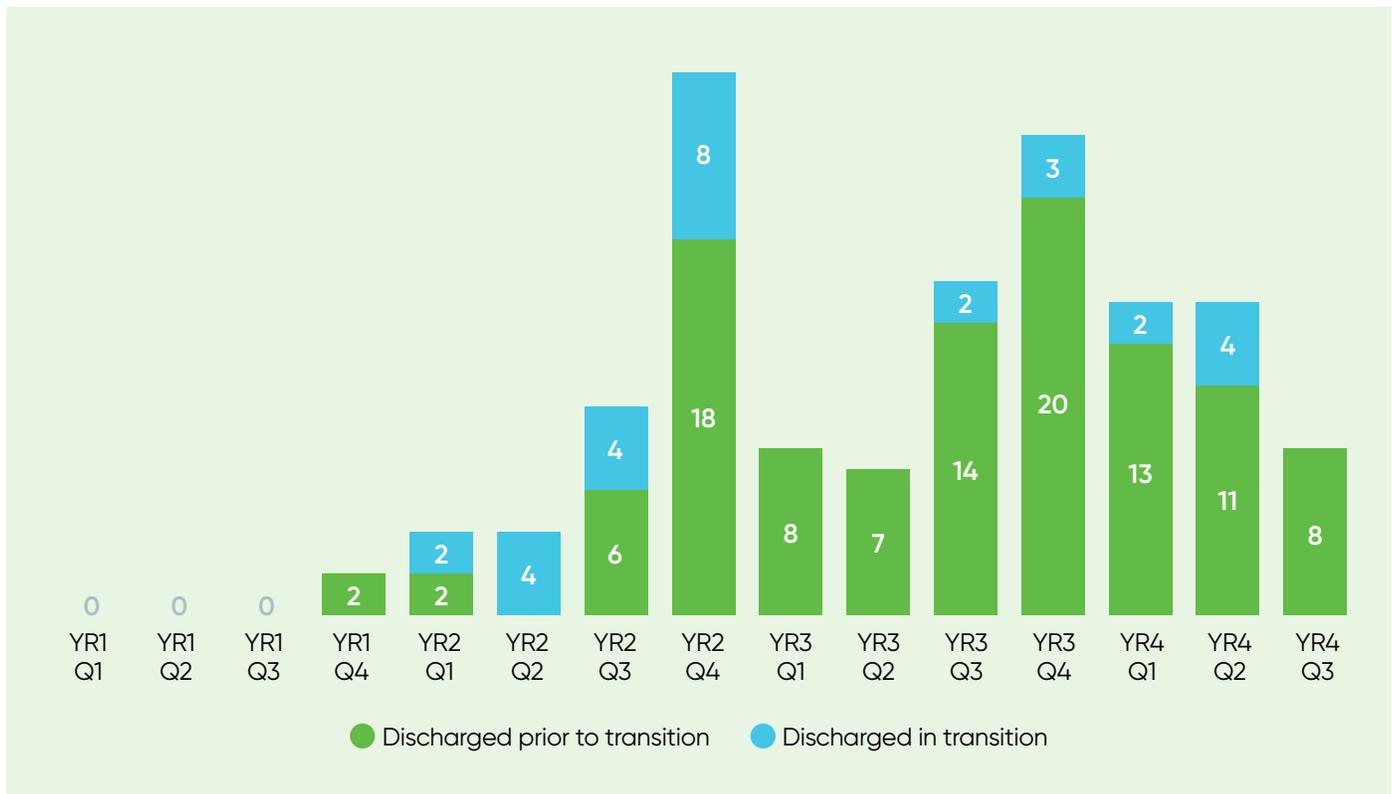
CFTMs are an essential activity in HFW as they are the main way teams come together to work on the goals in the Plan of Care. Conducting CFTMs are an important feature of NYS SOC HFW that separates it from the high acuity care management provided through HHSC. The goal of HFW is to have approximately monthly CFTMs for each family, although this can be challenging.

Early in the project, there was quite a bit of variation in the number of CFTMs per open case. The project came close to the goal of three in the last quarter of Year One and then was somewhat consistent at about 1.5 CFTMs, but then fell again once Erie County exited the project. In addition, in late 2018, there was a shift in documentation from the trackers to using Wrap-NY, so there may have been inconsistent documentation of CFTMs during this transition. There has been a slight, steady increase in the number of CFTMs per open case since Year Three, quarter one from 0.70 to 1.15 CFTMs in Year Four, quarter three.

Some teams are approaching or meeting the standard of regular monthly CFTMs (36% had two or more CFTMs in the most recent quarter), whereas other teams struggle to complete any regular CFTMs. For instance, in the most recent quarter, 39% of teams did not have a CFTM in the quarter (which brings the overall average down). Frequency of team meetings was variable across sites: in the most recent quarter, two sites had at least one CFTM for every open case, while another two sites did not have any CFTMs for any of their open cases (one of these sites was in the process of exiting the project, and thus was likely focused on closing cases rather than CFTMs).

Some care managers have occasionally expressed challenges in knowing when a meeting is a CFTM versus a regular meeting, therefore there is likely some variation in what is recorded as a CFTM. For instance, some care managers were not recording meetings as CFTMs when peers were not able to attend, whereas other care managers were recording more general check-in meetings as CFTMs with little reference to the Plan of Care.

In addition to challenges completing CFTMs, delays in getting to the first CFTM have also been observed. On average, it took teams 60 days to progress from the first face to face contact to the first CFTM, which is double the goal as outlined in the timely engagement standards (i.e., 30 days; Document Assessment and Review Tool, developed by the Wraparound Evaluation & Research Team).

Figure 15. Number of CFTMs per open case, by quarter
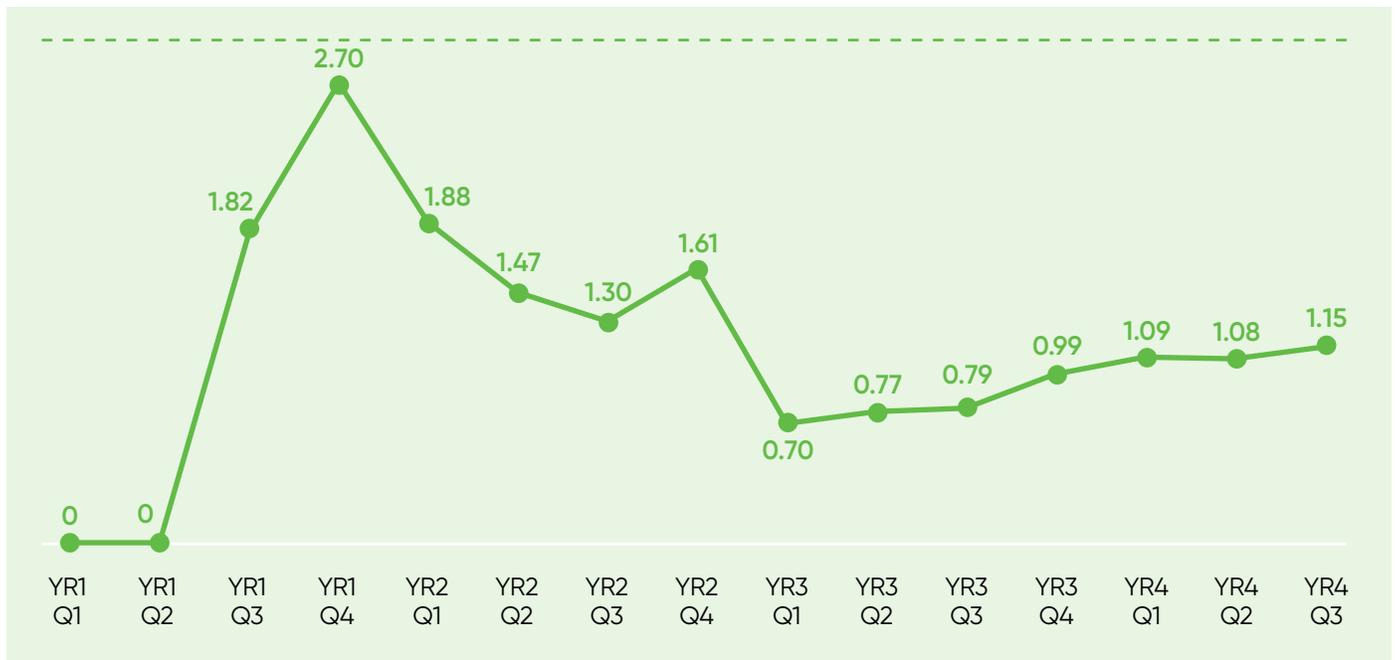
Although there are a handful of youths who have a LOS over two years, the mean number of days in care is 337 days (about 11 months), with the median slightly lower at 291 days, (about ten months). Figure 16, below, shows the LOS breakdown. It must also be noted that because these youths are all still actively enrolled in HFW, their LOS will continue to grow until discharged.

Figure 16. Count of youths with each corresponding LOS (shown as a range of days since the youth has been enrolled), for active cases only (N=108)
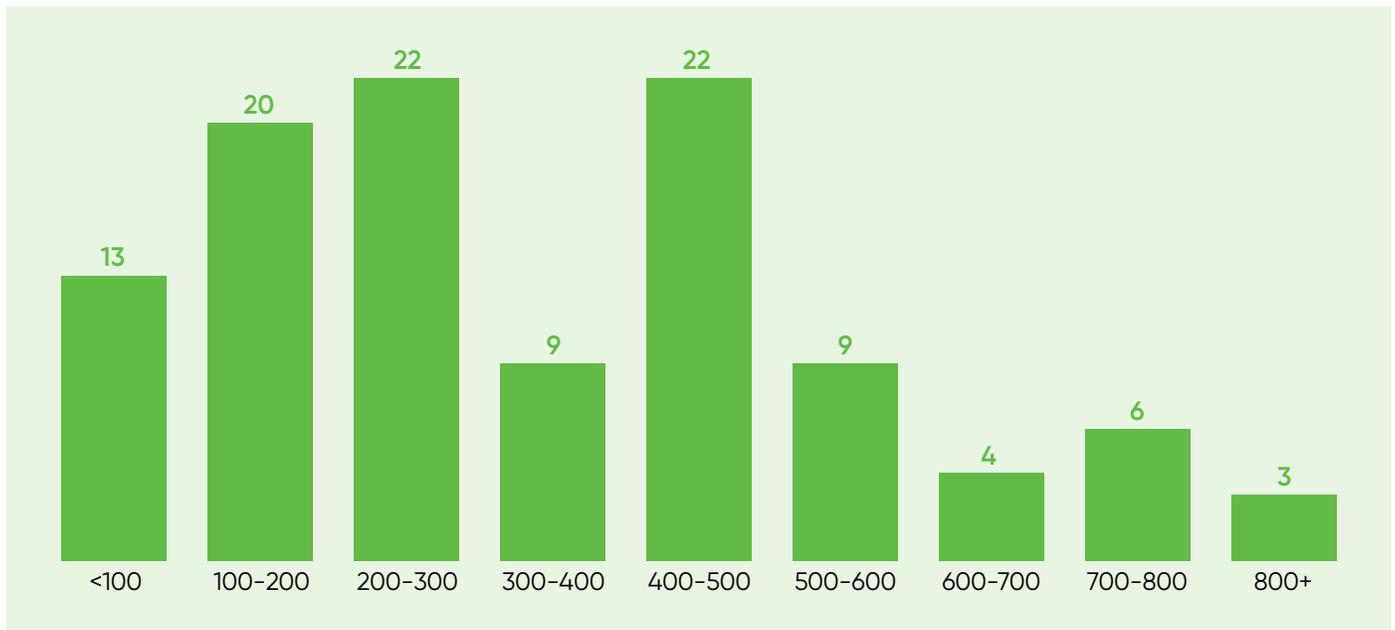
Discharged youth had an average LOS of 238 days (about eight months) which was shorter than the average length of stay for those currently enrolled; this held true when broken down by youths discharged in the Transition phase (mean = 319 days, about 11 months) and youths discharged prior to the Transition phase (mean = 216 days, about seven months). LOS patterns look similar for both types of discharges; both display a right skew, such that the majority have shorter LOSs, and a few youths with long LOSs.

Figure 17. Count of youths with each corresponding range of days the case has been enrolled, for discharged cases only (N=138)
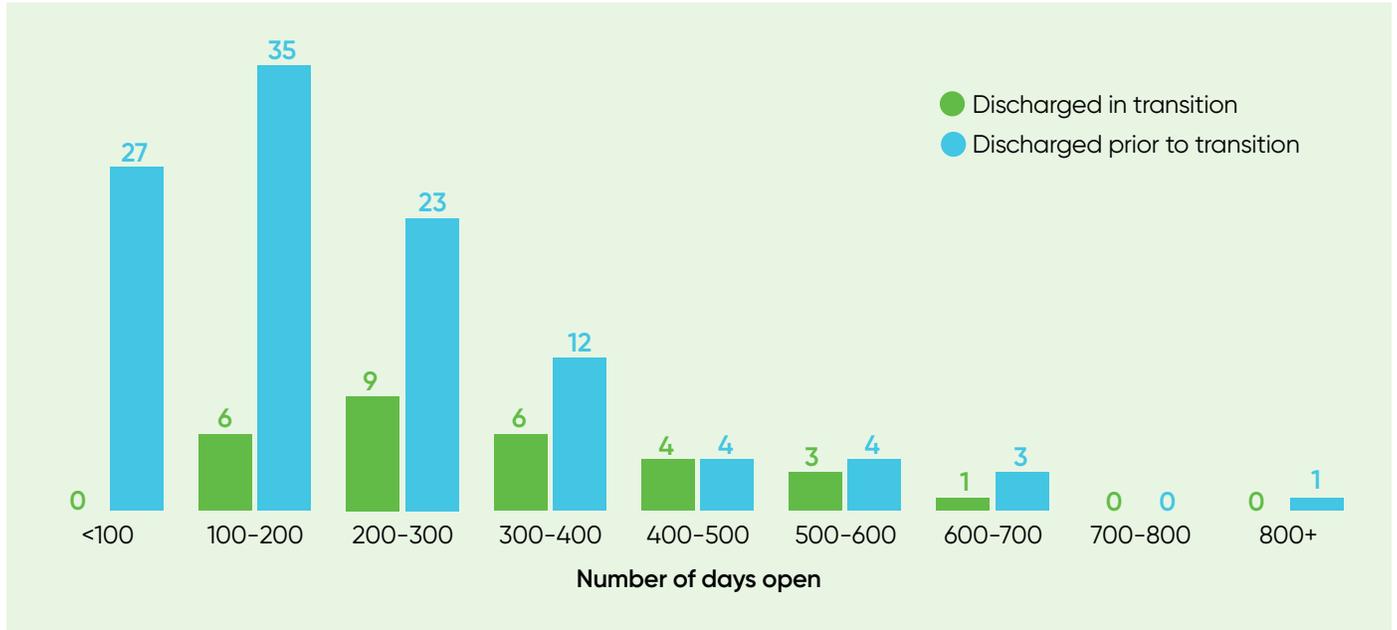
Besides LOS, another way to measure service dosage is the number of CFTMs completed per discharged youth. Figure 18 displays the count of youths who completed each number of CFTMs during their time in HFW. Counts are separated according to whether the youth was discharged prior to or in the Transition phase. On average, youths who discharged prior to a Transition phase completed two CFTMs, whereas youths who discharged in a Transition phase completed seven CFTMs. This data, combined with the LOS information above, indicates that youths discharging in transition are completing CFTMs approximately every 47 days, whereas those discharging prior to transition are completing CFTMs every 87 days. Delays between CFTMs may be an indicator of challenges with the HFW process that could lead to early discharge. Identifying these cases early on and applying course corrections may be one strategy to decrease discharges prior to the Transition phase.

Figure 18. Count of youths with each corresponding number of CFTMs, for discharged cases only (N=138)
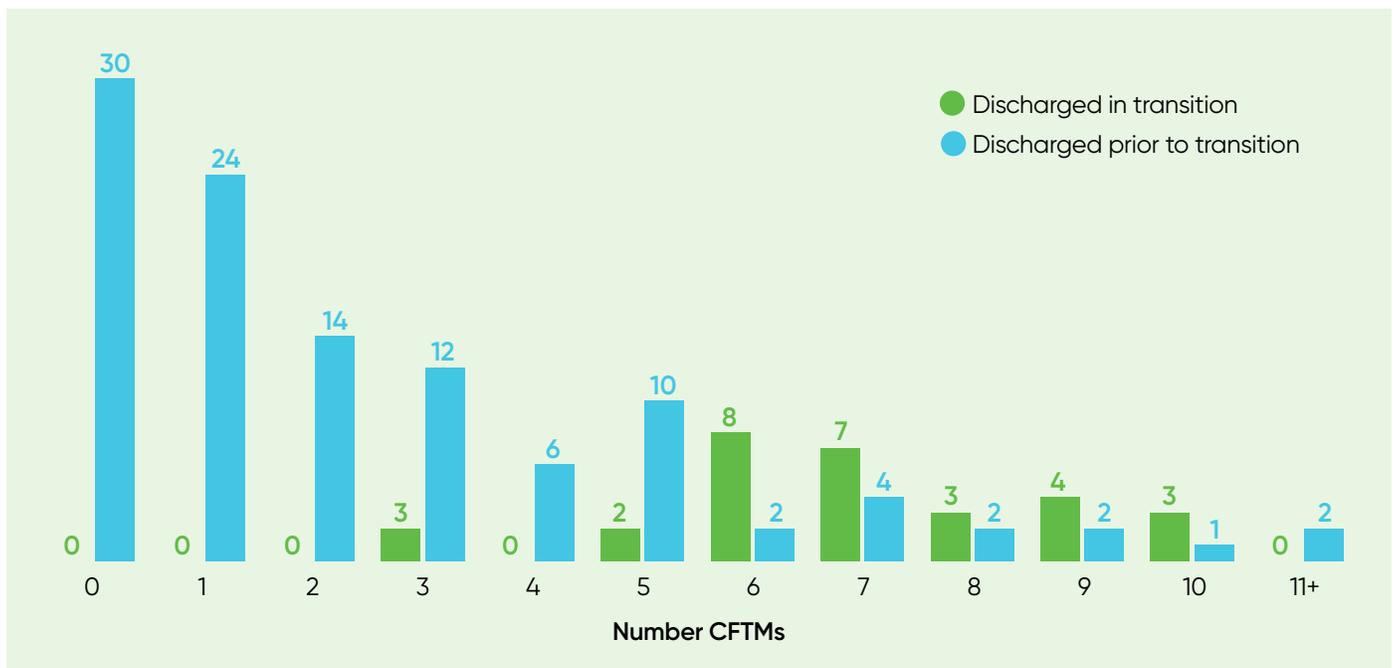
Note. Phase at discharge and CFTM dates are reported by the case manager.

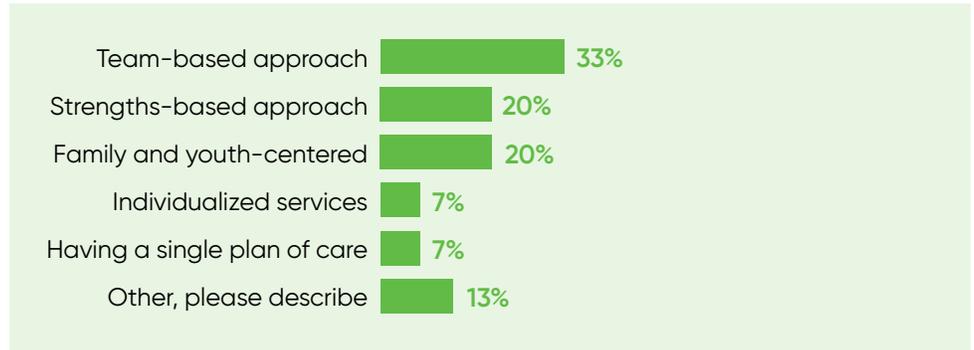### Project Reflection Survey NYS SOC HFW Process Responses

At the end of the third quarter in Year Four, care managers completed a brief survey to reflect on their experiences in the NYS SOC project. This survey specifically addressed identifying the helpful and challenging parts of NYS SOC HFW and solicited suggestions for future HFW operation. Response options for items were selected by reviewing responses from care manager interviews in prior years along with an "other, please describe" option. Nearly all active care managers completed the survey (88%; 15/17).
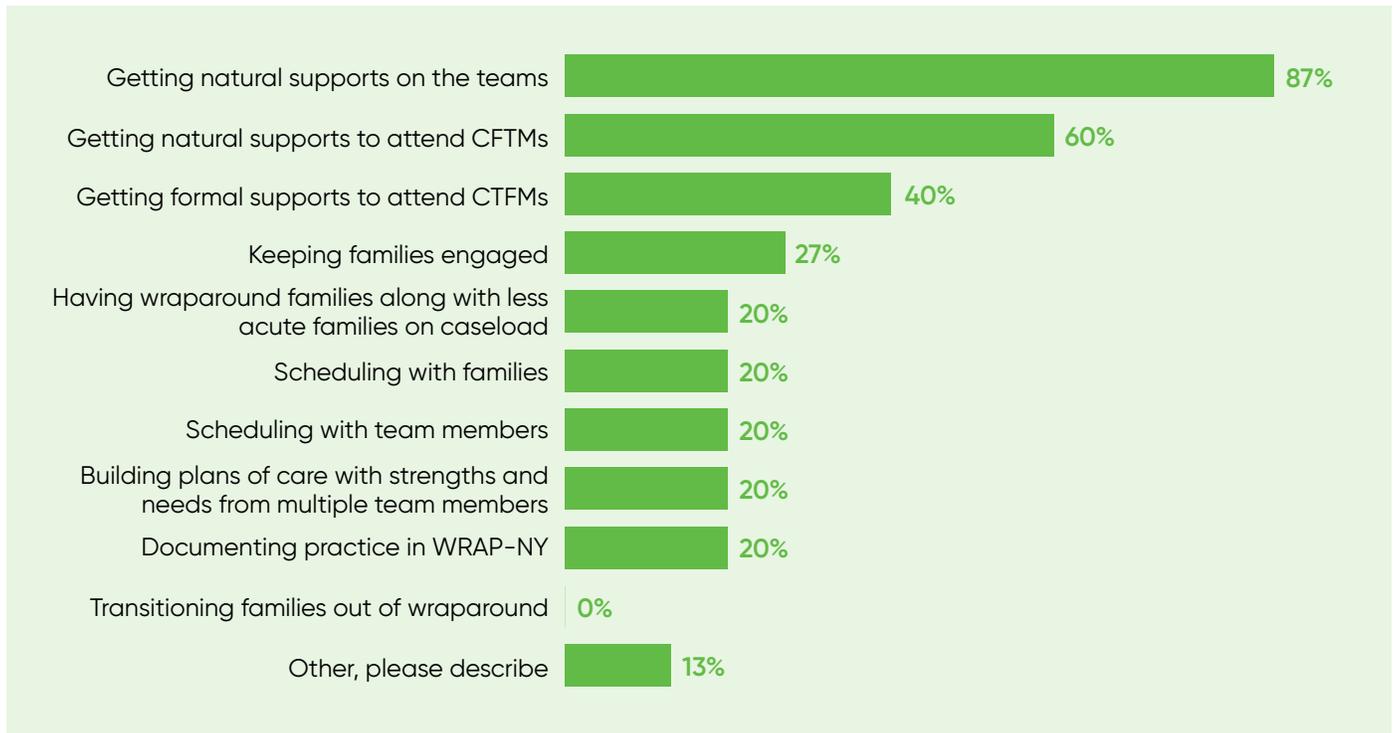
In their project reflection responses, care managers reported on what part of NYS SOC helps families the most. The team-based approach was most often selected, followed by strengths-based and family/youth-centered. "Other" responses typically reflected multiple of the other options together (e.g., team-based and strengths-based).

Figure 19. The part of NYS SOC HFW helps families the most (N=15)

Team-based approach	33%
Strengths-based approach	20%
Family and youth-centered	20%
Individualized services	7%
Having a single plan of care	7%
Other, please describe	13%

In their project reflection responses, care managers reported on what was difficult to implement in HFW. Building complete HFW teams with informal supports was a challenge for nearly all care managers. Attaining full team attendance with formal and informal support people at CFTMs was also frequently reported as a challenge. It is interesting that the team-based approach was the aspect of HFW most often selected as helping the family the most, while building those teams and getting them to attend CFTMs were some of the most challenging parts of HFW. Keeping families engaged was a challenge for about a quarter of care managers.

Figure 20. What is difficult to implement in NYS SOC HFW (N=15)

Getting natural supports on the teams	87%
Getting natural supports to attend CFTMs	60%
Getting formal supports to attend CTFMs	40%
Keeping families engaged	27%
Having wraparound families along with less acute families on caseload	20%
Scheduling with families	20%
Scheduling with team members	20%
Building plans of care with strengths and needs from multiple team members	20%
Documenting practice in WRAP-NY	20%
Transitioning families out of wraparound	0%
Other, please describe	13%

Care managers also reported on what changes they would suggest for future iterations of NYS SOC HFW. The majority of care managers suggested smaller caseloads for HFW, which is notable because few reached the goal caseload of 10-12. Because caseloads lower than 10-12 cases are not currently sustainable in the HHSC system, perhaps there are

ways to streamline aspects of the HFW process, so that workloads are more manageable. Most care managers also suggested expansion of the service population to youth younger than 12 years old. This is consistent with NYS' future plans to expand the HFW service population to youth younger than 12 years old. About a third of care managers suggested that more coaching and training opportunities would be helpful. Some other responses specified desire for more efficient screening and enrollment process, as well as additional support, including training on the Wrap-NY website, content expectations for required documentation, refresher trainings, and more peer coaching.

Figure 21. Changes you would suggest to improve NYS SOC HFW in the future (N=15)

Category	Percentage
Smaller caseloads	53%
Expand service population to youth younger than 12	53%
More coaching opportunities	33%
More training opportunities	33%
Expand service population to lower acuity youth	20%
Mixed caseloads of high acuity wraparound families and lower acuity families	13%
Tailor the process for youth transitioning to adult services	13%
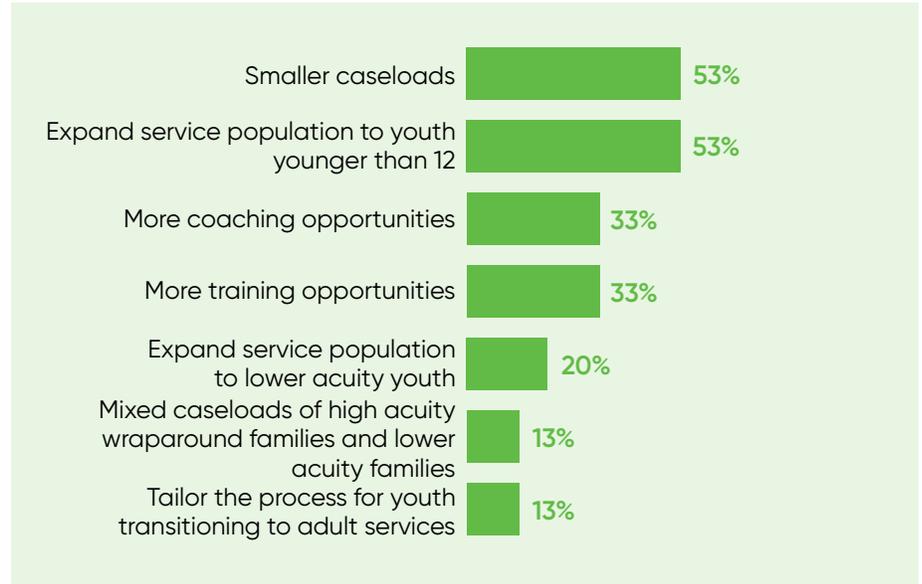
HFW Practice in the Time of COVID-19 Restrictions

The prevalence of COVID-19 and social distancing recommendations put into place to stop the spread of the virus impacted the way HFW was delivered. With in-person meetings much less feasible, agencies had to quickly develop alternative modes of service delivery. To better understand how restrictions impacted HFW delivery during Year Four, activities in the quarter just prior to restrictions (Q1), the quarter when restrictions began (Q2), and the quarter when restrictions were fully in place (Q3) were compared.

These disruptions did not lead to a reduction in the overall average number of CFTMs completed per open case; in fact, it went up slightly during the quarter when restrictions were fully in place in New York State (i.e., Year Four, quarter three). On average, care managers were able to conduct as many CFTMs during social distancing restrictions as they were conducting prior to restrictions.

Figure 22. Number of CTMS per open case, per quarter

Quarter	Value
10/1/2019 – 12/31/2019 YR4, Q1	1.09
1/1/2020 – 3/31/2020 YR4, Q2	1.09
4/1/2020 – 6/30/2020 YR4, Q3	1.16

Note: the green dashed line indicates the goal of 3 CFTMs per open case per quarter.

However, even though the overall average rate of CFTMs increased slightly, there was no increase in the percentage of families who received CFTMs while social distancing recommendations were in place. The reasons why some families were not able to participate in CFTMs over the displayed quarters is unknown. However, participation in CFTMs appeared to be a challenge for some teams even in the absence of social distancing recommendations. It is important

to note that some agencies/care managers faced delays and/or logistical challenges to using virtual means to conduct CFTMs. Due to this, one may expect the percentage of families participating in CFTMs in Year Four, quarter three to be lower than previous quarters. The quarter three percentage was lower than quarter one, but similar to quarter two (which mostly occurred prior to restrictions), so it's unclear if fewer families participated in CFTMs due to social distancing recommendations.

Figure 23. Percent of open cases w/ CFTMs, per quarter
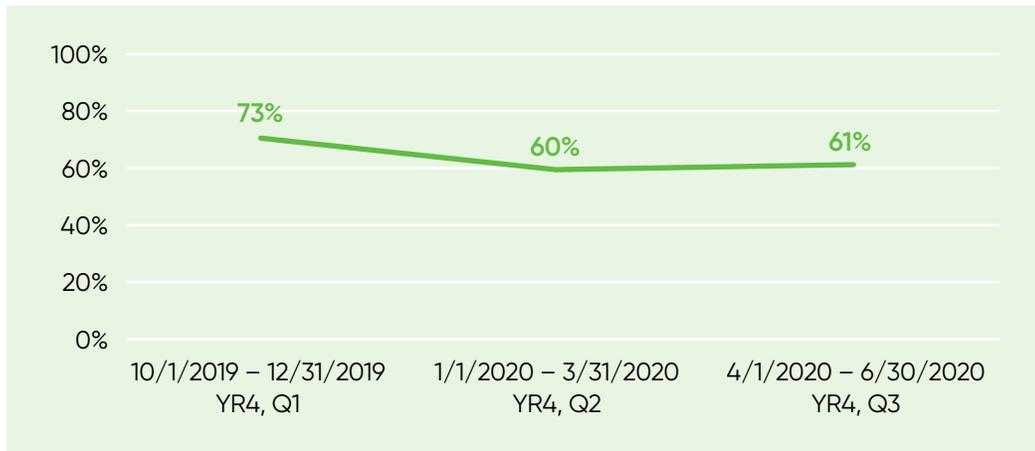
Note: cases were included if they had an enrollment date at least 1 month prior to the start of the quarter and were either open or had a discharge date after the end of the quarter.

In Year Four, quarter two, county administrators reported on their experiences using virtual conference technology platforms (e.g., Zoom, Webex). Representatives from each of the nine agencies/counties who responded indicated the use of virtual conference technology for CFTMs. In addition, 88% (7/8) agencies/counties who responded indicated that once in-person meetings resume, they anticipate continuing to use video conferencing programs to conduct or participate in CFTMs. Reasons for not continuing the use of virtual CFTMs referenced the face-to-face requirements for services for HHSC. Some respondents specified that virtual CFTMs would only be used if requested by the family but that in-person CFTMs would be prioritized. Some preferred that CFTMs would resume in-person for family members, but providers or team members, that could not attend physically, could join virtually.

One administrator felt that virtual CFTMs were advantageous in some situations, and hoped that they could continue to offer them, explaining:

> There are often times when we may receive a cancellation due to time restraints, or harsh weather conditions, or a family member being home sick. If we are able to continue offering virtual service, there will be less interruptions due to cancellations or missed appointments.
>
> Travel time also reduces the amount of meetings we are able to schedule in a day, as we serve an extremely rural area.

Many felt that virtual CFTMs are a good option to have available for families, providers, and informal supports that could be used, as needed.

The positive and negative aspects of virtual CFTMs relayed by administrators are summarized below:

Table 9. Positive and negative aspects of virtual CFTMs, administrator responses

Positive
Offers another option for families, providers, team members
Does not require travel, which may increase feasibility of attendance and efficiency (particularly in rural areas)
Offers an option when weather or family illness would have led to cancelation
Providers and team members can more easily attend for a portion of a meeting (e.g., 15 minutes) if they have a scheduling conflict
Negative
Health Homes Serving Children require face-to-face visits
In-person CFTMs viewed as preferred over virtual CFTMs when possible

Care managers also offered important insight into the changes in HFW work due to COVID-19 recommendations. In general, the reduction in in-person contact led care managers to diversify their communication methods. Not only did many care managers begin using video conferences, but they also tended to use other methods such as telephone calls, texts, and e-mails with a greater proportion of their families. The following graph displays care managers' reports of the percentage of their families with which they used each communication method pre- and post-adoption of COVID-19 related restrictions.

Care managers also reported their perceived advantages of virtual CFTMs. Most believed it was advantageous to offer virtual CFTMs as another option for families in the spirit of family voice and choice.

Figure 24. Communication methods used, care manager responses (N=15)

Method used with >50% of families

● Telephone call ● Video conference ● Text ● Email ● In-person
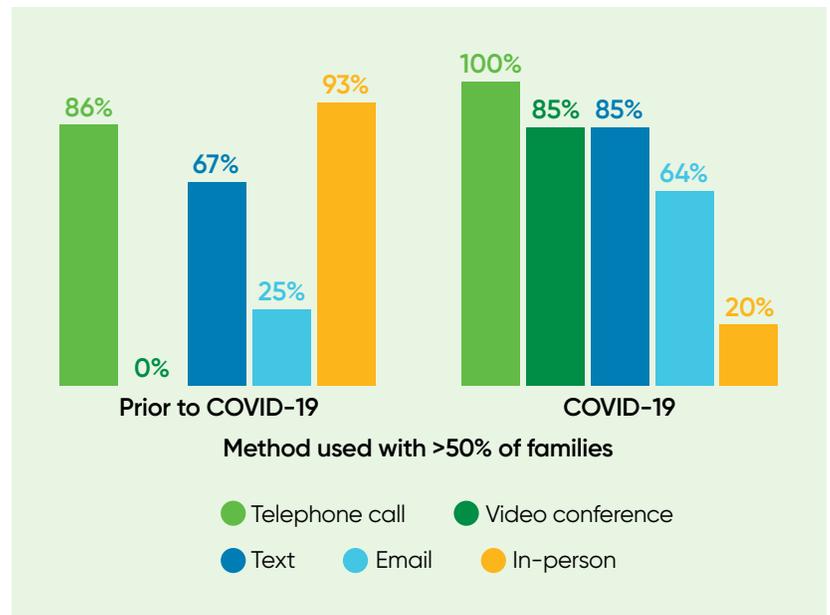
Figure 25. Advantages of virtual CFTMs, care manager responses (N=15)

Offers another option for families	73%
More efficient (e.g., no travel needed)	53%
Easier to schedule CFTMs with family	47%
More CFTM attendance of formal supports	47%
More CFTM attendance of informal supports	20%
Have not used virtual meeting platforms with families	13%
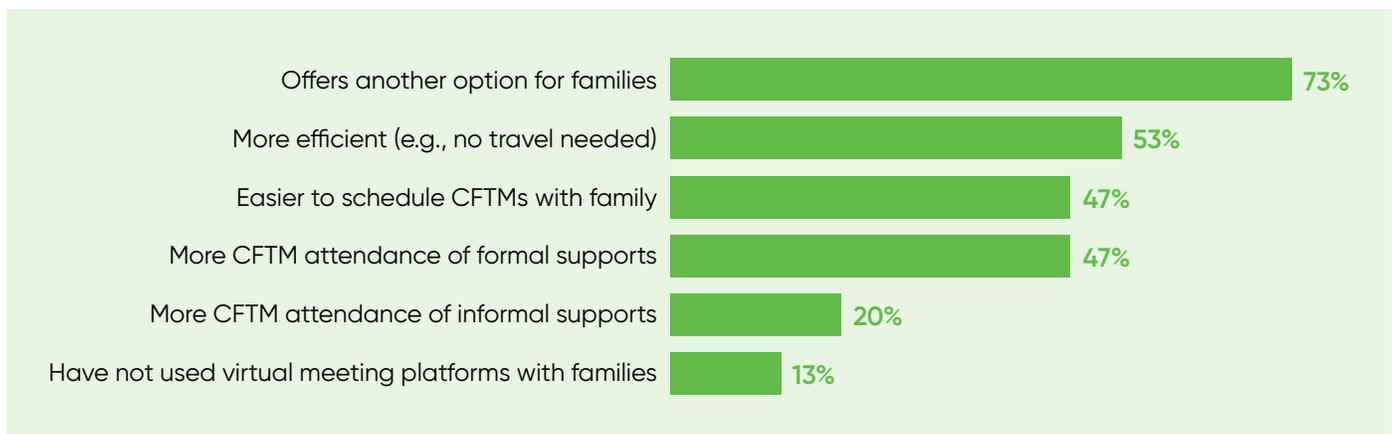
Care managers also reported challenges that their families experienced with virtual communications. The most common issue was families having difficulties with technology. Sharing devices and unreliable devices were also somewhat common. Even so, most families reportedly had access to devices and necessary peripherals (e.g., wifi, cellphone data).

Figure 26. Issues experienced with virtual CFTMs for greater than 50% of families, care manager responses (N=15)

Difficulties with technology	47%
Several people share one drive	36%
Unreliable device (e.g., phone, tablet, computer)	33%
Unreliable WIFI/reception	21%
Non-response	14%
No access to device	7%
Limited minutes/data	7%
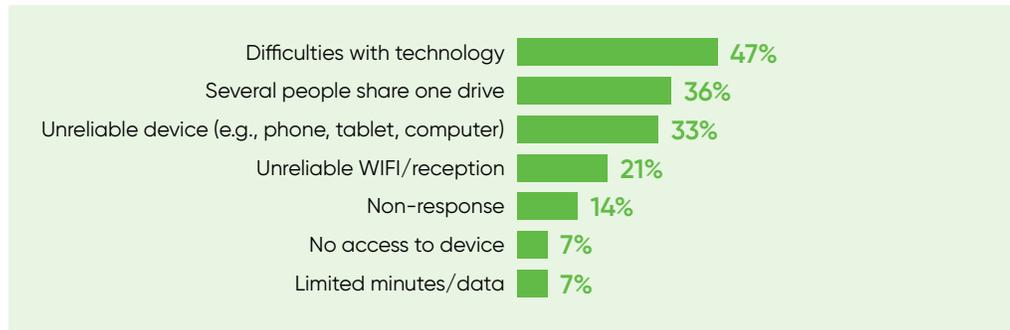
Peer Advocates and HFW

The Family Peer and Youth Peer Advocate tools (FPAT and YPAT, respectively) were created for this pilot project by CHSR in collaboration with the Peer Leads and OMH. These tools were designed for youth and caregivers to report on the ways in which peers work with youths and caregivers during the HFW process. They are scored on a 1 ("strongly agree," indicating activity was prevalent) to 5 ("strongly disagree," indicating activity was rare) scale. These scales were included as part of the reassessment and discharge interviews. The mean score of the FPAT was 1.84 and the YPAT was 1.85, indicating respondents generally agreed that activities were present.

Family peer advocates tended to struggle more often with two activities: helping to connect the youths with activities and helping to connect the family with informal support people (see Figure 27 for response averages per item on the FPAT). Helping to connect youths with activities in the community and families with informal support people may be especially challenging in the current environment that encourages social distance and limited contact in the community. These are two vital but also challenging activities of HFW.

Figure 27. Family Peer Advocate items at follow-up (N=90-93)

Helped your child get involved in community activities that your child is interested in	2.38
Assisted you in finding friends and family who could help you	2.27
Helped you prepare for team meetings	1.89
Increased your confidence to parent a child with a behavioral health challenge	1.88
Empowered you to be more active in your child's services	1.88
Shared with you their experiences with mental or behavioral health system	1.87
Educated you in how to get the needed services for your child	1.86
Showed you strategies you could use to solve problems	1.86
Educated you about the service systems your child is involved in	1.84
Helped you manage your stress	1.83
Helped you to make progress on your family's wraparound goals	1.82
Related to you	1.75
Encouraged you to speak up for what your child needed	1.72
Gave you hope for your family's future	1.71
Encouraged you to say what's important to you in meetings	1.68
Was reliable	1.63
Was trustworthy	1.62
Met with you at a place and time that worked for you	1.56

Youth peer advocates tended to struggle more with activities such as showing youths ways to lower stress and helping to connect the youths with activities and informal support people (see Figure 28 for response averages per item on the YPAT). Youth peer advocates scored similarly high to adult peer advocates in flexibility regarding meeting youths and caregivers at a convenient time and location.

Figure 28. Youth Peer Advocate items at follow-up (N=57)

Item	Score
Showed you how to lower your stress	2.21
Helped you get involved in things that you like to do in the community	2.09
Assisted you in finding friends and family who could help you	2.00
Shared with you their mental health experiences	1.95
Gave you hope for your future	1.89
Helped you figure out how to deal with some of your problems	1.82
Related to you	1.82
Was positive role model for you	1.81
Encouraged you to speak up for what you needed	1.79
Was trustworthy	1.79
Was reliable	1.75
Encouraged you to say what's important to you in meetings	1.74
Helped you to make progress on your wraparound goals	1.74
Supported you in doing things that you like to do and/or are good at	1.68
Met with you at a place and time that worked for you	1.67

Wraparound Scale

One outcome scale specific to the HFW program is the Wraparound Scale, which assesses whether basic elements of the HFW process were present. This scale was created by CHSR and was included as part of the reassessment and discharge interviews. Wraparound items were scored on a 1 ("strongly agree," indicating care coordination was more reflective of Wraparound) to 5 ("strongly disagree," indicating care coordination was less reflective of Wraparound) scale.

Figure 29 displays the mean caregiver and youth/young adult scores per item. One report per caregiver and/or youth/ young adult was included. In cases where multiple assessments were available per caregiver and/or youth/young adult, the most recent assessment was included. The item indicating wraparound is different from other services exhibited the most agreement, whereas items assessing if wraparound connected you to the community or if your family is doing better after wraparound exhibited slightly less agreement. Average scores on all items were below the midpoint of the scale, indicating most respondents had at least some agreement with these items, suggesting the basic components of HFW were present in most cases. Youth scores were slightly more positive than caregiver responses across all items.

Figure 29. Wraparound items at follow-up (CG N=101-103, Y N=61-64)

Item	Caregiver	Youth/YA
1. Your Wraparound plan helps you and your family get closer to your goals	2.20	2.05
2. Wraparound team meetings help you and your family focus on your plan and get things done	2.19	2.05
3. Wraparound helps connect you to people, places, and activities in your community	2.36	2.11
4. Wraparound is different from other services you have received	2.06	2.02
5. Your family is doing better after starting Wraparound	2.29	2.06

Review of fidelity data

Practitioner fidelity to the HFW model is critical for the related aims of ensuring high-quality HFW implementation and positive family outcomes. If fidelity to expected model practice is lacking, families cannot be said to have received HFW, and the expected changes in families' lives may not be evidenced. This is a critical point, as HFW has demonstrated promising evidence of effectiveness, but only where model fidelity was high (Bruns, Suter, Force, & Burchard, 2005).

Four instruments have been used to monitor NYS SOC HFW for adherence to the HFW model. The first two tools, the Team Observation Measure (TOM) 2.0 and the Wraparound Fidelity Index-EZ (WFI-EZ), were administered once to each consenting participant between their third and seventh CFTM. There are also two document review tools adapted from the Document Assessment and Review Tool[9]; The 45-Day Review and the 2nd CFTM Review were administered at 45 days post-referral and after two CFTMs, respectively.

The following sections describe findings from these fidelity instruments. Additionally, they will explain how each instrument is used, why they were chosen, and how the results presented here should be interpreted[10].

Fidelity to HFW reflected in records on Wrap-NY. Document review is an important method for assessing fidelity to HFW because it involves the review of each family's Plan of Care, which guides their care while in HFW.

The first type of review examined Plan of Care components expected to be generated during the Engagement phase, which ends by the 45-day post-referral mark. Figure 30 displays whether foundational components of the Plan of Care are present and written in ways that meet model expectations. This review focused on the Crisis Plan, family story, and family vision of 155 families' records.

Figure 30. Results of review of key records from Engagement based on items from the 45-Day Review (N=155)
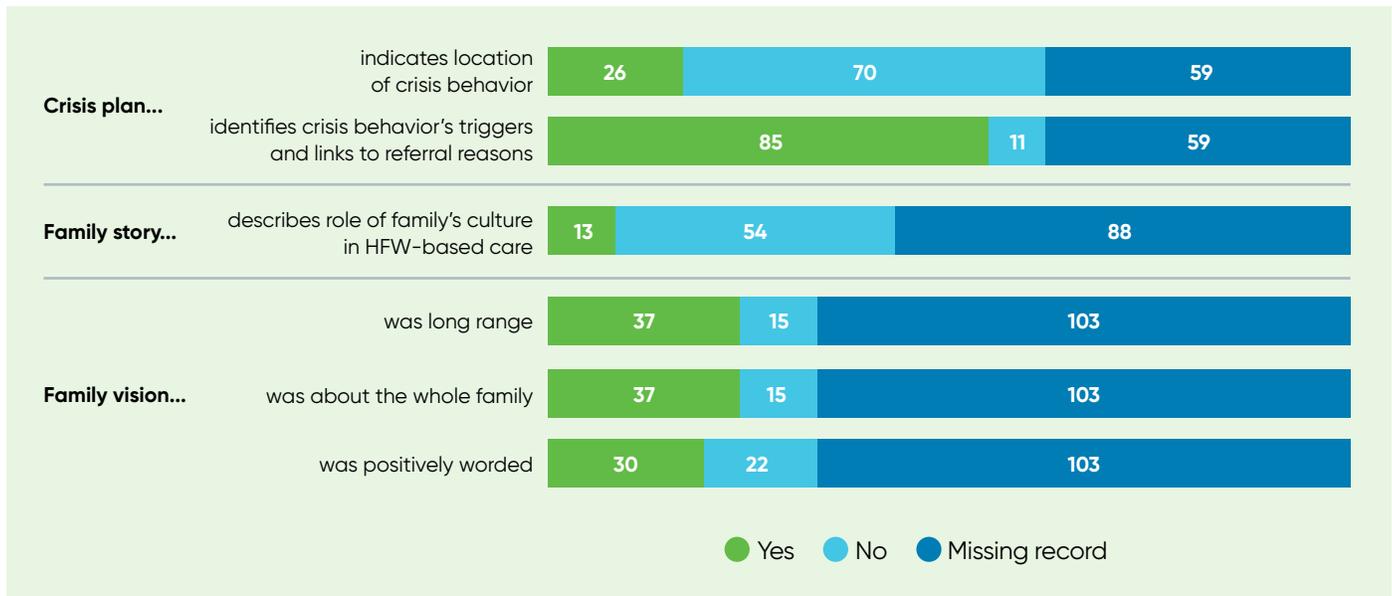

The second type of review examined Plan of Care components that are expected to be generated following the final milestone of HFW's Plan Development phase and the beginning of the Plan Implementation phase (i.e., between the first and second CFTM). Figure 31 displays whether key Plan of Care components created during the Engagement phase are integrated around strategies that guide the family's work in HFW, specifically focusing on the needs statements, records reflecting review of progress (i.e., outcomes), and strategies of 94 families' records[11].

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[9] The WFI-EZ, Tom 2.0, and Document Assessment and Review Tool are tools from the Wraparound Evaluation and Research TEAM (WERT) at the University of Washington.

[10] Erie data was excluded from some sections because much of the fidelity data for this county was acquired early on prior to completion of CM training, see Appendix D for explication.

[11] Fewer 2nd CFTM reviews are available for families because not every family that progressed to the 45-day post-referral mark had record of two team meetings when data were pulled for review (6/30/2020)

Figure 31. Results of review of key records from Plan Development and early Implementation based on items from the 2nd CFTM review (N= 94)

Yes   No   Missing record
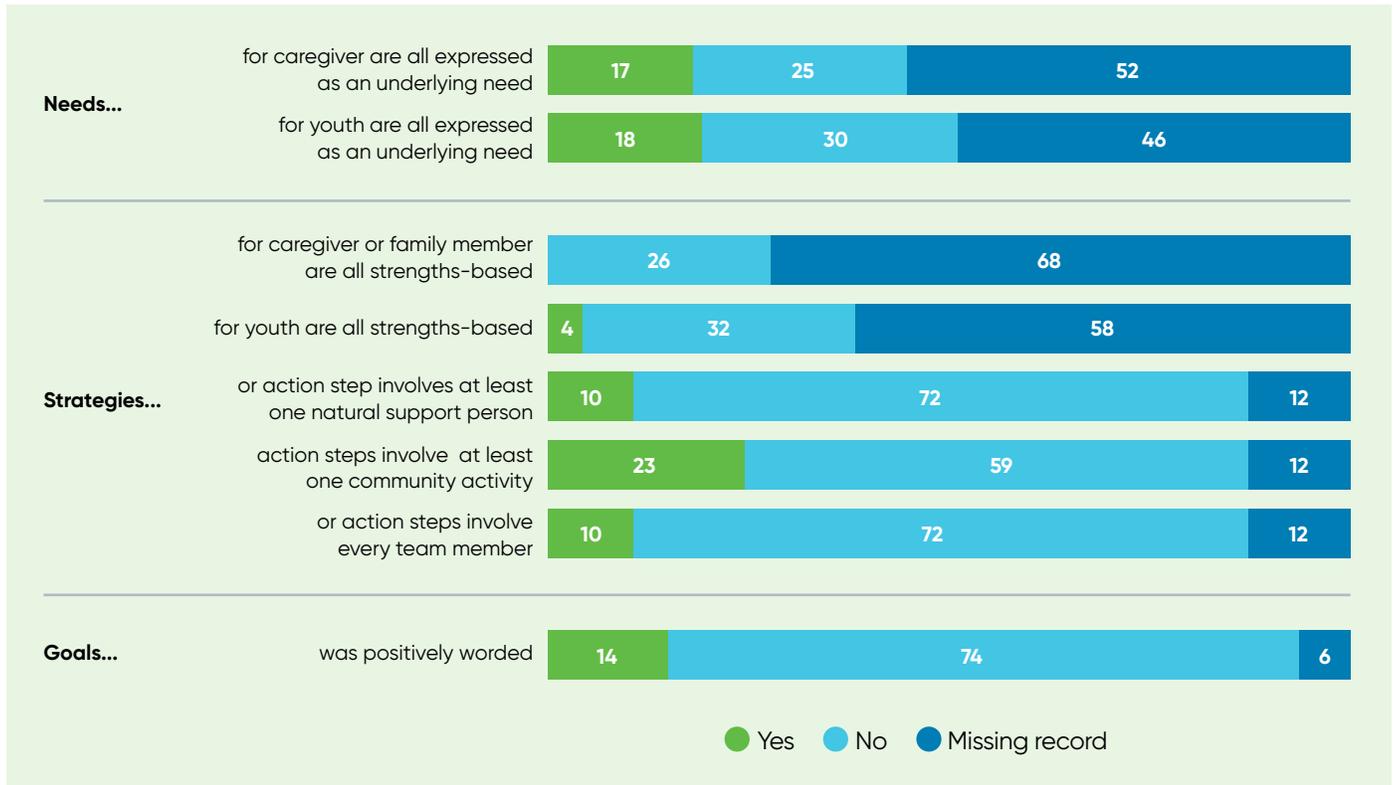
Note. At least two needs and one caregiver or family member need were required to be present to examine whether they were expressed as underlying needs. Strengths-based refers to whether a strategy was based on a need that reflected specific youth and caregiver skills, interests, or abilities.

Unfortunately, many of the Plan of Care components that were expected to be present at the time of both reviews were not entered into Wrap-NY. This made it difficult to identify the extent to which care managers are consistently creating Plans of Care that reflect model fidelity. HFW prescribes completion of Crisis Plans within the first ten days of referral and completion of Family Stories and Visions within the first 30 days of referral. However, Figure 30 shows high proportions of youths did not have key Engagement phase records even at 45-day post-referral. Nearly forty percent (n=59; 38%) of youths were missing Crisis Plans, and over half were missing Family Stories (n=88; 57%) and Family Visions (n=103; 66%). While Figure 31 shows lower proportions of missing Plan Development and Implementation records, caregiver (or family member) needs and strategies were missing for 55% (n=52) and 72% (n=68) of families, respectively. It is unclear why so many caregiver needs and strategies were missing. One possibility is that caregivers preferred the HFW process focus on their child, but this is inconsistent with a key aim of HFW to assist the whole family, not just the youth.

Reviews of available records (i.e., those present and scored) showed some strengths and weaknesses in fidelity to the model. Engagement phase records showed that a specific area of strength was that 89% of Crisis Plans identified behaviors that tended to precede behaviors requiring emergency response and described behaviors that were also indicated as focal areas on eligibility and enrollment paperwork. One area where improvement is needed is including a description of the role of the family's culture in HFW-based care, which was present in less than one-fifth of available records.

Plan Development and Implementation phase components revealed lower fidelity to HFW standards than on Engagement. Fidelity to the HFW model is more difficult in these later phases because it requires building a coordinated Plan of Care from components or records from the Engagement phase. In addition, understanding how the pieces fit together and entering them in the appropriate spots in Wrap-NY can be difficult and may require ample technical assistance.

Fidelity to HFW reflected in team member perceptions. HFW team members' perceptions of fidelity to the HFW process was also assessed using the WFI-EZ survey. The survey asks all HFW team members to rate the extent to which they agree that HFW was implemented faithfully, on a scale of 1 ("strongly disagree," indicating low fidelity) to 5 ("strongly agree," indicating high fidelity) in five domains. Average responses for each domain were then translated into percentages (e.g., an average agreement score of 4/5 would be an 80%). These results include responses from 175 participants across 41 teams, for an average of roughly four respondents per team (see Figure 32)[12].

The average percent agreement across all participants and domains was 74%, indicating a perception that HFW was generally practiced to fidelity. Participants gave stronger ratings for Strength-and-Family-Driven, Needs-Based, and Outcomes-Based domains, all with percent agreement scores of at least 77%, indicating participants agreed that practice features in these domains were implemented with fidelity. The two lowest domains, Effective Teamwork and Natural/Community Supports had ratings that suggested participants found practices in these domains were less consistently implemented.

Figure 32. WFI-EZ Percent Fidelity: Key Domains and Overall (N= 175)
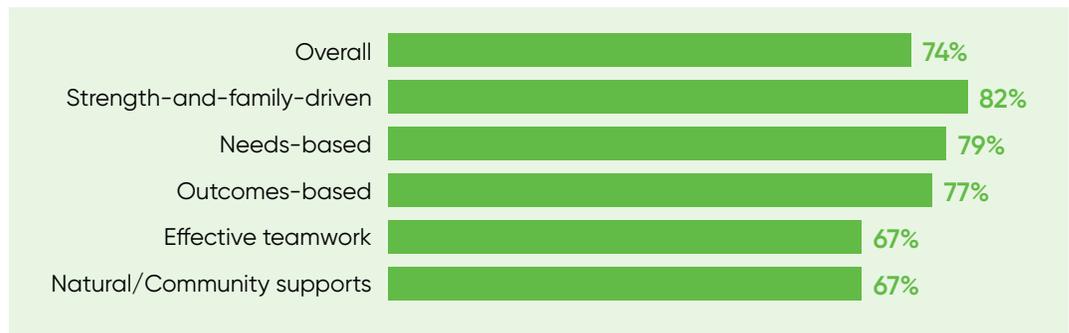
When broken out by role, respondents' ratings were similar to the overall ratings (see Table 10). Strength-and-Family-Driven, Needs-based, and Outcomes-based were all rated similarly and showed the highest ratings, while Natural/Community Supports was the lowest or second lowest across all roles. Ratings also tended to follow the national average for respondents.

Table 10. WFI-EZ mean percent agreement by domain and respondent type in NYS SOC vs. National Average.

Domain	Youth (N=24)		Caregiver (N=38)		Facilitator (N=37)		Peer Support Service Provider[†] (N=48)		Other Team Members[††] (N=28)	
	NYS	National	NYS	National	NYS	National	NYS	National	NYS	National
Overall	**73%**	**69%**	**72%**	**72%**	**75%**	**74%**	**74%**	**73%**	**79%**	**73%**
Strength-and-family-driven	77%	72%	78%	78%	87%	83%	82%	82%	85%	82%
Needs-Based	79%	72%	74%	74%	81%	75%	75%	75%	81%	75%
Outcomes-Based	76%	73%	75%	75%	77%	76%	76%	76%	84%	75%
Effective Teamwork	66%	64%	68%	68%	62%	68%	66%	66%	72%	66%
Natural/ Community Supports	65%	66%	66%	66%	66%	66%	66%	66%	75%	66%

Note. The highest- and lowest-rated domains for each role are in green and red, respectively.
[†]Family peer support service provider=27; Youth peer support service provider=21.
[††]Other Family Relative=6; Therapist/Clinician=5; Missing/Not Given=4; Teacher/school staff=4; Case Worker=3; Other=3; Birth/Adoptive parent=1; Adult Friend=1; Probation officer=1)

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[12] The National Wraparound Initiative also collects WFI-EZ data from sites across the country, thereby allowing comparisons between NYS data and national averages. These averages serve as a benchmark and can facilitate interpretation of local data.

One role, however, stood out: other team members (e.g., therapists and family relatives). They tended to rate fidelity to the model higher than youths, caregivers, and facilitators in the NYS pilot, and higher than other team members participating nationally. It is unclear why this difference exists. While the other team members in the NYS SOC project could genuinely perceive NYS HFW implementation to be closer to model fidelity than their nationwide counterparts, another explanation is that the two groups are dissimilar in such a way as to make comparison inappropriate[13].

Fidelity to HFW in CFTMs. Assessing fidelity to HFW by observing team meetings is also critical, as the team meeting is the vehicle through which critical HFW work is done (i.e., needs are clarified, strategies are developed or revised, progress is monitored, etc.). The TOM 2.0 is completed by an external data collector after conducting a live observation of a CFTM. It includes an overall fidelity score and the same five domains as the WFI-EZ plus two additional domains specific to meetings: Skilled Facilitation (the facilitator's ability to conduct a high-quality meeting) and meeting attendance, which is not included in the current report because it was not assessed reliably. The current results describe the extent to which 44[14] observed CFTMs followed HFW practice standards, representing almost half (49%) of families who were eligible for an observation by the time of assessment[15] (see Figure 33). Until March of 2020, live observations occurred in person; since then a small number occurred via Zoom (n=6) due to social distancing mandates in place stemming from the COVID-19 pandemic. Observers scored each item based on whether or not a standard was present.

NYS demonstrated an overall fidelity score (average percent fidelity of each observed meeting) of 70% across all four years (See Figure 33). This increased over time, with an overall fidelity score of 72% (n=34) in the fourth year, up from 67% (n=10) over the first three years. Fidelity on all key elements also improved, except for on Effective Teamwork where it remained high.

NYS SOC fidelity in team meetings were similar to or exceeded national averages on four of five domains but was lower overall and on the Natural/Community Supports domain (see Figure 33). Natural/Community Supports has been shown to need improvement throughout the project and will likely continue to be difficult to address during the pandemic due to social distancing mandates.

Figure 33. TOM 2.0 percent fidelity overall, and by key element and skilled facilitation compared to National Averages (N=43)[16]

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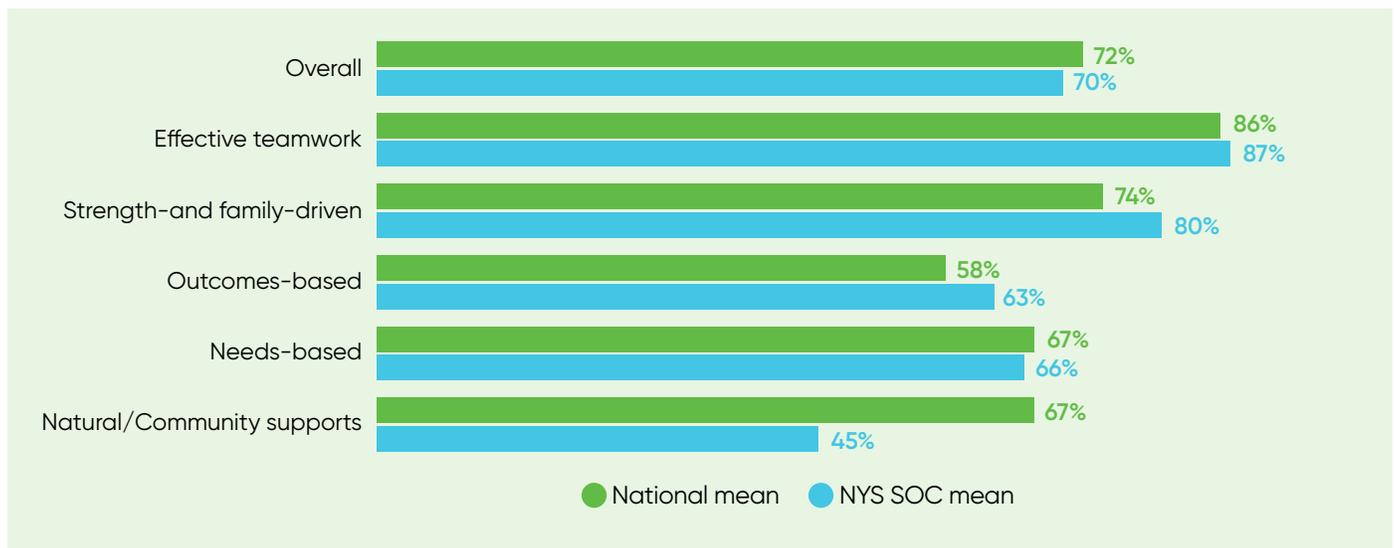
[13] That is, the other team members participating in the NYS pilot are a small, heterogeneous group, comprised of professionals (e.g., therapists) and natural supports (e.g., family relative). Their combined percentages are therefore more sensitive to one type of role that may tend to rate fidelity higher. The roles of other team members participating nationally is unknown, but could be more homogeneous, with larger proportions of respondents representing one or two types of team members that tend to rate model fidelity lower. Thus, it is probably best to not interpret NYS-national comparisons within the other team member role until larger NYS samples are attained.

[14] Each families' CFTM was observed only once, per evaluation protocol.

[15] As of 6/30/2020, 89 families (a) indicated interest on the evaluation interest and contact form and (b) had at least two recorded CFTMs.

[16] *Note*. National mean percentages are based on data available through 2016; The number of observations for national averages is not available.

In addition to improvement on key elements, observers indicated that on average nearly four out of five (79%) key practice features reflecting skilled facilitation were implemented across all observed meetings. Skilled facilitation is specific to team meetings; it focuses on care managers' skill in organizing a meeting and ensuring it flows productively. Care managers also showed improvement from the first three years (68%; n=10) to the fourth year (83%; n=43) on skilled facilitation, driven by improvements in all practice areas.

While there are multiple potential explanations for this increase in fidelity to HFW in team meetings, one possibility is the increased effectiveness of the NYS SOC training. Newer cohorts of care managers in the NYS SOC pilot generally participated in a newer, enhanced iteration of the training. All observations took place with care managers who attended one or more of the first five iterations of training. Cohorts who participated in trainings three through five represented almost all of the observations in Year Four (29 out of 34 year four observations). One care manager who participated in two training cohorts 18 months apart remarked during annual care manager interviews that the most recent training had greatly improved by offering care managers much more specific instruction and guidance on many HFW practices and facilitating CFTMs. She noted that she learned practices that were inconsistent with what she learned during the first iteration. Thus, most of the observations in the last year when fidelity was observed to be higher were facilitated by care managers who participated in more developed trainings, suggesting training effectiveness increased.

SUMMARY

In general, findings suggest:

- A strength of NYS SOC is that nearly all referrals to HFW end up enrolling in the program (91%), resulting in 246 youths served in NYS SOC through Year Four, quarter three.

- Nearly 80% of youths discharge from HFW prior to the Transition phase, which indicates the HFW process was not completed. Youths who discharged in the Transition phase completed more CFTMs (seven vs. two), more frequent CFTMs (on average every 47 days versus every 87 days), and had a longer LOS (11 vs. seven months). CFTM productivity may be an early predictor of families who are more likely to complete all four phases of HFW.

- Care managers identify the team-based approach as helping the family the most; however, building those teams and getting them to attend CFTMs were some of the most challenging aspects of HFW. Since building a functional team is both important and challenging, this is an area ripe for additional training, TA, or commitment of other resources.

- Care managers adapted well to changes in HFW delivery due to COVID-19 restrictions; they tended to use a diverse array of methods to maintain contact with families including virtual meetings. Because of this, the rates of completion of CFTMs looked similar to pre-COVID-19 times.

- Care managers reported that virtual CFTMs were challenging for some families mostly due to difficulties with technology. However, many providers appreciated the option of virtual CFTMS and hoped that it could

remain available in the future to maintain flexible options for families and team members.

- Youth and family peers were particularly effective at offering their services in a flexible way to youths and caregivers (e.g., at a place and time that was convenient). They were less successful at helping to connect youths to activities in the community.

- Youths and Caregivers reported that the basic components that set HFW apart from HHSC care coordination were present in most cases.

- Across both observation and WFI-EZ survey fidelity assessment, strength-and-family-driven were high scoring fidelity domains and natural/community supports was the lowest scoring HFW domain.

- HFW Records had substantial missing data, making it difficult to review fidelity. Of record components available, Engagement phase components showed higher fidelity than Plan Development and Implementation components. Document review fidelity was the lowest of all three methods.

- CFTM fidelity improved over the grant tenure. Overall averages on fidelity ratings were similar to or exceeded national averages in all domains except for the natural/community supports domain. Improvement may have been driven by enhancements made to the HFW training, which benefited newer cohorts of care managers who also tended to participate in observation later in the project.

There are some areas identified for HFW practice improvement. The incorporation of natural/community supports into the HFW process was a challenge. This was the lowest scoring fidelity domain. In addition, YPAT and FPAT (completed by youths and caregivers) results also point to challenges with assisting and connecting families to these supports. In past interviews, care managers had expressed that some families preferred a smaller team, with only the care manager and peers.

Another area where improvement is needed is with documenting the HFW process; many HFW records were missing and incomplete, as identified during document review processes. These records are important because they are provided to the family as well (e.g., family story, Plan of Care, Crisis Plan). Families need complete documents so that they can participate fully in the HFW process.

Another challenging part of HFW is completing all four phases with families. It is expected that some families will be unable to complete all four phases of HFW, however at this point of HFW implementation, only about 20% of youths are discharging after completing a Transition phase of HFW. The Wraparound Implementation and Practice Quality Standards suggest that most transitions should be "planned for in advance" and "only happen when the youth and family have sufficiently met their needs" (Coldiron, Bruns, Hensley, & Paragoris, 2016, pg. 16, indicator F8).

Finally, consistent and regular CFTMs are another challenging area of implementation; slightly more than a third of teams did not have any CFTMs in the most recent quarter. CFTMS are a necessary component of HFW, and CFTM productivity may be an early predictor of families who are more likely to complete all four phases of HFW.

Despite these challenges, by the end of the HFW pilot project, most aspects of HFW are in place with NYS SOC HFW practice. A strength of NYS SOC is emphasizing strength and family driven domains, which were high scoring domains in both CFTM observations and team member surveys. Teamwork was identified by care managers as the most important aspect of HFW and was also the highest scoring domain in CFTM observations.

Future implementation should focus on maintaining these strengths and providing additional support around the suggested areas of improvement.
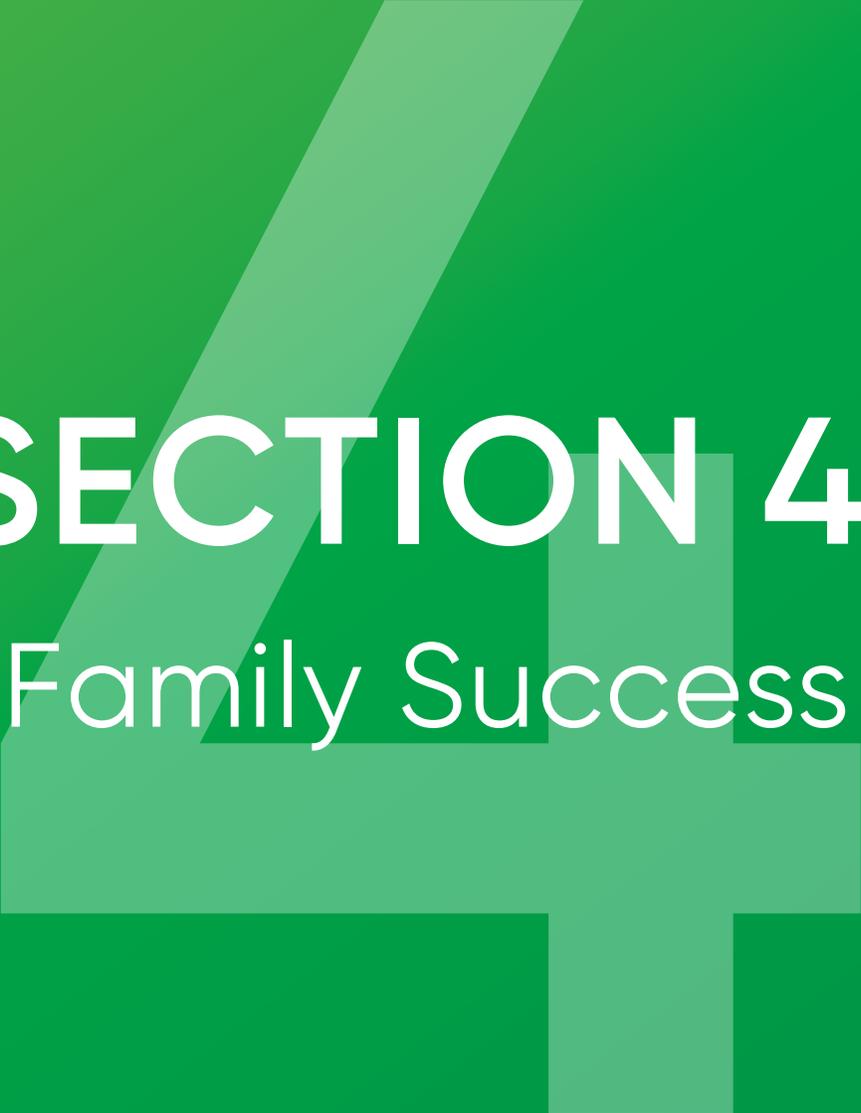
SECTION 4:
Family Success

Section IV:
Family Success

INTRODUCTION

The ultimate goal of the NYS SOC project is to impact the lives of the youth and families that it serves.

A meta-analysis of HFW found that this care coordination practice has significant positive impacts on families in the areas of mental health outcomes (based on four studies) and overall youth functioning (based on six studies; Suter & Bruns, 2009). Further, more recent findings also suggest that HFW could result in cost savings, such that HFW participation led to a reduction in monthly health care spending as compared to the control group in the areas of mental health inpatient spending and general outpatient spending (Snyder, Marton, McLaren, Feng, & Zhou, 2017).

The following sections will examine outcomes for children and their families in:

- Child/youth strengths (CANS-NY child strength items: resourcefulness, adaptability, persistence, resilience, talents/interests) and needs;

- Caregiver strain (Caregiver Strain Questionnaire);

- Caregiver and child/youth empowerment (Family Empowerment Scale; Youth Empowerment Scale-Mental Health);

- Child/youth hope (Children's Hope Scale);

- Child/youth impairment and symptomology (Columbia Impairment Scale; Pediatric Symptoms Checklist); and

- Use of high cost, emergency services (Medicaid service use).

ACTIVITIES RELEVANT TO FAMILY SUCCESS

The aim of all NYS SOC project activities intend to improve families' lives. SOC development activities intend to create effective HFW trainings which, in turn, build a workforce skilled in HFW, as well as develop an environment in which HFW can be implemented as intended. HFW, practiced as intended, is expected to ultimately have a positive impact on family outcomes. Thus, all NYS SOC activities are relevant to family success.

FINDINGS

Family success in HFW was assessed in several ways, including changes in youth impairment, youth symptomology, youth needs and strengths, caregiver strain, family and youth empowerment, youth hope, and service use. Exploration of a wide range of outcomes helps to discover the ways in which HFW affects families.

Strengths and Needs

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

There were some positive findings when looking at changes in CANS-NY scores corresponding with participation in HFW for families with both an eligibility assessment and at least one later assessment (i.e., reassessment or discharge). First, while 98% of families scored as High Acuity at baseline, only 73% met the criteria at follow-up (t (105) = 5.990, p < 0.001; see Figure 34). Families also showed reductions in needs across some critical CANS-NY subscales. Families were less likely

to meet the high acuity criteria for trauma[17], behavioral health, child needs & functioning, and caregiver strengths and needs at follow-up. The percentage of youth meeting high acuity criteria in medical health, developmental, substance use, impairment in self-care, and risk factors and behaviors did not change significantly. However, these domains also had lower rates of meeting high acuity criteria at eligibility so there was less "room" for reduction in acuity.

Figure 34. Percent of families meeting high acuity on overall CANS-NY assessment and in each domain, for N=106 families with both baseline and reassessment or discharge data (*=*p*<0.05)
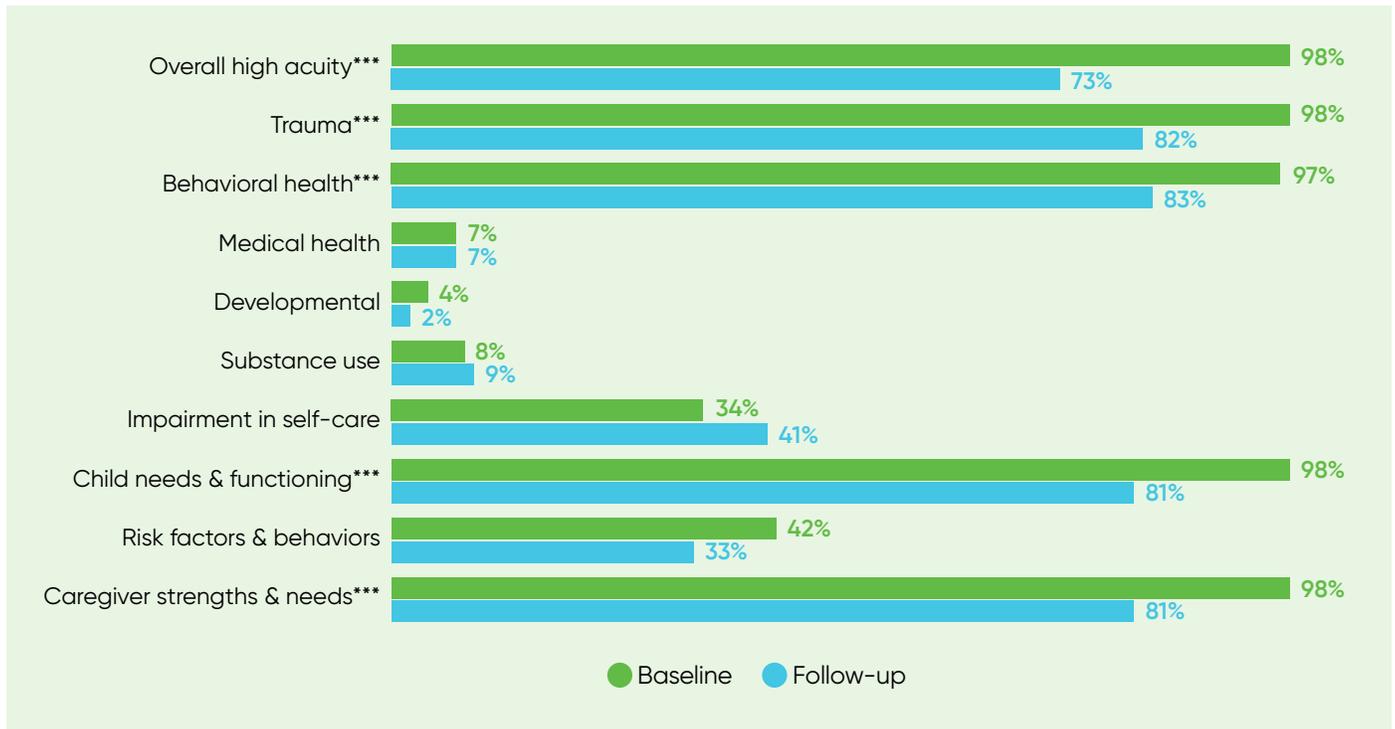
*Note. † = p<0.1, * = p<0.05, ** = p<0.01, *** = p<=0.001*

One part of the CANS-NY that is not captured in the acuity scoring is youths' strengths. The youths' strengths portion of the CANS-NY has several items that would be expected to improve over the course of HFW: optimism, resourcefulness, adaptability, persistence, resilience, and talents/interests. These items were explored for changes between the eligibility and a follow-up CANS-NY. All these items improved while participating in HFW (lower scores indicate a greater strength; see Table 11), with the exception of talents/interests, which did not change significantly.

Table 11. CANS-NY select Child Strengths at eligibility and follow-up (N=87-88)

Child Strength	N	Time 1	Time 2	t	p
Optimism***	87	2.13	1.82	3.77	<0.001
Resourcefulness***	88	1.95	1.66	3.45	0.001
Adaptability***	88	1.95	1.59	3.55	0.001
Persistence**	87	1.80	1.49	2.95	0.004
Resilience***	88	2.09	1.64	4.52	<0.001
Talents/Interests	88	1.53	1.47	.65	0.516

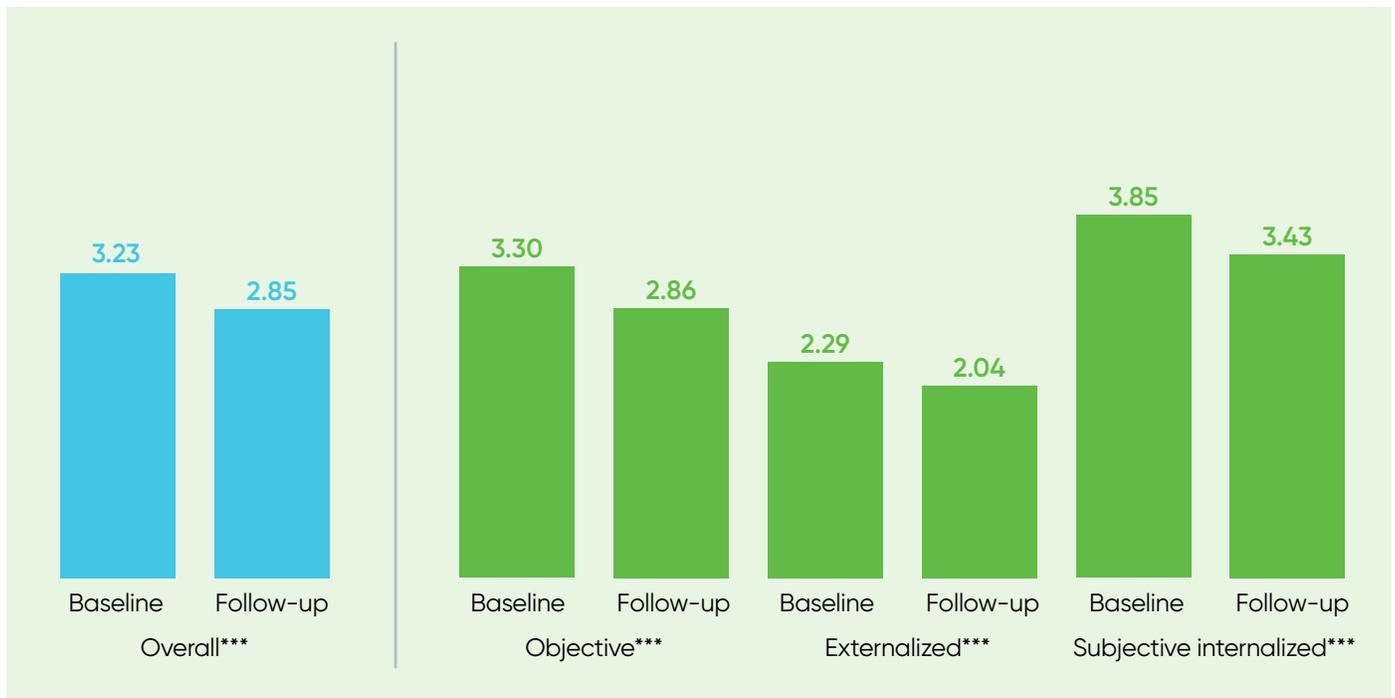*Note. † = p<0.1, * = p<0.05, ** = p<0.01, *** = p<=0.001*

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

Caregiver Strain

To be designated high acuity according to the CANS-NY, caregivers must exhibit a high level of need. Caregiver strain is likely prevalent among the participants in the NYS SOC pilot. As teams progress on meeting underlying needs and family vision and build skills for self-efficacy, caregiver strain should reduce.

The Caregiver Strain Questionnaire (CSQ) was used to determine changes in caregiver strain during HFW. This tool measures how things have been with the family/household (Brannan, Heflinger, & Bickman, 1997). It contains three subscales: objective strain (observable disruptions to life), externalized strain (negative feelings that are projected outward, such as anger, resentment, and embarrassment), and subjective internalized strain (negative internalized feelings, such as worry, guilt, and fatigue). Scoring on the CSQ is on a 1 ("not at all", indicating the item is not an issue) to 5 ("very much," indicating the item was very much an issue) scale. Subjective internalized strain was the most prevalent and externalized strain the least prevalent at both baseline and follow-up for caregivers in HFW. All types of caregiver strain decreased significantly between baseline and follow-up. These findings suggest that caregiver strain reduced while participating in HFW.

**Figure 35.** Caregiver strain, matched pairs at baseline and follow-up (N=78)

*Note. † = p<0.1, * = p<0.05, ** = p<0.01, *** = p<=0.001*

Empowerment

Another result of building self-efficacy skills with the HFW process would be increased feelings of empowerment within the family and services. Data from the Family Empowerment Scale (FES) was used to identify changes in family empowerment after starting HFW. This tool measures how able the caregiver feels to take care of situations involving their family, their youth, and the youth's services (Koren, Dechillo, & Friesen, 1992)[18].

**Figure 36.** Family empowerment at baseline and follow-up (N=72-73)

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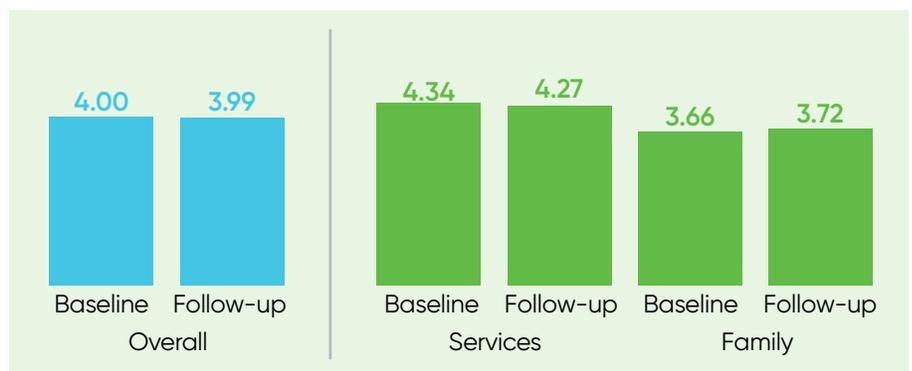
[18] Scores can be presented by subscales and/or as the total score. The FES has subscales focused on family, services, and community. To maintain brevity of interviews, interviews included the family and services items.

Scoring on the FES is on a 1 ("never," indicating low empowerment) to 5 ("very often," indicating high empowerment) scale. Empowerment at all timepoints was somewhat high, above the midpoint of the scale. There was not a significant change in family empowerment between baseline and follow-up for the overall scale, nor for the two subscales. Interestingly, caregivers tended to have higher empowerment when it came to their child's services than when it came to their family at both baseline and follow-up. One priority of family peer advocates is to help families navigate the children's services and service systems. However, for HFW families, this assistance may be less needed in service navigation; rather, families may need more assistance in feeling empowered within the family.

Data from the Youth Empowerment Scale (YES) was used to determine changes in youth empowerment after starting HFW. This tool measures how able the youth feels empowered with the self and with services (Walker, & Powers, 2007).[19] Scoring on the YES is on a 1 ("never," indicating low empowerment) to 5 ("very often," indicating high empowerment) scale. Empowerment at all timepoints was somewhat high, above the midpoint of the scale. Although follow-up averages on the overall total and the two subscales were consistently higher than baseline averages, the changes were not significant. Similar to the FES, scores on the self subscale were lower than the services subscale, suggesting efforts to build self-empowerment may be more fruitful.

Figure 37. Youth empowerment at baseline and follow-up (N=51)
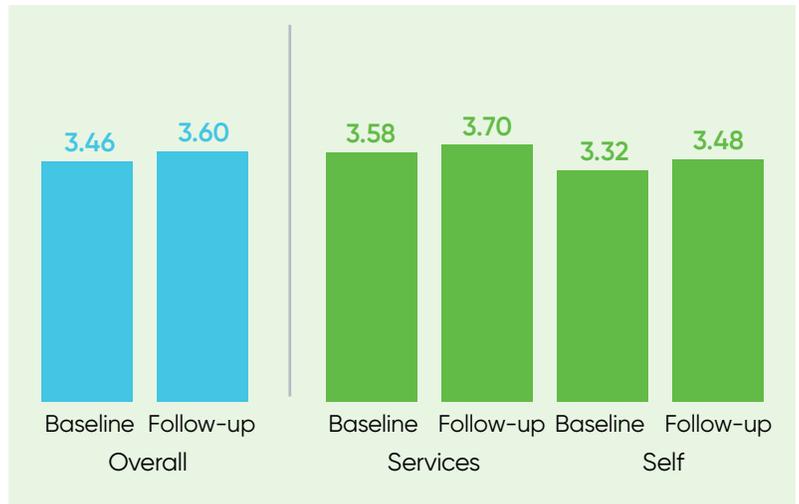
Youth Hope

Progressing on the Plan of Care and making improvements on underlying needs should also build youth hope. Youth hope was assessed with the Children's Hope Scale (CHS; Snyder, Hoza, Pelham, et al., 1997). Scoring for the CHS is on a 1 ("none of the time") to 6 ("all of the time") scale. Youths' average hope score was above the midpoint of the scale at both time points and went up between baseline (Mean = 3.54) and follow-up (Mean = 3.76), but this difference was not statistically significant.

**Figure 38.** Youth hope items, matched pairs at baseline and follow-up (N=50-51)
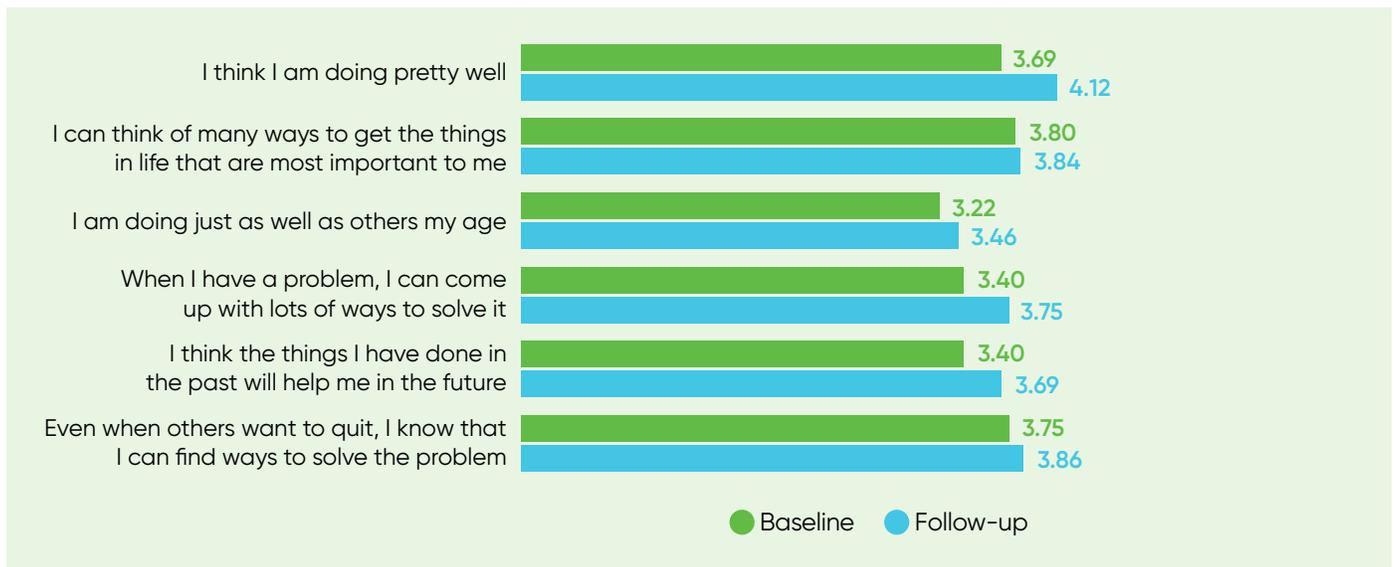
[19] Scores can be presented by subscales and/or as the total score. The YES has subscales focused on self, services, and system. To maintain brevity of interviews, interviews included the self and services items.

Youth Impairment and Symptomology

While progressing on underlying needs with HFW, youth improvement in both impairment and symptomology would be expected to follow. The Columbia Impairment Scale (CIS) was used to determine changes in impairment between the start and end of programs. This tool measures areas where the child needs help in functioning in various domains such as with family, peers, or in school (Bird, Shaffer, et al., 1993). Scoring for the CIS is on a 0 ("no problem") to 4 ("very bad problem") scale. Caregivers report that youth impairment was moderate (averaging around the midpoint of the scale) at baseline, and decreased significantly at the follow-up measurement, *t* (75) = 4.30, *p* < .001. Largest mean differences were observed for items reflecting the youth feeling nervous/afraid, conflicting with siblings, and feeling sad/unhappy. Youths' reports of impairment were somewhat low, below the midpoint of the scale (2) at both baseline and follow-up. Youths reported less impairment than caregivers at both timepoints. Mean impairment at baseline (mean= 1.54) was higher than impairment at follow-up (mean = 1.35); however, this difference was not significant *t* (52) = 1.65, *p* = .11.

Figure 39. Youth impairment, caregiver (N=76) and youth (N=53) report, matched pairs at baseline and follow-up
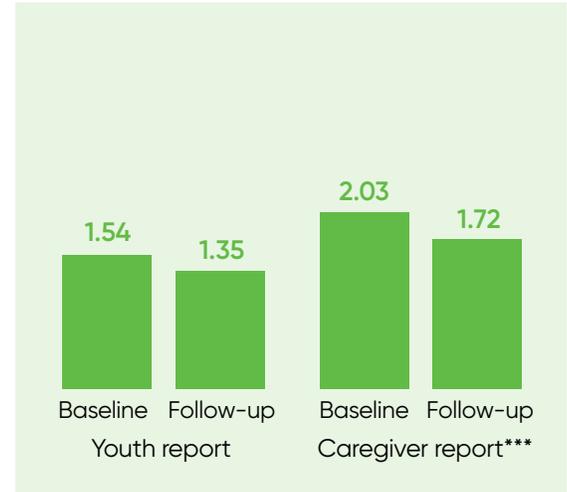
*Note. † = p<0.1, * = p<0.05, ** = p<0.01, *** = p<=0.001*

The Pediatric Symptoms Checklist (PSC) was used to determine changes in symptoms between the start and end of programs. This tool measures symptoms associated with the child's behavior, emotions, and learning (Jellinek, Murphy, et al., 1999). Scoring for the PSC is on a 0 ("never," indicating that this symptom is never present) to 2 ("often," indicating the symptom is often present) scale. According to caregiver responses, internalizing, attention, and externalizing youth symptoms all showed improvement between baseline and follow-up (*p* < .05), suggesting improvement in all areas of symptomology.

Figure 40. Youth symptoms, caregiver report, matched pairs at baseline and follow-up (N=78)
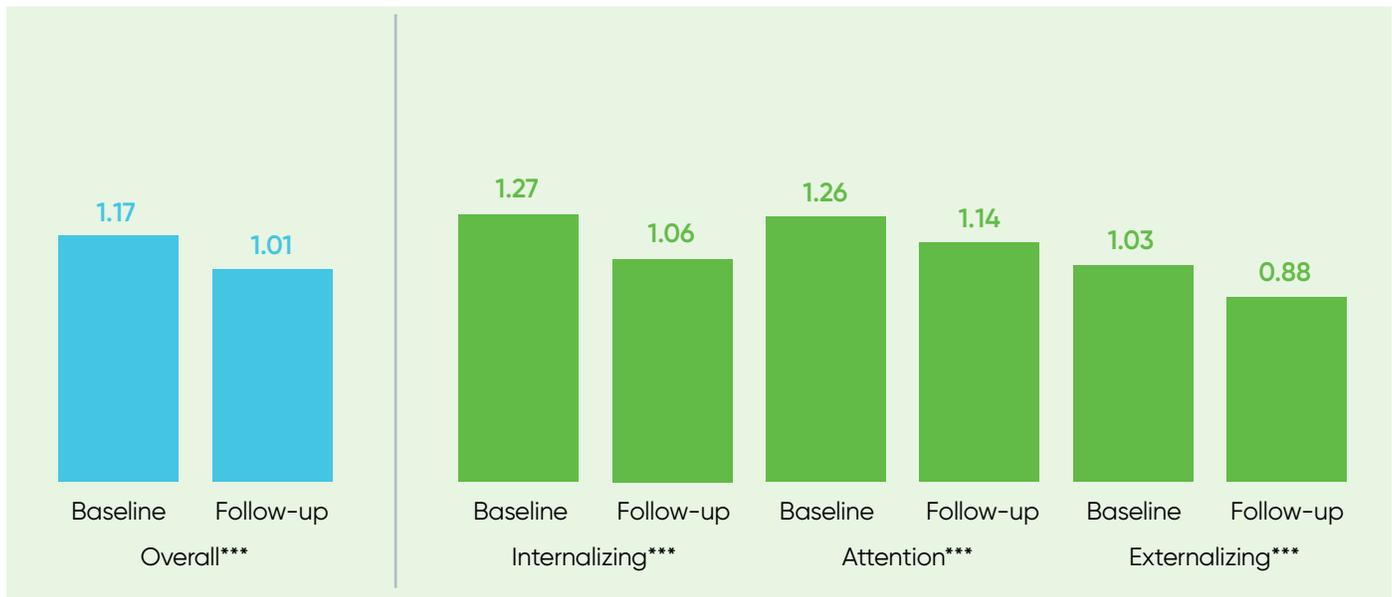
*Note. † = p<0.1, * = p<0.05, ** = p<0.01, *** = p<=0.001*

Youths reported fewer symptoms than caregivers at both baseline and follow-up, with a baseline mean of 0.81 and a follow-up mean of 0.71; the decrease was marginally significant, *t* (51) = 1.88, *p* = .07. Youths tended to report attention symptoms as occurring most often, whereas caregivers reported attention and internalizing symptoms at similar frequencies. The reduction in youths' reported attention symptoms from a mean = 1.12 to mean = 0.96 was marginally significant, *t* (51) = 2.00, *p* = .05. Although mean differences in youths' reports of internalizing and externalizing symptoms were slightly lower at follow-up, scores were not significantly different between baseline and follow-up.

Figure 41. Youth symptoms, youth report, matched pairs at baseline and follow-up (N=52)
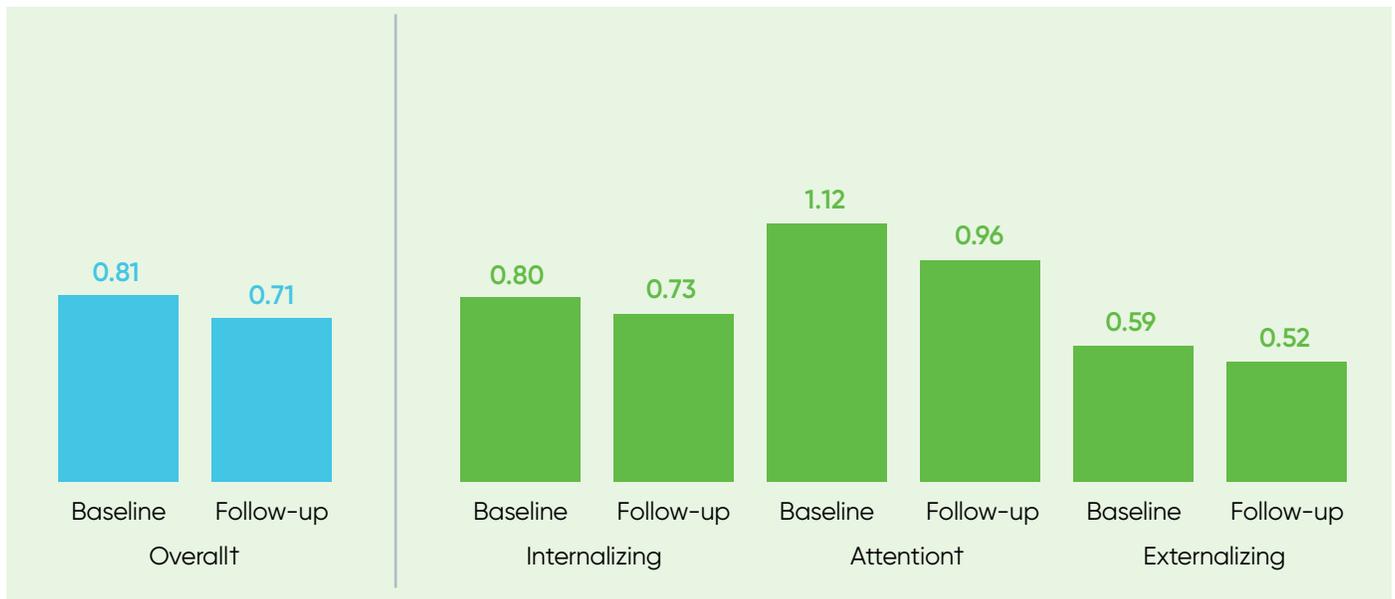
*Note. † = p<0.1, * = p<0.05, ** = p<0.01, *** = p<=0.001*

Service Use and Cost Analysis of Medicaid Data

The HFW practice model aims to improve client's behavioral health outcomes by addressing their needs through care coordination, engagement with needed services, and creation of support systems. HFW may thus have significant impacts on service utilization and service setting (e.g., home- or community-based settings, versus out-of-home or institutional settings). As a result, participation in HFW is expected to result in shifts in utilization from higher-intensity behavioral health services (e.g., out-of-home placements) to lower-intensity services and outpatient venues, potentially resulting in changes to Medicaid spending. Medicaid Data Warehouse fee-for-service and managed care plan reported (encounter) claims were examined to determine the impact of HFW on enrolled clients' changes in utilization before versus after HFW enrollment, in comparison to a Propensity Score-Matched control group of clients who did not receive HFW, allowing for determination of outcomes specific to, and caused by, HFW participation.

Defining Time Periods. All clients were required to have a six-month pre-period. For HFW clients, this period was defined as the six months prior to enrollment in HFW; most, though not all, HFW participants were enrolled in HHSC in this pre-period. For Comparison clients, this period constituted the first six months of HHSC enrollment.

All clients also had a post-period of at least six months, ending on or by 12/31/2019. As such, all HFW clients had enrolled in HFW by at least 6/30/2019 (thus allowing at least a six-month post-period); all Comparison clients were required to have enrolled in Health Homes by 1/1/2019 (thus allowing a six-month pre-period and six-month post-period). An additional six-month period was then allowed for Medicaid claims data entry lag. See Figure 42 for graphic illustration of time periods for each group.

Figure 42. Graphic depiction of pre- and post-period definitions by group
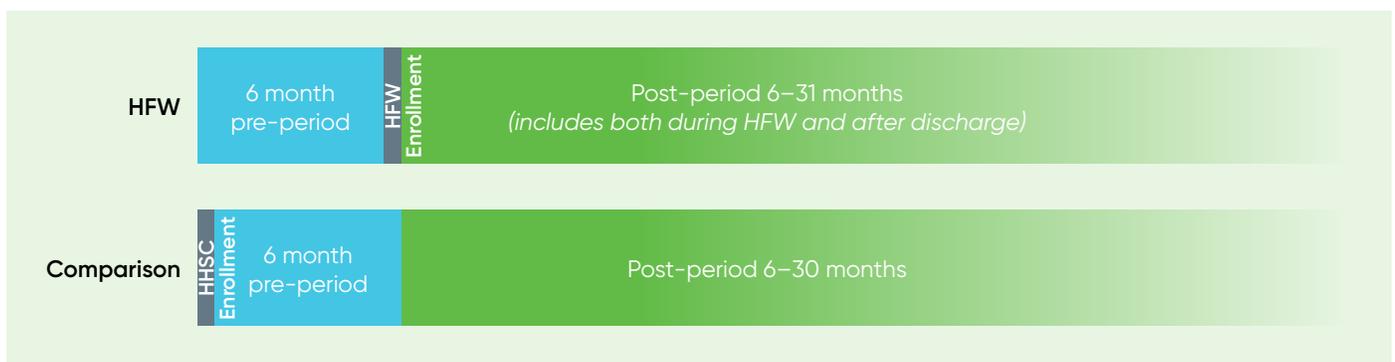
Comparison Group Development via Propensity Score Matching. 116 appropriate HFW clients were identified. All had enrolled in HFW by 6/30/2019, were Medicaid-eligible, and had valid Medicaid Client Identification Numbers (CINs).

A comparison group of clients was created by the OMH Office of Performance Measurement and Evaluation (OPME) research team using a Propensity Score Matching approach. Propensity Score Matching is a statistical technique that attempts to estimate the effect of a treatment, policy, or intervention by accounting for the covariates that predict receipt of this treatment, thereby allowing comparison of "like to like" cases when random assignment is not possible. The process creates a matched set of treatment and comparison clients with similar propensity scores, or likelihoods of being assigned to the treatment group, based on key covariates.

Comparison clients were drawn from youth who received care management through Health Homes in a similar time period to the instantiation of HFW but were never enrolled in HFW themselves and did not receive care management through an agency implementing HFW. This group thus presents the impact of "treatment as usual" (i.e., Health Home care coordination) for a similarly high-need group. Clients were matched to the HFW group using Propensity Score Matching to ensure similar backgrounds and histories, symptomatologies and clinical profiles, and pre-period Medicaid utilization. Analyses used a one-to-one matching approach, where individual HFW clients were matched with a single Comparison client, and used partial matching, where better alignment within a pair resulted in more similar propensity scores but exact matching was not required.

Selected Client Characteristics. Of the 116 HFW clients, 114 were able to be included in the final sample, as two were unable to be matched and were excluded from further analyses. A sample of 114 Comparison clients were selected as matches.

Clients' potential post-periods ranged from six to 31 months. Distributions of post-period months varied by group, such that Comparison clients had longer average post-periods (20.2 months vs 14.2; $t(1,226) = 5.409$, $p < 0.001$). However, the post-enrollment period timespans of the two groups are sufficiently similar for analysis (see Figure 43).

Figure 43. Histogram of post-period months available by group
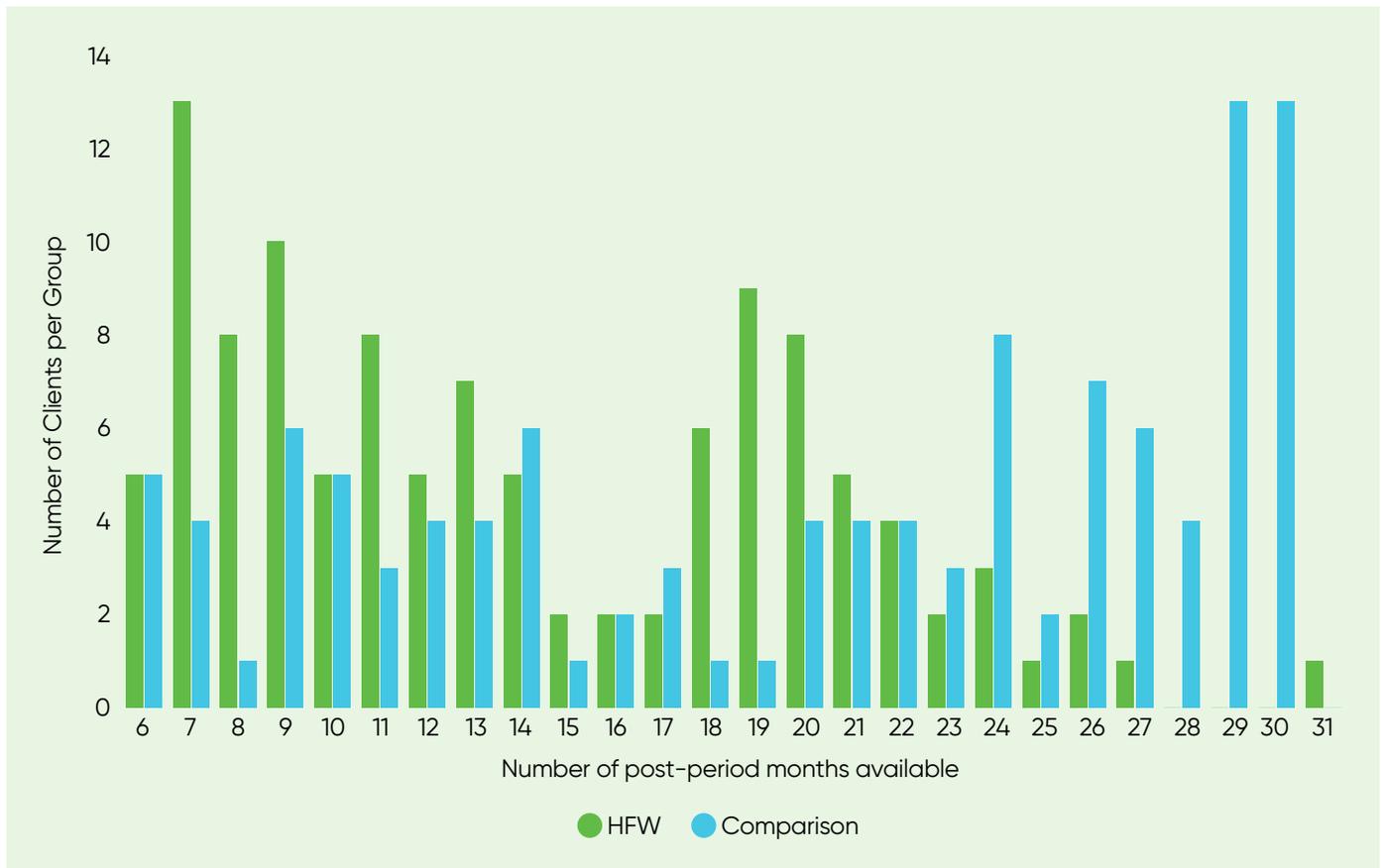
Selected youth in the HFW and Comparison groups were very similar. Post-hoc independent-samples t-tests on the covariate distributions demonstrated that the final HFW and Comparison samples differed on only a few metrics (see Table 12). Specifically, HFW clients were less likely to have a diagnosis of depression (60% vs 75%; $t(1,226) = -2.416$, $p = 0.016$). HFW youths' pre-period utilization histories were also significantly different from their Comparison peers: they were less likely to have a mental health-related inpatient stay (by about 15%; $t(1,226) = -2.537$, $p = 0.012$) or ED visit (by about 15%; $t(1,226) = -2.558$, $p = 0.011$). But importantly, pre-period spending was not significantly different between the two groups ($p > 0.1$). As such, the two groups can be considered highly similar in terms of demographics, behavioral indicators, and diagnoses, with some difference in utilization history.

Table 12. Covariate distribution between HFW and Comparison groups.

Category & Variable N=114 per group (unless otherwise noted)	HFW mean score / %	Comparison mean score / %	p-value
Demographics			
Age	14.4	14.3	ns
Sex (% male)	49%	52%	ns
Race: White (N=87, 90)	61%	60%	ns
English as Primary Language (N=100, 101)	96%	96%	ns
CANS-NY			
Behavioral Health	100%	99%	ns
Developmental Health	26%	25%	ns
Medical Health	24%	21%	ns
Self-Care/Activities of Daily Living	40%	38%	ns
Substance Use	25%	29%	ns
Trauma	85%	89%	ns
Risk Behaviors	100%	98%	ns
Adverse Childhood Experiences	96%	94%	ns
School/Academic Function	97%	97%	ns
High Acuity	90%	89%	ns
Diagnoses			
Attention Deficit Hyperactivity disorder	34%	40%	ns
Adjustment disorder	21%	24%	ns
Anxiety disorder	51%	54%	ns
Depressive disorder	60%	75%	*
Disruptive disorder	43%	51%	ns
Mania disorder	24%	25%	ns
Psychotic disorder	15%	18%	ns
Utilization History			
Mental Health Inpatient stay in pre-period	26%	42%	*
Mental Health ED visit in pre-period	36%	53%	*
Pre-Period spending (6 month total)	$19,990	$15,598	ns
Post-Period			
N post-period months available	15.1	20.3	***

*Note. ns= not significant, † = p<0.1, * = p<0.05, ** = p<0.01, *** = p<=0.001*

Claim Categories. Spending was analyzed by categories created by the OMH OPME team, with some supplementary categories. Claims were classified by service type (mental health, substance use disorder, physical [non-behavioral] health, care coordination, other) and service venue (inpatient, outpatient, emergency department, residential treatment facility, prescription). Capitation payments were excluded from all analyses.

Substance use disorder-related spending was extremely limited in the examined sample. Only 7 HFW clients and 4 Comparison clients had any SUD-related spending in the pre-period, and spending was similarly limited in the six-month post-period. As such, all SUD-related claims were combined with the Mental Health-related claims to simply produce Behavioral Health and Physical Health service types.

Change in Spending by Group (Group x Time Analyses). Changes in Medicaid claim spending between the six-month pre-period and the first six months of the post-period were examined with a series of 2 (time: pre-period, post-period) x 2 (group: HFW, Comparison) Repeated Measures ANOVAs. While some participants had longer post-periods available, only the first six months were included in these analyses to allow for a consistent period for all clients. Notably, 73% (N=82) of the HFW clients were enrolled in HFW for this full six-month post-period. Spending was analyzed on a per-person per-month basis; as such, spending is displayed as the average spend per month in each period (e.g., total pre-period spend, divided by 6).

Table 13. Six Month Pre- versus Post-Period Spending Effects by Group, Time Period, per month

	HFW mean per-month spend		Comparison mean per-month spend		Main effects		Interaction
	Pre-period	Post-period	Pre-period	Post-period	Time	Group	
Total Per-Month spend	$3,332	$2,298	$2,600	$1,698	***	†	ns
Behavioral Health Total	$2,754	$1,483	$1,648	$710	***	**	ns
Inpatient	$1,444	$841	$1,083	$212	***	†	ns
Outpatient	$565	$448	$364	$283	*	*	ns
Emergency Department	$51	$32	$59	$28	**	ns	ns
Residential Treatment	$552	$47	$56	$117	ns	ns	*
Prescriptions	$141	$115	$86	$70	†	†	ns
Physical Health Total	$96	$100	$122	$230	ns	ns	ns
Inpatient	$11	$9	$22	$117	ns	ns	ns
Outpatient	$58	$56	$72	$70	ns	ns	ns
Emergency Department	$26	$35	$28	$43	*	ns	ns
Care Coordination	$228	$543	$653	$569	***	***	***
Other	$253	$172	$177	$189	ns	ns	ns

*Note. ns= not significant, † = p<0.1, * = p<0.05, ** = p<0.01, *** = p<=0.001*

In general, analyses demonstrated in significant main effects but few interactions. Typically, HFW clients showed greater spending than Comparison clients in both periods, and both groups showed decreased spending over time (see Table 13). Such a pattern was evidenced for total spending, wherein pre-period spending was significantly greater than post-period ($F_{(1,226)} = 16.521$, $p < 0.001$), and HFW spending marginally greater than Comparison ($F_{(1,226)} = 3.515$, $p = 0.062$), but there was no interaction between these two factors ($p > 0.5$; see Figure 44).

Physical health-related spending nearly doubled for Comparison clients but remained relatively steady for HFW clients, though this change did not represent a significant difference, likely due to the especially high variability and large number of clients with $0 spending in this category.

Behavioral health-related residential treatment spending and care coordination were the two categories that demonstrated significant interactions.

Care coordination claims showed significant main effects and an interaction (all *ps* < 0.001). In this case, HFW clients showed large increases in care coordination spending, while Comparison clients showed a slight decrease (see Figure 45). This shift likely reflects the fact that Comparison clients were required to be enrolled in HHSC for at least their entire pre-period, whereas about half of the HFW clients only became involved with a HHSC upon their enrollment into HFW (16 clients had no care coordination-related spending in their pre-period, and 44 more only had such claims in the month prior to HFW enrollment).

Residential treatment spending did not have significant main effects (*ps* > 0.1) but did have a significant interaction, $F(1,226)$ = 4.625, p = 0.033: HFW clients showed high pre-period but low post-period spending, whereas Comparison clients showed low pre-period spending that rose slightly (see Figure 46). This category includes OMH Community Residence, OMH Residential Treatment Facility, OASAS Residential Redesign Part 820, and OASAS Residential Rehab for Youth services.

Based on these results, behavioral health-related residential treatment spending was then examined more closely to determine the generalizability of the finding. Seven HFW clients had pre-period residential treatment spending, but only one Comparison client had any pre-period residential treatment spending. However, there were only three HFW clients with post-period spending in this category (of the original seven, five did not have post-period spend in this category, while one additional person had only post-period spend), but two Comparison clients with relevant post-period spend (the original client and another; see Table 14), demonstrating a notable decrease in frequency of residential treatment usage specific to HFW. Number of days in residential treatment was also examined, however, data were found to be incomplete[20].

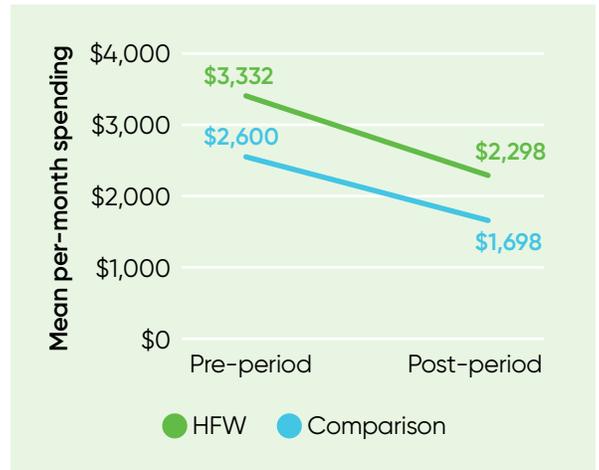**Figure 44.** Total Spending Effects by Group, Time Period, per month

Figure 45. Care Coordination Spending Effects by Group, Time Period, per month

Figure 46. Behavioral Health-Residential Treatment Spending Effects by Group, Time Period, per month

[20] Number of days in treatment was then examined to determine whether HFW clients had shorter stays in the post-period than in the pre-period, and as compared to the Comparison clients. Unfortunately, most of the clients with significant spending in this category were recorded as having 0 days in treatment, or were recorded as having residential treatment-related services every day even after enrolling in HFW. This disparity between spend and days is likely attributable to many claims having a "start date," reflecting the beginning of a residential treatment stay, but no recorded "end date," or not having a start date at all. As such, stay length could not be effectively evaluated with the information available.

Given HFW's focus on serving the highest-need youth, the small number of clients (7 of 114, or 6%) with behavioral health-related residential treatment claims was somewhat unexpected. The rate of residential treatment history within this Medicaid analysis sample was thus compared to the rate in the total HFW client population.

As part of the eligibility assessment, HFW client's immediate histories of out-of-home (residential treatment facility) placements are considered. To date, 28 out of 288 (10%) total youth who completed this eligibility screen were reported to be returning to their home and community from an out-of-home placement; while this item may not capture youth with a history of RTF placement in the full six months before their enrollment in HFW, the similarly low rate also indicates that such a history is relatively infrequent even across the full client pool. Nine of these youth were able to be included in the Medicaid analyses; the remaining youth were enrolled after the 6/30/2019 deadline (N=9), were not on Medicaid and so did not have available CINs (N=8), or were closed prior to enrollment (N=2).

Table 14. Number of Clients with Residential Treatment claims in the Pre- and Post-Periods within each group.

|	HFW	Comparison
Pre only	5	0
Pre and Post	2	1
Post only	1	1

Interestingly, of the included nine, only four of these youth were recorded as having pre-period residential treatment-related claims in the Medicaid dataset. The other five did not have any claims that were identified by OMH OPME's taxonomy as reflecting behavioral health-related residential treatments. This gap may reflect differences in understanding of RTF histories, a lacuna in the taxonomy used, or an artifact of psychiatric hospitalization placement claims potentially not being available in New York State Medicaid records. Further, two other youth also had pre-period mental health-related residential treatment claims and one had SUD-related residential treatment claims, potentially reflecting RTF placement histories at some point in the six-month pre-enrollment period but not immediately prior to enrollment, resulting in the seven total identified HFW clients.

Within-HFW Analyses. HFW clients' post-periods were also subdivided into months during which they were enrolled in HFW ("during HFW"), and months "after discharge." All clients had at least one post- period month after enrollment in HFW. On average, clients were enrolled in HFW for 8.9 months (ranging from 1 to 22 months), and their "after discharge" period was 5.2 months long (0 to 23 months). Not surprisingly, clients with longer HFW enrollment also tended to have fewer "after discharge" months (r = -0.503, p < 0.001; see Figure 47 for graphical distribution of HFW clients' enrolled versus after discharge months available).

Figure 47. Distribution of During HFW and After Discharge Post-Period Months Available, by number of During HFW months.
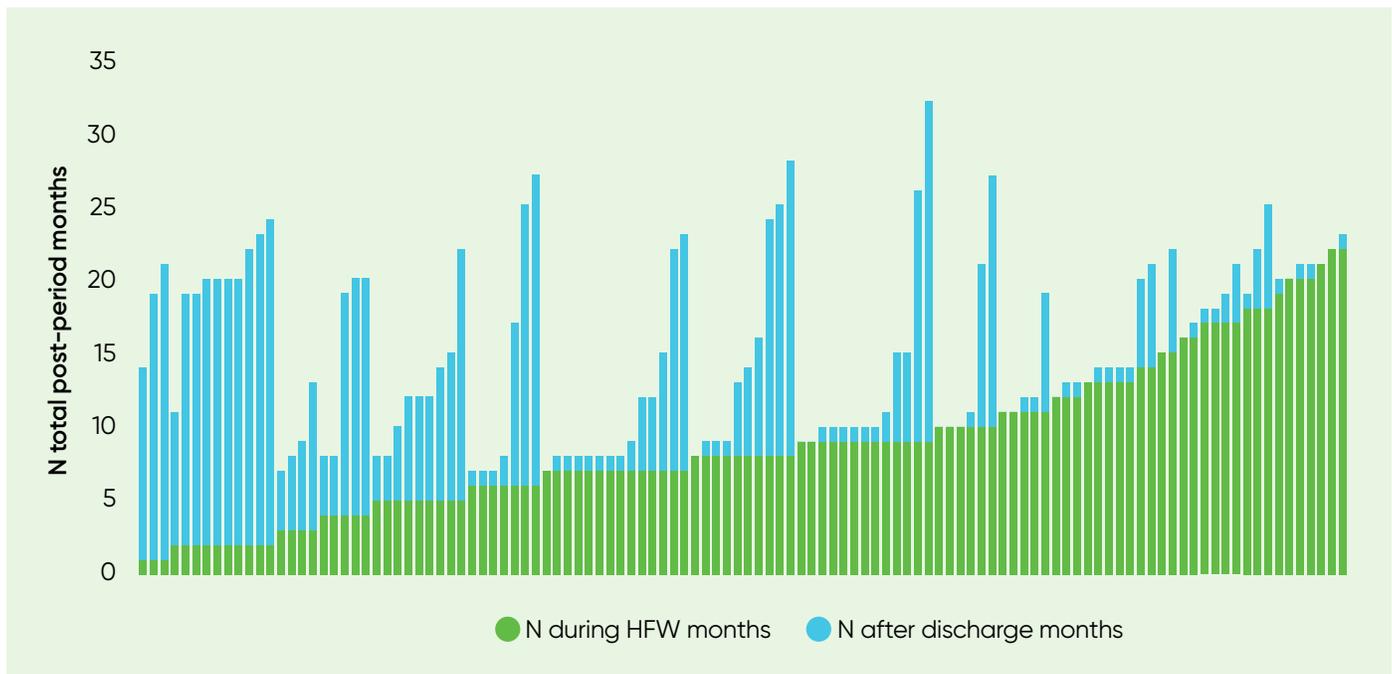
Fifty-nine clients had at least one "after discharge" month available (mean = 10.1, range = 1–22). Spending before, during, and after HFW was examined for these clients to determine the impact of HFW after formal involvement. Costs for each client were summed within each sub-period and divided by the length of the sub-period to produce a within-period per-person per-month average cost.

The number of enrolled months per person was not correlated with during-HFW per-month average costs nor with after discharge per-month spending (after discharge physical health inpatient spend was marginally correlated with months enrolled, r = 0.223, p = 0.09, but no other correlations approached significance, ps > 0.15).

Average monthly spending was compared before enrollment in HFW, during HFW, and after discharge using a series of 1x3 (time) Repeated Measures ANOVAs (see Table 14). Total average monthly spending showed only a marginal effect of time (p = 0.099), declining after enrollment (post-hoc paired-samples t-test p = 0.035) but then increasing somewhat after discharge. Behavioral health spending showed a significant effect of time ($F(2,116)$ = 4.748, p = 0.010; see Figure 48). Post-hoc paired-samples t-tests demonstrated that spending declined significantly during HFW enrollment ($t(1,58)$ = 3.166, p = 0.002), and remained marginally lower after discharge than before HFW involvement ($t(1,58)$ = 1.747, p = 0.086).

More specifically, behavioral-health related outpatient spending ($F(2,116)$ = 12.783, p = 0.001) and prescription spending ($F(2,116)$ = 4.432, p = 0.014) showed significant decreases over the periods examined, and emergency department spending showed a marginally significant decline (p = 0.085).

Figure 48. Average monthly behavioral health-related spending before, during, and after HFW participation.
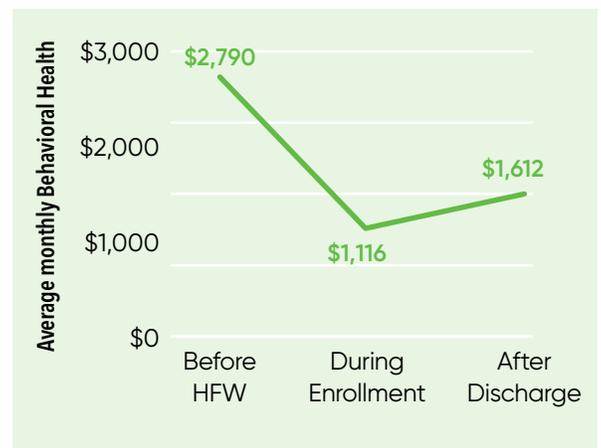

Table 14. HFW Client Spending Effects by Period, per month; N=59.

	Before HFW	During HFW	After Discharge	Main Effect: Time
Total Per-Month spend	$3,206	$2,008	$2,366	†
Behavioral Health Total	$2,790	$1,116	$1,612	*
Inpatient	$1,397	$539	$538	ns
Outpatient	$748	$380	$229	***
Emergency Department	$47	$27	$19	†
Residential Treatment	$423	$62	$762	ns
Prescriptions	$175	$109	$64	*
Physical Health Total	$102	$82	$124	ns
Inpatient	$0	$12	$18	ns
Outpatient	$76	$51	$60	ns
Emergency Department	$25	$19	$46	*
Care Coordination	$211	$481	$211	***
Other	$104	$328	$419	ns

*Note. ns= not significant, † = p<0.1, * = p<0.05, ** = p<0.01, *** = p<=0.001*

Physical health-related spending was relatively low on a per-month basis overall, but emergency department physical health spending demonstrated a significant increase after discharge from HFW ($F(2,116)$ = 3.454, p = 0.035).

Again, not surprisingly, care coordination-related spending showed a significant effect of time ($F(2,116) = 22.561$, $p < 0.001$), increasing during enrollment but decreased again after discharge, likely reflecting clients' movement to lower acuity care coordination after discharge from HFW.

Behavioral health-related residential treatment spending did not show a significant effect of time. Descriptively, though, spending in this category decreased during enrollment and increased after discharge, reaching an average spend even higher than before HFW. However, the small number of participants with such spending, coupled with the requirement to have at least one after discharge month available, may have biased this pattern: of the seven HFW cases identified to have pre-period spending in this category, three did not have any "after discharge" months available for analysis at the time of the data extraction. While several new clients did have residential treatment spending at some point after their discharge from HFW, the longer-term disposition of those still enrolled cannot yet be determined.

As such, HFW participation may lead to significant decreases in spending that continue at least to some extent after discharge from HFW.

SUMMARY

The goal of the Family Success portion of this report is to measure impact the lives of the youth and families that HFW serves.

In general, findings suggest:

- After participation in HFW, families were less likely to meet the high acuity criteria for trauma, behavioral health, child needs & functioning, and caregiver strengths & needs.

- Youth strengths of optimism, resourcefulness, adaptability, persistence, and resilience (from the CANS-NY) improved significantly with HFW participation.

- All types of caregiver strain (objective strain, externalized strain, and subjective internalized strain) were significantly lower following HFW participation. Subjective internalized strain, which includes negative internalized feelings, such as worry, guilt, and fatigue, remained the highest area of strain at both baseline and follow-up.

- Empowerment and hope average scores were higher following participating in HFW; however, differences were not significant. Interestingly, caregivers and youths tended to have higher empowerment regarding services than regarding self/family at both baseline and follow-up. One priority of peer advocates is to help families navigate services and service systems. However, for HFW families, this assistance may be less needed; families may instead need more assistance in feeling empowered within the self/family.

- Average scores for youth functioning and symptoms were lower at follow-up compared to baseline. Caregiver reports of youth symptoms and function improved significantly, whereas differences in youth reports, although lower at the second time point, were not significantly different. Caregivers tended to report that youths had more impairment and symptoms compared to youth reports at both timepoints.

- Overall Medicaid spending was found to decrease from the pre-enrollment to post-enrollment period, but these changes were not specific to the HFW group.

- It was anticipated that HFW participants would show an increase in low intensity services following HFW enrollment as the care coordination process connected them to services. However, the HFW group did not demonstrate an increase in outpatient services following HFW enrollment as anticipated.

- The HFW group showed a significant decrease in residential treatment spending, with fewer clients in these settings in the analyzed post period than pre- period, while the Comparison group showed an increase in spending and number of clients with such spend.

- HFW clients' behavioral health-related spending decreased from pre-period levels during HFW participation, and remained lower than pre- period averages even after discharge from the program. In particular, behavioral health-related outpatient, emergency department, and prescription spending continued to decline in post-enrollment months.

Findings from interviews and CANS-NY assessments suggest that families are doing better after participating in HFW. However, without a comparison group on these tools, one cannot determine if HFW is more effective than alternative care (e.g., high acuity HHSC care coordination). Interestingly, caregivers tend to report greater youth challenges than youth tend to report (e.g., symptoms and impairment). Caregiver reports yielded significant improvements in most domains caregiver strain and caregiver reports of youth impairment and symptoms. Although mean improvements were observed in most youth response areas, the improvements were not significant. This may be in part because there was less matched data (baseline + a follow-up interview) available for youths compared to caregivers, which translated to less statistical power to detect significant differences in youth data. In addition, youths started off rating themselves as less severe compared to caregivers on scales like impairment, so there was less room for improvement over time.

Analysis of Medicaid data offers the opportunity to compare services use of HFW participants to a Comparison group of HHSC enrolled youth to determine if HFW has advantages beyond high acuity HHSC care coordination. Results suggest that Medicaid spending went down similarly for both the HFW and the Comparison group over time. However, there was a difference between groups on residential treatment spending with these costs decreasing for HFW group and increasing for the Comparison group over time, suggesting that HFW participation may be advantageous in reducing residential placements.

CONCLUSIONS

Conclusions

SOC IMPLEMENTATION

Although county representatives indicated substantial knowledge of SOC, development is still needed. Overall SOC implementation was moderate, but only about one-third of county respondents felt SOC was substantially or extensively implemented in their community. In addition, many of these representatives were unaware of local SOC activities. This suggests that further work is needed in SOC development and implementation.

The topic areas listed below were identified as less robustly implemented across the state; focusing statewide training and technical assistance on these topics can aid SOCs in building, supporting, and maintaining their SOC framework:

- Information dissemination of HFW and supporting development of HFW practice;

- Development and use of a strategic plan;

- Service delivery guided by SOC values and principles of cultural and linguistic competence;

- Service delivery guided by SOC values and principles of youth-guided approach;

- SOC system infrastructure (specifically financing and processes for strategic communications and managing care and costs); and

- Availability and use of home- and community-based services and out-of-home services, specifically behavioral management skills training, therapeutic behavioral aide services, tele-behavioral health services, and medical detoxification.

Further targeting efforts with specific stakeholders and systems (e.g., school) can help improve knowledge and communication around local and regional SOC development and implementation. Because schools are a system that reaches nearly all youth and are often a frequent referral source, it is particularly important to advance SOC values and principles there. NYS SOC has begun collaborating with Project AWARE, which will likely lead to greater SOC implementation in schools.

Providing technical assistance to improve coordination among systems within counties may do more to bring all systems into the SOC. This is currently being pursued through NYS SOC-funded day-long workshops (i.e., SOC Action Planning Workshops) with local child-serving leaders to examine strengths, needs, and gaps of the local community, in order to develop goals and strategies to better serve children, youth, and young adults. These workshops, along with The Strategic Planning Guidance for System of Care Expansion (Dodge, 2014), are a helpful first step to beginning work on a strategic plan.

Due to high variation of county SOC development within regions (with the exception of Long Island), general training and TA applied at the regional level many not be the most beneficial. A better approach may be to use technology to present different "grade" levels of SOC information. That way, both beginner and advanced counties can find the appropriate level of information to continue to build their SOC. Within regions, the county with the most developed SOC in a region could serve as a mentor to neighboring counties in the region. These mentors could be leveraged as local leaders to assist less developed SOCs. RiTATs may provide an opportunity to build these mentoring relationships.

TRAINING

The NYS SOC project developed extensive trainings for care managers and peer advocates to support them within their roles in HFW. This specifically included a six-month SOC Wraparound Certification Training for care managers and the Peer Participation in Wraparound Training and CSC/HHI Trainings for peer support staff. A total of 82 care managers, 22 supervisors, and 119 peers were trained. On average, training recipients found the trainings effective, relevant, and enjoyable; they particularly appreciated interactive and hands-on activities.

Documentation was identified as a challenge to HFW implementation as well as a weakness in trainings. This may be addressed by developing separate trainings on these topics, providing hands-on training with computers so staff can practice using online documentation systems during the training, and producing improved technical support

documentation and webinars. In addition, about one-third of care managers requested more coaching and training opportunities. Plans for the next SAMHSA grant include more continuing education opportunities which may help with this.

HFW PRACTICE

At the time of this report, 246 youth were served with HFW, and total open cases had remained around 100 for the past year, which is about 63% of full capacity. Providers have struggled to reach and maintain full caseloads of youth. In the future, to increase the maintenance of full caseloads, the program will expand to a younger population and maintaining full (or close to full) caseloads will become a program requirement.

Of youth that were discharged, over three-quarters left prior to completion of the program. Youth retention may be increased by refining eligibility criteria and selection for HFW participation and assisting with early engagement techniques. In addition, maintenance of regular CFTMs may increase momentum, such that teams are making more progress on needs may instill greater family engagement in HFW. Follow-up with youths that left HFW, as well as further examination of data on these youths, may be helpful in identifying additional ways to retain youth engagement.

Care managers identified the team-based approach as the part of NYS SOC that helped families the most, followed by the strength-based, family and youth-centered approaches. Most care managers recommended smaller caseloads. However, caseloads lower than 10-12 are not currently sustainable in the HHSC system. It may be possible to reduce workloads by more efficient documentation and strong collaboration among formal support team members.

By the end of the HFW pilot project, most aspects of HFW are in place within NYS SOC HFW practice. A strength of NYS SOC is emphasizing strength and family driven domains, which were high-scoring domains in both CFTM observations and team member surveys. Teamwork was the highest scoring domain in CFTM observations. The incorporation of natural/community supports into HFW was a challenge for HFW implementation. This was the lowest scoring fidelity domain. In addition, YPAT and FPAT (completed by youths and caregivers) results also point to challenges with assisting and connecting families to these supports. In past interviews, care managers had expressed that families preferred a smaller team, with only the care manager and peers. It may be advantageous to explore this domain and its influence on family outcomes to determine if the presence of informal and community supports improves success. If so, efforts should be made to improve implementation of this domain; if not, standards could be relaxed in this domain. Alternatively, standards could be reconsidered to include peer involvement as a natural/community support.

Complete and timely document entry remains a challenge for care managers, and additional assistance is needed to support care manager entry of records into Wrap-NY. Document records often include extensive case notes, however fields reflective of HFW plans are more sparse. These records are important because they are provided to the family as well (e.g., family story, Plan of Care, Crisis Plan). Families need complete documents so that they can participate fully in the HFW process.

Improved documentation will increase reliability of document review fidelity assessment methods, which will be important as this is currently the only method for fidelity assessment proposed for the second SAMHSA grant. Currently documentation review is the lowest scoring form of fidelity assessment. Given the increased utility of observation and team member survey methods, it may be worthwhile to consider retaining these components in the second SAMHSA grant.

FAMILY OUTCOMES

There is evidence that, on average, families and youths feel their family was doing better after starting Wraparound. Family peer and youth peer advocates were generally perceived as effective by the families they worked with. Statistically significant improvements in youths' needs, impairment, symptomology, and strengths were seen over the course of SOC engagement. Youth empowerment and hope also improved, though not significantly. In addition, caregiver strain was significantly reduced. Analyses of Medicaid data also support the positive outcomes of HFW. HFW participants had lower overall costs after enrolling in HFW compared to the six months prior to enrollment. In addition, HFW participants showed a decrease in Medicaid residential costs after enrolling in HFW compared to a Comparison group who showed an increase in Medicaid residential costs over the same period. These findings support an improvement in family outcomes following participation in HFW.

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APPENDICES

Appendix A.

TABLE OF DATA SOURCES USED IN REPORT

Data source	Data collection method	Sample/Subject	Frequency/ Timepoint	Description
IPP (Infrastructure, Development, Prevention and Mental Health Promotion) Survey	Online survey	NYS team and county representatives	Quarterly	Indicators include: number of policy changes completed, the number of people trained in areas consistent with the goals of the grant, the number of consumers/family members who provide mental health-related services, the number of organizations that entered into formal written agreements consistent with the goals of the grant.
SOC Implementation survey	Online survey	Individuals identified as important to the county level SOC	Completed twice, baseline assessment in Year Three and follow-up in Year Four	Rating Tool for Implementation of the System of Care Approach for Children, Youth, and Young Adults with Behavioral Challenges and Their Families (revised 2015). This tool is designed to "...assess progress in a community or region implementing the system of care approach for children, youth, and young adults with behavioral health challenges and their families."
NYS SOC Wraparound Certification Training surveys	Online survey	Training attendees(e.g., Care managers, FPA, YPA, supervisors, RTF providers)	Following each training session	Training surveys ask attendees to provide feedback on the training style/format, segment specific impressions (how new was the material, how relevant was the material, how confident you will use the concepts, and how prepared do you feel), knowledge questions, and overall impression.
Peer Participation in Wraparound Training surveys	In-person survey	Training attendees (e.g., FPA, YPA)	Following each training session	Training surveys were developed by the OMH team to provide feedback on overall satisfaction, suggested changes, and ideas for webinars.
Cultural and Structural Competence and Health Habitus Integration training qualitative interviews	In-person and telephone interviews	Training attendees (e.g., CM, FPA, YPA)	At least 3 months post training	Qualitative interviews were developed by the NKI team to explore trainees' familiarity with the information imparted in the training, but more importantly, reveal whether and how trainees integrate the strategies and tools they acquired in the training into their HFW practice.
Administrative records	SPOA and/or care managers complete documentation from records data	Caregiver and youth/young adult	Baseline, 6 month reassessments, and discharge	Administrative records collect some data on every family, including demographics, referral information, systems involvement, diagnoses, services received, level of family engagement, and level of peer participation.
CANS-NY	SPOA and/or care managers complete documentation	Caregiver and youth/young adult	Baseline, 6 month reassessments, and discharge	The CANS-NY is an assessment tool completed by the provider with the family. It identifies needs and strengths of the youth (primarily) and caregiver in various domains: Trauma, Behavioral Health, Medical Health, Developmental, Substance Use, Impairment in Self Care, Child Needs Functioning, Risk Factors and Behaviors, and Caregiver Strengths and Needs. Acuity is based on how items are scored in certain domains.
Medicaid data		Youth/young adults enrolled in HFW and matched comparison group	Once, at the end of Year Four	Medicaid data for HFW participants enrolled as of June 2019 and a matched comparison group, covering fields such as number of claims/visits, length of visits, and cost for the period prior to, during, and post HFW/care coordination.

Data source	Data collection method	Sample/Subject	Frequency/Timepoint	Description
Interviews with Youth and Families	In-person and phone interviews	Caregiver and youth/young adult	Baseline, 6 month reassessments, and discharge	These interviews were optional and included NOMS, CFOS and other assessments of functioning, social connectednesss, empowerment, hope, perception of care, impairment, caregiver strain, housing, education, and criminal justice status.
Fidelity instruments - Team Observation Measure (TOM) 2.0	Observation of child and family team meeting using a validated tool	Child and family team - care manager, YPA, FPA, family, other team members	Once per case, anytime between the 3rd-7th CFTM	The TOM 2.0 measures the extent to which practice reflects the wraparound model during a CFTM. Domains include: Full Meeting Attendance, Effective Teamwork, Driven by Strengths and Families, Based on Priority Needs, Use of Natural and Community Supports, Outcomes-Based Process, and Skilled Facilitation.
Fidelity instruments - Wraparound Fidelity Index (WFI-EZ) surveys	In-person survey	Child and family team - care manager, YPA, FPA, family, other team members	Once per case, anytime between the 3rd-7th CFTM	The WFI-EZ surveys measure the extent to which practice reflects the wraparound model by looking at care manager, family, and team member experience and satisfaction with the wraparound process.
Fidelity instruments - Documentation review *45 day review *2nd CFTM review	In-person survey	Child and family team - care manager, YPA, FPA, family, other team members	Once per case, anytime between the 3rd-7th CFTM	The WFI-EZ surveys measure the extent to which practice reflects the wraparound model by looking at care manager, family, and team member experience and satisfaction with the wraparound process.
Fidelity instruments - Documentation review *45 day review *2nd CFTM review	Documentation: Review and coding of records in online documentation system (Wrap-NY), administrative records, and materials (agendas) from team meetings.	Service provision	After family has been enrolled/registered for 45 days, after 2 CFTMs have occurred, and after a family has discharged (and has had at least 2 CFTMs)	The four documentation review tools measure the extent to which practice reflects the wraparound model as evidenced through documentation at various timepoints while a family is enrolled in HFW. Domains include: Timely Engagement, Meeting Attendance, Driven by Strengths and Families, Natural and Community Supports, Needs-Based, Outcomes-Based Process, Safety Planning, Crisis Response, Transition Planning, and Outcomes.
Project Reflection Survey	Online survey	Care managers	Once, at the end of Year Four	This survey solicited feedback from care managers on HFW implementation and feedback on the pilot project, including HFW during COVID-19 social distancing restrictions.

Appendix B.

THEMES, CATEGORIES, AND CATEGORY DEFINITIONS OF RESPONSES ON THE SYSTEM OF CARE IMPLEMENTATION SURVEY

Theme	Category	Definition
Service system issues	Service coordination issues	Descriptions of breakdown in interagency interactions at the state or local levels (e.g., agencies not working together with families' interests as their primary focus).
	Navigation difficulties	Descriptions of families' experiences with navigating complex service systems.
	Shortage of services	Descriptions of a lack of available services to meet mental health needs, often creating further challenges, crises, and needs for higher-intensity care (e.g., in-patient).
	Negative effects of Medicaid Redesign	The negative effect Medicaid Redesign (MR) has had on services. MR was said to have reduced reimbursement rates and service availability, resulting in fewer services and providers. MR has also created a competitive, reimbursement-focused environment.
Funding issues	Private v. Medicaid funding	Descriptions of issues with private insurance not offering as many treatment options as Medicaid, thereby creating two systems of care.
	Inadequate funding	Descriptions of a lack of funding or misalignment of funding to support SOC work and treatments, typically from the state, but also at the local level.
Planning and implementation challenges	Excessive changes to SOC	Changing plans or structure of SOC without giving current plans/structures enough time to succeed.
	Need for a plan	Descriptions of the importance of having a plan or the future creation of a plan. Some specified sustainability or strategic plans.
	Difficulties actualizing SOC	Description of agencies or services systems not moving concepts, values, or verbal commitments described in plans into action or infrastructure to actualize SOC.
Leadership and representation	Leadership commitment to SOC	References to leaders or actions typically carried out by individuals in leadership positions either supporting or not sufficiently supporting SOC values, infrastructure or procedures.
	Increase representation	Descriptions of decision-making bodies needing to increase diversity or participation among specific stakeholders (e.g., peer advocates).
State of local SOC	Strong SOC	General, positive statements of current SOC.
	SOC in development	General descriptions of SOC growing or availability of future opportunities for growth.
	SOC deteriorating	Descriptions of local SOC deteriorating.
	Lack of knowledge about SOC	References to SOC concepts, values, infrastructure, or practices of which SOC stakeholders are not aware.
	Efforts to increase knowledge	References to SOC concepts, values, infrastructure, or practices SOC stakeholders are actively learning.

Appendix C.

CULTURAL AND STRUCTURAL COMPETENCE (CSC) TRAINING INTERVIEW FINDINGS

Under the auspices of the current grant, the Center for Research on Cultural and Structural Equity in Behavioral Health (C-CASE) at the Nathan S. Kline Institute for Psychiatric Research developed and implemented the Cultural and Structural Competence (CSC) training for providers (i.e., family and youth peer advocates, care managers, and supervisors) working with families with children and/or youth with serious emotional disturbances. Nine trainings were conducted in Years 2-3. In Year 4, the team conducted one additional CSC training session, bringing the total trainings to ten. These ten trainings took place in seven counties: Albany, Kings, Monroe, Oneida, Onondaga, Rensselaer, and Westchester counties. A total of 168 individuals have been trained with 22 being trained in Year 4.

As described in detail of the third-year report, the CSC training is designed to enhance primarily the peer advocate's skill set by integrating the social and structural determinants of health perspective and the cultural humility approach into their practice. This theoretically guided training is based on the recognition that cultural and social factors shape the tendencies (i.e., habitus) and actions of families and youth to attend to their mental and physical health in certain ways. The training provides the communication strategies and tools to elicit the families and youths' habitus and behavior and bring this information: (1) to the team meetings with care managers and supervisors; and (2) to their interactions with family and youth from the phase of engaging in HFW to transitioning out of HFW, always adopting a culturally humble approach.

CSC Training: Evaluation

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

Data Collection Tools: Survey & In-Depth Interviews

Self-administered same-day evaluation surveys are given to all participants at the end of the one-day in-person CSC training. The survey takes approximately 10 minutes to complete. It assesses health habitus-related knowledge and CSC training experience, including differences between cultural competence and cultural humility approaches to service delivery, perceived utility of health habitus, trainee self-efficacy, and opinions on how health habitus training concepts and tools can be incorporated into practice, as well as trainee demographic characteristics. To date, a total of 158 trainees have completed same-day surveys, for a response rate of 94%.

To assess CSC training efficacy and impact on practice, our team also conducts a follow-up assessment at least three months after training. This second assessment includes a survey (duration 10-15 minutes) to ascertain health habitus-related knowledge, attitudes, and practice since CSC training, including intentions to maintain or begin using CSC training principles post-training. The survey is administered either in-person on a laptop using the Audio Computer Assisted Self Interview program or online via an emailed link. To date, 55 trainees have completed the follow-up survey.

Follow-up in-depth qualitative interviews are also conducted at least three months after training to contextualize the training assessment and begin identifying implementation experiences. The qualitative interviews explore trainees' familiarity with the information imparted in the training, but more importantly, reveal whether and how trainees integrate the strategies and tools they acquired in the training in their HFW practice. To date, 27 trainees have participated in qualitative interviews.

In the third-year report, we presented the findings from the same day survey and the follow up survey. Below, we provide a brief discussion of findings from the qualitative data.

Description of Qualitative Sample

Most of the qualitative interviews were conducted with peer advocates (n= 23, 85%); 16 were Family Peer Advocates (59%) and 7 were Youth Peer Advocates (26%), while 4 were supervisors (15%). The average age of participants was 42.6 years of age (range: 22-76). All participants but one self-identified as female. Black/African Americans represented 15% of the sample, Hispanic/Latinx 7%, More than one race 4% and White non-Hispanic 74%.

Data Collection and Analysis

The interviews were conducted in-person, in private spaces by a total of four interviewers trained in qualitative methods. Interviews were audio-recorded and transcribed for content thematic analysis. An interview guide was used as a data collection tool.

The analytic process consisted of the following four steps: In Step 1, two of the interviewers, familiar with the data and how it was collected, read the 27 transcripts and preliminary organized the data using as headings the overarching themes and domains that were included in the interview guide. Any themes or domains that emerged in the interviews that were not in the guide but deemed relevant to the CSC training process and implementation were also included under new headings in this first analytic step. Step 2, a third researcher, a member of the CSC training team who was not involved in the collection of the data, read twenty of the organized transcripts and conducted selective coding. That is, developed and applied codes to specific features or dimensions of the themes and domains, and when indicated, developed and applied subcodes to specific features and dimensions of codes. Step 3, the first two coders reviewed ten out of the twenty coded transcripts and edited the existing themes and codes. Finally, in Step 4, the three coders jointly reviewed the ten transcripts that were doubled coded, resolved any disagreements and finalized the coding scheme. The first two coders used the finalized coding scheme to code all 27 interviews

Below, we present the four main themes and present a few illustrative quotes under each theme.

Findings

Theme 1.

Comprehension and Retention of Training Components: Data that referred to trainees' understanding and recollection of key components of CSC training were included under this heading. Cultural humility, implicit bias, and health habitus were the primary training components coded under this theme. For instance, when asked about her understanding of health habitus, a 22-year old female White non-Hispanic Youth Peer Advocate provided the following reply that included the value of interacting with families with cultural humility and recognizing one's own biases:

> I think it was for me, I understood it (health habitus) as a way of getting to know people better so that you could understand where they came from and then better serve them as far as their needs. Like if they said, "I had a really difficult time in the past, like I could never make my appointments because you know, I don't have a car, or you know, I have difficulty because I have five children and I can't get babysitting." You could then understand, oh yeah, this is why they have difficulty meeting me. So I think it was just to better understand where people are coming from, not to come in with those judgments of why aren't they meeting their therapist appointments or why aren't they getting to this or that (appointment)? Or why aren't they wanting to go to the doctor? Well maybe they had a bad experience before. So I think that to me, it was what they (trainers) were trying to get us to realize was that we might be coming in with judgments, but to get past those and really dig deeper into why are people really having these experiences and wanting to maybe stay away (from service)or be distant or having issues.

In describing her understanding of the cultural and structural origins of a family's health habitus, a 49-year old female Black/African American Family Peer Advocate referred to the need to recognize and respect the reasons why families may distrust providers and to identify the cultural and structural barriers to engaging in services:

I think the history has been medical providers and mental health providers have stated, ok these are the standards, these are the expectations, this is what you need to meet in order to be healthy; you need to come to these appointments. And a lot of families, either their culture, whether it's their ethnic culture, religious culture, or just even the culture of their community, just may not be trusting of that kind of service. So, it's important for providers to know how they feel about coming to these appointments. And when they don't come to the appointments, then like I said, the history has been that providers will tend to judge them, and if you miss three appointments, you're cut off from the system. And so, they don't get the help the providers think they need, but the providers never know why. They just think that the family is being negligent. And they can have many different things that get in the way of that. Like I said, it can be how they feel culturally or just even financial issues with getting back and forth to these appointments. So, it's important for everyone to know where everyone stands and to have that respect.

Finally, explicit and implicit bias, their impact on service delivery and the recommendation to take the Implicit Association Test developed by Harvard University as a self-awareness and humility tool is the training component discussed below by a 51-year old female White non-Hispanic Family Peer Advocate:

Yes I did (take the IAT). I'll tell you about that; that was interesting. For me personally, I think it's just having that awareness that we all have a bias of one sort or another. But for me, it's recognizing it and moving past it. Because that's one of the things about high fidelity wrap that I just believe in voice and choice... So it's recognizing that your choice may not be my choice. Your choice might make me uncomfortable, in which then I have another choice to make. Do I continue? Or do I change tracks? Or do I gracefully exit? A big part is awareness. ...Well it did impact me at first, because I wound up with this huge bias towards – or against if you will – um, disabled people. And I went, what is that? I'm gonna tell you, I took it three times. Because first of all, I'm not terribly technically adept, and I'm doing this on a tablet, so for me, my personal goal was to get that score down... But to have that awareness, to think back, do I pause because someone is missing a limb? What changes about myself when I encounter perhaps someone of another race or someone who chooses another gender, or all these different things. So I try to make sure I take that moment and go, what is my role in whatever, whether I'm at the grocery store – what is my role here to engage with you, to engage with the grocery checker, to engage with my family? And what am I experiencing, and is it appropriate?

Theme 2.

Practice Informed by the Training: Data that referred to whether and how trainees included the strategies and tools shared in the training into their practice were included under this heading. Strategies for engaging families and youths, approaching families and youths with cultural humility, practicing active listening, applying the health habitus tools (i.e., interview guide, writing the health habitus note), writing one's own health habitus, applying understanding of families' and youths' health habitus in engaging, and supporting families to set and meet their goals were the codes under this theme. We included data on experiences of writing about one's own personal health habitus under the theme of practice because this key training exercise exemplifies strategies for eliciting health habitus as well as writing a health habitus note. For instance, a 28-year old female White non-Hispanic Youth Peer Advocate indicated that writing about her own health habitus enhanced her self-awareness about taking care of her own health. Moreover, she suggested using the personal health habitus form to engage the youth she supports and serves:

How I take care of myself, I remember that, so to eat every day because my life experience comes from my eating disorder and I became fearful of something that kept me alive which is food. And for me personally, how I keep myself healthy is to remind myself that there is no such bad food in this world, and that I think things shouldn't control us. I think we are in control, and I think that we forget that sometimes we feel that we are weak individuals. But we're really not because humans are just one of the only creatures that's out

there that can just keep coming back from things. Like you get pushed down, and when it rains it pours, but it's all about kind of getting back up and keeping that conversation going. Just because I got pissed off at my therapist who said something to me, it was because she was doing her job. Because what bothered me about what she said was true and how I take care of myself. Even if she piss me off the last time I went to see her, I still go back because I know that's what's good for me; that's what is healthy for me; that's what keeps me safe. ... Just that I think if I'm able to do that more with my youth and making, like, a little form and asking them to write their own health habitus, I think that would be very helpful because I think that would be a conversation starter, especially when you first meet them.

This suggestion to use the personal health habitus form to engage the family and youth was mentioned by other participants. For Family Peer Advocates who had children of their own, writing their own health habitus provided insights into intergenerational health behaviors that they used to engage families. A 45-year old female of more than one race and Family Peer Advocate explained the impact of this exercise as follows:

...it helped me see that I wasn't being practical enough in accessing services for myself. Sometimes for personal reasons it had nothing to do with the providers, but in the end that really affects me as an individual. I actually keep more on top of my kid than I do of myself and that happens a lot with mothers; we do that. ... I think it was generational because I'm an immigrant from a country where not everybody has health care and it wasn't as ingrained in our heads, like OK it's important to go to your annual checkup. My mother would take us to just to the doctor when we are sick. It wasn't that much of a culture of being healthy and accessing services the way that you would, so I guess it was generational as well. Sometimes, just lack of just having a health care provider. ... Many of my families and especially the mothers that I work with were doing exactly the same thing and they weren't taking care of themselves, and I would always tell them, if you are not OK, nobody else is going to be OK. I never make emphasis about it. I always talk about self-care in terms of education and taking time for yourself but not really making sure you need to go to your appointments: "Now when was your last checkup, OK now you took the kids and now it's your turn to do it as well." So, I think that (after the training) I have been more aware of mentioning that part of taking care of yourself.

Active listening was another skill participants mentioned as acquiring or further developing because of the training. A 22-year old female White non-Hispanic Youth Peer Advocate described how she endeavors to use this skill:

The youth usually has something to talk about, so I try really hard just to let them talk. And I do a lot of open-ended questions so that way it gives them the opportunity to really speak about how they're feeling. I try my best to make eye contact... And I try to be open and stuff and not have my arms crossed or feeling like I should be somewhere else. I try really hard to give my individualized attention to them. ... I thought I was being an active listener before, but then after this training I thought maybe I talk too much, and maybe, I know that I was interrupting. Like, if they would say something and I had something I wanted to say about it, I'd definitely be like, well. So in that aspect I think that changed.

Although many of the participants indicated that they do not use the interviewing guide as a tool, most used the topics in the guide to organize their conversations with family and youth when they try to engage them in HFW, understand their strengths and needs and develop a plan. Similarly, many indicated that they did not use the form to write a health habitus note, but when discussing their progress notes, it became obvious that they included health habitus information and insights. For instance, a 58-year old female White non-Hispanic Family Peer Advocate indicated how she used the health habitus note in her communication with families by stating:

A lot of days, if I plan to have that conversation with them, I'll go through the different – there's the eight (text) blocks I think (eight text boxes in the health habitus note), I'll go through them and read them to myself and sort of have the interview practice yea, I'll have that in my head. I don't usually pull it out because I want it to be more relaxed, and so I try to not have that paper out. And then I just take notes and I ask

them if they mind if I take notes, and then I show them afterwards what I've written down so they can tell me whether I was accurate or not, or I read it back. That dad, he didn't want to read it. I don't know if he has reading issues, he really didn't share that, but he just wanted me to read it to him, so I read it to him. And I still haven't typed my HH note for him because I feel like there's more conversation I need to have with him. ... I do my note from my visit, and I might say I did the health habitus interview, and I might even put a couple of things in there about what we talked about for the health habitus, but I don't go in my full note for the health habitus itself.

This finding that participants wrote a health habitus note but did not always label it as such was quite common, as other interviews suggested. We found that checking the health habitus note box in the different agencies' records system was a rare phenomenon. A 33-year old female Black/African American Family Peer Advocate said that she was very aware of why she identified a progress note as a health habitus note:

On our note taking process it's just really a checkbox but it sounds as if it's an indication of whether or how families seek services, whether or not they do, and when it comes to health or mental health, their process of seeking help. How valuable or how important it is to them (caring for their health in this way), that's my understanding of the training itself. It gave a lot of information but then it made you say, how do you implement this or how do you track this as a family peer advocate, given all this information. So, I know why I check a (health habitus) box or not check the box, if that makes sense. ...So on our notes when it comes to health habitus we probably are describing it in the content (of the note).

This type of training outcome, that is, that different strategies, tools and insights from the training were integrated into the participants' practice was a major finding. This finding emerged when we examined how participants described their overall practice and the strengths and barriers confronting the families and youths they serve. For instance, a 49-year-old female Latina Family Peer Advocate with close to two decades of experience as an advocate incorporated many of the key constructs and insights from the training (e.g., structural and cultural barriers, the significance of assessing habitus, the "why" behind families' behavior, and the cultural humility approach) when discussing the challenges facing the families she serves and her role as an advocate:

I think it's important because we need to find out sometimes, like, why, especially with families like that. So, I deal with families that have youth that have a mental health component. And with health habitus, sometimes we get calls from school. Like, this parent missed X amount of appointments and stuff like that, so we need to be able to ask questions in a non-judgmental manner, like, ask the right questions so that I find out the truth behind why. It's not always that they don't wanna show up or they don't see the need. ... there are so many more reasons, like, yea I understand like, the transportation aspects and not being able to, like, you know, when you have multiple kids and the medical transportation is not feasible for everybody because you can't take your other kids with you, you know. And then you have to block out the whole day and stuff like that. But, I think it's also important, like in that case with the family when it has to do, like, there are other things come into play like religion or cultural, you know, because it's not always just the limited resources, you know, or income. ... But the doctors' offices, they didn't really ask, 'why are you missing these appointments, why are you late, why aren't you making it out to Middletown or this other town,' which is even further away, for these doctor appointments? They just assumed – they (doctors) weren't people of color – so they just assumed they were non-compliant. They didn't ask the right questions. ... Like, if you see someone sitting in front of you, and they're like, Hispanic, you tend to like, ask, do you understand this? Do you need someone to translate, you know? But when you have someone that's Caucasian, the assumption is they can read. And you should never make the assumption.

A similar account of having absorbed key components and insights from the training was given by a 54-year old female White non-Hispanic advocate who indicated that she was relatively new in her position as an advocate. In her discussion of how she interacts with the families she engages in HFW, her health habitus and cultural humility insights became apparent:

...Health habitus is a way to frame interactions with people so that you understand where they're coming from and where they want to go and what barriers they have to getting what they need.... we've been trained in this, and so we have an understanding of people from different perspectives now, so we can look at a person's history, a client's history, and that's where this comes from. So we have to be understanding of it and non-judgmental about it... It (training) came at a good time for me to help me in my role. Since then, I see barriers all the time. I mean, at the time, I was new at it, so I didn't know how it was going to impact my role. ... In terms of cultural, that's a definite learning experience for me. So, we have families with traumatic histories from a cultural perspective, and there's so much to learn from them. (For instance) we have a family with multiple traumatic experiences that started from when they emigrated from a violent country. And the mother and the two sons were either the victims of violence or witnessed violence, and that's the start of multiple traumatic events that happened in their lives and that are continuing to happen. ...So, I think one way we do that (engage cultural humility into our work) is spending a long time in the engagement process and letting them tell their story in their own time.

A brief analytic insight based on Themes 1 and 2: The overarching finding that trainees had absorbed and integrated the constructs, insights and communication strategies and skills into their practice emerged indirectly in the interviews. Therefore, to accurately assess whether trainees understood the information and practiced the skills of the CSC training we should not rely exclusively on the responses to direct evaluation questions (e.g., how would you define or explain health habitus; do you remember x facet of training or how do you use the interview guide). Instead, we should complement the analysis with the indirect data that emerged when trainees discussed the following three interview topics: (1) experiences writing one's own HH, (2) challenges and strengths of families/youths they work with, and (3) their role as advocates. By analyzing the content and language used to discuss these three domains, we concluded that a culturally humble approach and an approach informed by the notion of the structural and cultural origins of health habitus has become features of the advocates HFW practice.

Theme 3.

Implementation of CSC and HFW Training. Data that referred to both trainings are included under this heading because trainees often did not differentiate between the two and instead, perceived CSC as part of HFW. Interpersonal implementation support (i.e., from other team members such as advocates, care managers, and supervisors) and institutional implementation support were the two codes under this theme. The extent of implementation of the CSC and the HFW trainings was influenced by whether an agency elected to train solely their peer advocates or also included care managers and supervisors as members of a care team. It should be added that several advocates discussed the value of sharing insights from the training with their team members who were not included in the training. For instance, a 24-year old, female, White non-Hispanic Youth Peer Advocate indicated that she and the rest of the care team (care manager and family peer advocate) discuss health habitus insights and try to render one of their colleagues more culturally humble:

Yea, everybody kind of talks about it without saying that it's health habitus. So, I mean, it's definitely utilized in the agency and in the group of people that I work with. ... I feel like they do pretty well (in terms of being culturally humble in her agency). There definitely are individuals that have very outward biases. But as an agency as a whole, I feel like it's pretty good. It's just there are select few that I know of that are just kind of not culturally humble and not open to new things or new ways of people doing things. ...I try to personally talk with them one-on-one to see why they're not open or why they are placing judgment on certain things. It's not always successful, but it does happen, I think. So, there's four of us on a team, and the other three of us kind of do it all with the one person. Individually, there's been like one time where, as a group, we all talked to them, but it's better served, or it's better received from them if it's one-on-one than as a group. ...I think that maybe it affects the family part of it a little bit because they're not as open to understanding why

a family, why the caregivers, why the rest of the family reacts the way that they react, or why they do certain things the way they do.

The value of working in an agency that supports the implementation of the CSC and HFW training, was briefly discussed by a 37-year old, female, White non-Hispanic Family Peer Advocate who specifically mentioned that she trained in HFW because her supervisor recommended it:

> I do, actually, I do (feel supported by my agency to implement the training). We had a meeting, me and my other co-worker, we're still new. We had a meeting to discuss how to create an action plan, a care plan, and keeping the cultural competency and working with their (family's) health habitus. I think my boss is actually very good and understanding, and she does support what we're finding out, and she pulls it back. So, it (technique of eliciting health habitus) has been mentioned several times.

Supervisors provided a different perspective on agency and their own support for implementing the CSC and the HFW training, an anticipated finding, given that implementation barriers and facilitating factors vary depending on a person's place in an organizational hierarchy. For instance, a 51-year old, female, White non-Hispanic supervisor who attended the CSC training described how, in conversation, her staff recognized that they are collecting health habitus information and described how they integrated health habitus insights into the family story following the reading of health habitus notes:

> ...we've had some conversations around some of the face-to-face time that our family peer advocates have with their families and us realizing, this was really centered around their health habitus and maybe you didn't even realize it, right? So just having supervision and coaching around some of those meetings and goals that they're working on and trying to tie in some of that health habitus work to make sure that it's being effective. ... I have not written one (health habitus note). However, I have helped and read through some of the notes for some of the staff who are fairly newer at doing it. And it was a conversation that we had after I read the notes, and it was relating to – if my memory serves me – mom's history – medical history, and surgeries and putting off care due to other things that were going on in the home and just in developing the family story with the family peer advocate. A lot of that was broached, so we had conversation about making sure we put that in as a health habitus.

The benefits of participating as a team in the CSC and the HFW trainings became apparent in the discussion of a 36-year-old female, White non-Hispanic Family Peer Advocate who was newly hired and had been working as an advocate for only nine months.

> I have never seen a note like that before. I'm not saying we don't (write one), I just feel like my agency doesn't have a lot of – we have a lot of collaborations, but I feel like I'm on my own. I'll be honest with you, I'm on my own. ... We don't have a care manager, but my supervisor did (participate in the training). ... But we never talked about it when we got back to the office. Never. And I think honestly, I probably am using it, I just don't know.

Indeed, as her discussion of the families she works with indicates, this advocate had become familiar with the health habitus insights but lacked support in writing the note and sharing these insights with her care team.

Theme 4.

Recommendations for Improving the CSC Training. Data on what to change, add or eliminate to improve the CSC training was included under this heading. Trainees offered a plethora of suggestions about all aspects of the training from the style of the delivery of the information to the best time to offer the training, to how best to

practice the skills. Specifically, they recommended offering CSC earlier in the HFW series, extending the duration of the training and/or providing refreshers/booster sessions. Most participants raised the need to devote more time to practicing the health habitus interview and to writing the health habitus note. Specific suggestions referred to the role playing component of the training, with most participants recognizing the value of this activity, but adding that it is challenging to engage in this exercise in a group setting, while others suggested doing the role playing only with members from their own agency/care team and practicing using the story of an actual family they serve. A few participants found the theoretical part of the training complex or tedious and asked for more interactive activities given the day-long length of the training session. Participants made excellent suggestions regarding the training tools, including using the personal health habitus to elicit the family or youth's health habitus, and using the series of health habitus notes to demonstrate to the family and/or youth their progress over time. These suggestions, where applicable, informed the development of the virtual version of the training, currently underway.

CSC Training: Next Steps

The C-CASE trainers are in the process of finalizing a virtual version of the CSC training to be delivered remotely to peers in four New York State regions as a component of the Peer Participation in Wraparound training that has been scaled up throughout the state. The team intends to hold these virtual trainings in the next four months (September 2020-December 2020).

Appendix D.

DECISION TO EXCLUDE ERIE COUNTY DATA FROM HFW PRACTICE ANALYSIS SECTION

Although Erie county was included in previous reports, as the project evolved, the evaluation team began to regard their practice as unrepresentative of the NYS SOC approach. This was due to a number of factors.

First, Erie county care managers began working with families before they participated in the NYS SOC training. Beginning in April 2017 when the first family was enrolled through November 2017 when the training began, 14 of Erie county's eventual 37 families were enrolled, or 38% of the total number of families they work with over the course of their participation in NYS SOC. Therefore, a sizable proportion of families were likely introduced to a version of HFW not wholly consistent with the NYS HFW model. As Erie county care managers were the only providers to work with families before training, let alone this many families, it is possible they developed an approach to practice that was difficult to undo even after participating in training. While enrolling families before training is not ideal, the NYS pilot needed to enroll families by April 1st of 2017 to meet SAMHSA requirements. Erie county therefore made an important contribution to the project by being willing to enroll a family so early in implementation, which was necessary to meet SAMHSA requirements, but this contribution may have made it difficult for them to reliably integrate lessons from NYS SOC training.

Second, Erie county had a history of providing HFW, but with specific practice objectives that were dissimilar from the NYS model (e.g., six-month targets for families' HFW tenure). Care managers were therefore likely to receive and act on local guidance that was incongruent with guidance from the NYS training.

Last, while only three of the 13 families who participated in observations and completed WFI-EZ surveys were from the group that enrolled before starting training, all but one family (or 92% of all families) participated in an observation before care managers completed the training. By contrast, all but one of the observations in other counties were with care managers who completed training. Thus, although Erie county is to be commended for fulfilling a key project requirement by enrolling families early in implementation, by doing so, their practice was unlike care managers from other sites, and likely less adherent to HFW, as evidenced by the difference in overall fidelity on the TOM 2.0 (Figure 49).

Figure 49. Comparison between Erie county (N=13) and all other counties' (N=44) TOM 2.0 overall fidelity percentage

About the Center for Human Services Research

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