Appendix D

Targeted Outcomes 3.1 and 3.1a

Targeted Outcome 3.1: High Fidelity Wraparound services, intensive case management, and intensive home-based services (including those listed on page 14a of the agreement) will be available to every child in state custody for whom they are medically necessary

Targeted Outcome 3.1a: HSD will produce to the Co-Neutrals and Plaintiffs' counsel a detailed progress report on the State's efforts to build High-Fidelity Wraparound capacity.

Introduction

This report provides an overview of the current status of High Fidelity Wraparound in New Mexico and a progress report on the plan to expand access to wraparound statewide. It incorporates an update on the wraparound billing methodology, beginning on page 10.

Purpose: Why Wraparound?

Wraparound is a service model for the top tier of children with behavioral health and mental health disorders. Most mental health disorders have their roots in childhood, with 50% of affected adults manifesting disorders by age 14 and 75% by age 24 (HHS, 1999; Institute of Medicine and National Research Council, 2009). An estimated 20% of children in the United States have a diagnosable mental health condition. Between 7% to 12 % of children in the United States meet the Serious Emotional Disturbed (SED) criteria (Interdepartmental Serious Mental Illness Coordinating Committee 2017).
Devastating consequences, including poor academic achievement, dropping out of school, substance abuse, involvement with the correctional system, lack of vocational success, inability to live independently, and suicide, often result from serious mental health conditions (National Alliance on Mental Illness (NAMI, 2010)). New Mexico has consistently ranked as the lowest, or one of the lowest states in child wellbeing in the U.S. New Mexico's 513,000 children under the age of 19 have a larger portion than most states of emotional, social, and psychological disorders.

The Cost of Care

Mental health conditions are the costliest conditions of childhood wellbeing. The population of children with the most serious and complex mental health needs are comparatively small, however, costs for these children are disproportionate to the costs of serving all children with mental health conditions. Behavioral health expenses are almost 5 times higher than for Medicaid children in general. Approximately 10% of youth

with the most serious and complex behavioral health needs consume 40% -70% of all child-serving resources (Bruns et al., 2010; Center for Health Care Strategies, 2011, March; Pires, Grimes, Allen, Gilmer, & Mahadevan, 2013). Children in the top 10% of behavioral health expenses are nearly 18 times more expensive than Medicaid children in general (SAMHSA Results from the 2008 national survey on drug use and health: National findings NSDUH Series H-36, HHS Publication No SMA-09-4434. Rockville, MS. SAMHSA Office of Applied Studies: 2009). This finding has been attributed to their high utilization of expensive and restrictive treatment in psychiatric inpatient and residential treatment settings, costs that are borne largely by the public sector (Cooper et al., 2008). Children with serious and complex mental health conditions are often involved with additional systemic supports in addition to Medicaid such as child welfare, juvenile justice, special education, early childhood, and systems for youth of transition age. These systems also spend substantial resources in high-cost services and it can be assumed that the costs of serving these children extend well beyond Medicaid.

The Effectiveness of the Status Quo

In patient or residential placements for treatment of mental health conditions are costly and have little evidence of long-term effectiveness (Burns, Hoagwood, & Maultsby, 1998; U.S. Public Health Service, 2000). Research has not demonstrated that children fare better in congregate facilities than family care and some studies have shown the outcomes are worse. Despite limited information related to efficacy with children, psychotropic medications are a commonly prescribed first-line treatment for a range of psychiatric diagnoses in children in a variety of clinical settings (Ninan, A., Stewart, S. L., Theall, L. A., Katuwapitiya, S., & Kam, C. (2014)).

Systems of Care

A system of care is 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 (Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health).

The System of Care approach has a core set values: Community-based, family-driven, youth-guided, and culturally and linguistically competent services. The approach also has guiding principles that call for a broad array of home- and community-based services and supports, individualized care provided in the least restrictive setting, family and youth involvement, cross-system collaboration, care management, and accountability.

The primary premise of systems of care is that safe and positive outcomes can be obtained through the increased use of more cost-effective home- and community-based services and supports. To accomplish this shift toward a greater emphasis and utilization of home- and community-based services, the system of care approach uses a care coordination approach called "Wraparound". This approach has been the primary way that systems of care are operationalized at the child and family level, and there is a growing evidence base documenting its effectiveness in achieving positive outcomes along with cost savings (Bruns & Suter, 2010).

Wraparound Defined

Wraparound is an intensive holistic method of engaging with individuals with complex needs so that they can live in their homes and communities and realize their hopes and dreams (The National Wraparound Institute). "High-fidelity Wraparound" is a term increasingly used to refer to a process that meets the definition and standards for Wraparound developed by the National Wraparound Initiative (Walker, Bruns, & Penn, 2008;http://nwi.pdx.edu/).The Wraparound approach entails assembling a child and family team that includes the child and family, involved providers, and natural supports identified by the family. The team develops an individualized service plan that tailors services and supports for the child and family across all life domains. The plan prioritizes community-based interventions that are least restrictive and least intrusive. The team continues to meet regularly to monitor progress and make adjustments to services and supports as needed. A dedicated Wraparound facilitator or care manager organizes and manages the process, working intensively with the child and family.

Trauma researchers, practitioners and survivors have recognized that the understanding of trauma and trauma-specific interventions is not sufficient to optimize outcomes for trauma survivors nor to influence how service systems conduct their business. What is required is a trauma informed response. A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization (SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed, 2014). The system responds with the appropriate sense of urgency to the needs of the child and family. The Wraparound process is able to respond in a trauma responsive way. (See Attachment 1.)

Effectiveness of Wraparound

The Wraparound approach has been academically examined and High-Fidelity Wraparound has consistently delivered desired outcomes. By 2014 there were 22 published controlled studies of Wraparound (Coldiron, Bruns, & Quick Studies, 2017).

Wraparound affords New Mexico the ability to evolve its behavioral health care while achieving desired outcomes: Family/youth engagement in their care, reduction of system involvement (Such as child welfare and juvenile justice), and reduction of behavioral health costs.

Youth/Family Engagement

Wraparound focuses on working with those youth that have the most complex needs. These needs are holistic in nature and may simultaneously affect a youth and family across various life domains. The complexity and number of these needs often overwhelm traditional services which opt to discharge youth or move them to higher levels of care. As youth and families get shuffled through services it is inherent that they develop a negative perception of their treatment which influences subsequent willingness to engage service providers.

Lengths of stay in Wraparound approaches range from about 7-18 months, with certain populations of children – such as those involved in child welfare or with complex co-occurring conditions – typically having longer enrollment. (Center for Healthcare Strategies, July 2014). One main reason for the length of treatment is that engagement difficulties are typically inherent in Wraparound cases. However, the Wraparound approach with its values such as Perseverance, Voice and Choice, Normalization and Outcome Based lends itself to bridge engagement barriers. Wraparound differs from other approaches because it is a highly collaborative process in which the needs of children and youth with mental health and behavioral disorders are addressed (Suter and Burns 2009). (See Attachment 2.)

Reduction in System Involvement & Improved Social & Emotional Functioning

Ironically, youth and families often have the same desired outcomes that systems do, such as exiting systems involvement, meeting educational milestones and feeling better. Even though youth and families share these common goals the approach of the latter in meeting them tends to not be effective when it comes to complex needs. Systems and behavioral health providers place focus and energy in realizing the goals as a means to reduce the concerning behavior(s). Strategies and interventions developed are meant to carry the youth/families to the destination. For the population with the highest and most complex needs this approach is not effective. A focus on goals and behavior assumes a lack of skill, even willingness, from the youth and family, often ignoring other reasons.

The Wraparound holistic approach lends itself to grasping barriers with their depth. The depth of these barriers are often founded on traumatic experiences and therefore do not lend themselves to quick, fit all, solutions. In Wraparound these barriers are termed as Underlying Needs and are often referred to as the root cause of the concerning behavior(s). As a matter of fact in Wraparound, the concerning behaviors are understood

as the individual's way for meeting their underlying need. Since underlying needs are often rooted in trauma it usually takes some time to truly discover them as the youth/family must be willing to be vulnerable with their Wraparound facilitator and team to discuss these topics.

In 2017, New Mexico conducted a demonstration pilot project to evaluate the impact of the High-Fidelity Wraparound (CYFD-Coop Consulting 2019). There was an undeniable theme that illustrated that youth involved in Wraparound have better quality of life and outcomes the longer they stayed in Wraparound. Those youth who discharged successfully from Wraparound reported:

- 56% increase in community supports;
- 58% decrease in child welfare involvement;
- 60% increase in nurturing parenting;
- 77% improvement in overall child health;
- 65% increase in positive behavior;
- 62 % increase in improvement in safety;
- 73% increase in school or work function.

One of the most impactful results of this evaluation was that 70% of those who completed the Wraparound process stated that their life had improved greatly.

Positive Return on Investment (ROI)

In addition to high prevalence rates, mental health conditions are the costliest conditions of childhood (Agency for Healthcare Research and Quality [AHRQ] Research Brief #242; Soni, 2009). Children with severe and complex mental health conditions experience multiple admissions to inpatient and residential treatment facilities and often have extended lengths of stay in those settings (Stroul, B., Pires, S., Boyce, S., Krivelyova, A., & Walrath, C. (2014). Return on investment in systems of care for children with behavioral health challenges). The costs for treatment in settings such as inpatient psychiatric hospitals or residential treatment centers are extremely high, while the evidence base for the efficacy of these services is relatively low (Burns, Hoagwood, & Maultsby, 1998; U.S. Public Health Service, 2000).

Every constituency is always charged with the responsibility of providing the best possible service at the best value available. As referenced above, care for youth/families with the greatest need tend to drive costs of behavioral health care. In part this is due to the approach explained above where behavior and goals are the focus. With such an approach, at the lack of outcomes, additional services are prescribed as well as increasing levels of care as acuity increases. Unfortunately, adding services and/or using higher levels of care still do not yield the desired outcomes.

As described above, Wraparound delivers the outcomes youth/families, systems, and providers seek. In addition, Wraparound delivers these outcomes while reducing costs.

There are also increasing data on ROI from the many states and communities that have implemented Wraparound. States and communities that have implemented the system of care approach (Driven through the implementation of Wraparound) have reported changes in service utilization patterns. Such changes have resulted in cost savings for the public systems that serve children with serious mental health conditions and their families (Stroul, B., Pires, S., Boyce, S., Krivelyova, A., & Walrath, C., 2014). This same publication included the following ROI data:

- A study found that youth in the Wraparound group experienced fewer out-of-home placements and fewer mean days in out-of-home placements than a matched comparison group that had graduated from residential care. Post-graduation costs were also approximately 60% lower than costs for the matched comparison group—$10,737 for the wraparound group, compared with $27,383 for the comparison group (Los Angeles County, CA).
- A study showed a net reduction in Medicaid spending of 29%, even though the use of home- and community-based services and targeted case management increased. Expenditures declined from an average annual expenditure of $58,404 before wraparound to $41,873 per youth per year. This decrease was due to a 43% decline in inpatient costs and a 29% decline in residential treatment expenses (Maine).
- Since its inception, Wraparound Milwaukee has reduced costs by more than 50% (from over $8,000 per child per month to about $3,450 per child per month). Declines in costs are attributed to reduced utilization of inpatient and residential treatment.
- After implementation of a system of care approach using Wraparound, Medicaid claims were decreased by 43% in the 12 months after enrollment, whereas the reduction in costs for the control group was only 20% for the same time period (Pennsylvania).
- Savings were greatest for children who had been in residential treatment facilities prior to the initiation of wraparound services—an overall 38% reduction in claims. This finding indicates that the approach is particularly effective for youth using high-cost services such as residential treatment (Pennsylvania).
- From FYs 2009 to 2012, per member per month expenditures on inpatient services decreased by more than 40% (from 27% to 16%), and expenditures for intensive community-based services increased. By 2012, intensive community-based services constituted the largest portion of Medicaid spending (Massachusetts).

High Fidelity

Researchers on human services implementation typically define fidelity as "the degree to which programs are implemented as intended by the program developers" (Dusenbury, Brannigan, Falco, & Hansen, 2003). When referring to Wraparound fidelity a few factors

must be taken into consideration: Wraparound does not have single developer, it is a based on a philosophical approach and it requires infrastructure for its implementation to be done to fidelity. Meaning that adherence to its practice model should also consist of measurement of both whether its core activities (Values and Core Elements) are being completed as well as whether necessary support conditions are in place (Bruns, E. (2008). Measuring Wraparound Fidelity).

Importance of Fidelity

Research on the efficacy of Wraparound consistently demonstrates the model's effectiveness. It is important to note that several of the controlled studies that found null results (e.g., Bickman et al. 2003; Bruns et al. 2014) documented that Wraparound was not implemented as intended or to fidelity (A Comprehensive Review of Wraparound Care Coordination Research, 1986–2014, Coldiron et al, 2017).

High Fidelity Wraparound is the term commonly used to describe a Wraparound process that tightly adheres to the Wraparound model. In recent years, concerns about the "black box" of Wraparound have led to efforts to better specify the wraparound practice model, provide more consistent training and implementation supports, and develop and deploy fidelity measures (Admin of Policy Mental Health. 2015, Eric J. Bruns, et al, 2015).

New Mexico Wraparound CARES (Comprehensive, Accessible, Responsive, Effective, and Strengths Based) has partnered with the University of Washington's Wraparound Evidence Research Team (WERT) for the use of three fidelity evaluation tools: The Wraparound Fidelity Index (WFI-EZ), The Team Observation Measure (TOM) and The Documentation and Assessment Review Tool (DART). (See Attachment 3.)

Progress and Next Steps

Revise SED Definition

Dr. Neal Bowen, Director of HSD's Behavioral Health Services Division (BHSD), is recommending the following changes to the existing SED Definition:

1. Remove the criteria cited by plaintiffs:

   In addition to one of the qualifying traumatic events above, there must also be an ex parte order issued by the children's court or the district court which includes a sworn written statement of facts showing probable cause exists to believe that the child is abused or neglected and that custody is necessary.

2. Update elements to reflect a clear, current, expert understanding of potential experiences that can lead to Complex Trauma (which is still not a diagnosis in the DSM 5, but proposed for the ICD 11). Among the elements to be changed:
   - Remove the list of experiences listed under "Diagnoses" Part B, as the current understanding of the development of complex trauma includes a broader array of experiences than is reflected in the list. In fact Cloitre (2020, The British Journal of Psychiatry, March pp 129-131) notes "trauma history is now recognised as a risk factor rather than a requirement for" either PTSD or Complex PTSD;
   - Replacing the list of trauma symptoms under "Symptoms" which reflect PTSD as defined in an earlier version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), with symptoms commonly observed with the presence of Developmental Trauma;
   - Clarify that the child must have functional impairment in at least two of the listed capacities, rather than exactly two.

The full proposed list of revisions will be complete in time for evaluation by the Behavioral Health Collaborative at the January 2021 meeting.

Since the current definition was approved by the Behavioral Health Collaborative in 2015, Dr. Bowen is proposing to raise the issue for vote at the January 2021 quarterly Behavioral Health Collaborative meeting.

General Eligibility Criteria for New Mexico

- Children or youth with a SED diagnosis;
- Functional impairment in two or more domains (CANS is used to determine);
- Involved in two or more systems (special education, behavioral health, protective services, juvenile justice); and
- At risk or in an out of home placement.

Service Definition

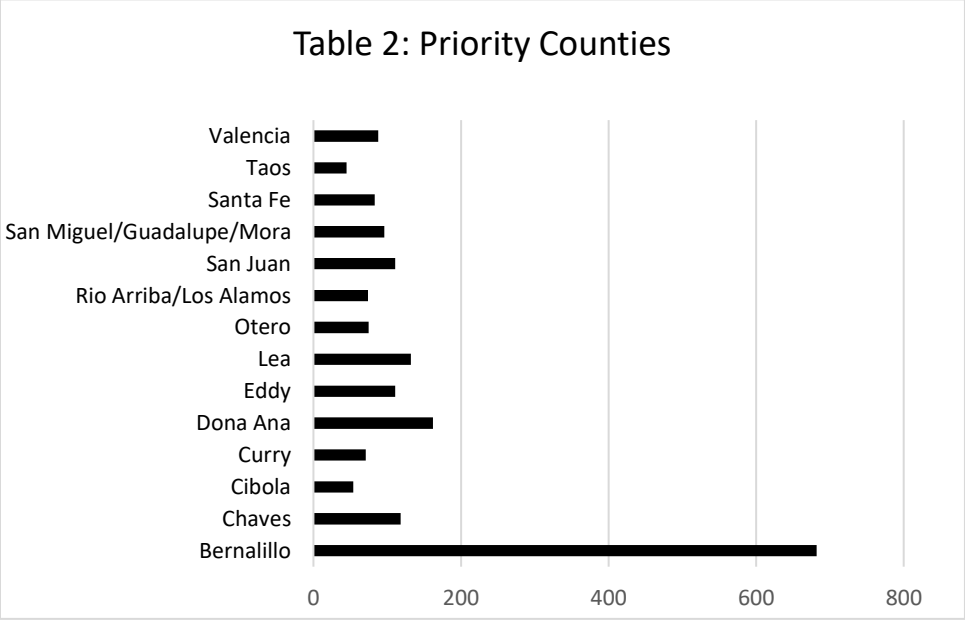
The purpose of High-Fidelity Wraparound (HFW) is to coordinate and assist young people and their families in achieving important outcomes by helping them meet unmet needs both within and outside of formal human services networks while they return to, or remain in, their local communities. Wraparound transitions with the child/youth through multiple phases of recovery and permanency.

HFW is youth-driven, family-centered, community-based, and strengths-based. HFW includes an individualized planning process and Action Plan to support the young person and their family in the Wraparound process. HFW will identify, access, obtain, and monitor mental health, social services, educational services, other formal services, and natural and community supports that will assist the young person and their family in meeting their needs and achieving their vision. (See Attachment 4.)

Phase One

Given that children in protective services custody are most at risk, the **2,132** New Mexican children in CYFD custody will be phase one of the implementation. Bernalillo, Chaves, Cibola, Curry, Dona Ana, Eddy, Lea, Otero, Rio Arriba/Los Alamos, San Juan, San Miguel/Guadalupe/Mora, Santa Fe, Taos, and Valencia counties all have over 40 children in CYFD custody. (See Attachment 5: Table 1.)

Wraparound is currently in 10 counties with 61 facilitators. To reach the goal of serving all children in CYFD custody we would need 101 facilitators in 17 counties (Table 2). The remaining 150 children in surrounding frontier and rural areas, could be served by agencies in nearby counties with an additional range differential (over 60 miles) with an additional 10 facilitators. Taos, Sierra, Socorro, Quay/De Baca/Harding, Lincoln, Grant/Catron, and Colfax/Union counties remain a high priority, especially Taos and Grant/Catron due to the higher number of children in CYFD custody and because of the geographical challenges.



The Cost of High Fidelity Wraparound

The return on investment of Hi Fidelity Wraparound is well researched, as stated and referenced above. The two areas of cost are broken out below:

Infrastructure Costs

These are currently being funded by CYFD SAMSHA federal grants and state general fund (2.5 FTE's in CYFD), including positions at NMSU. Services provided include: provider training; ensuring fidelity of the model, and evaluation of HFW.

Total costs are approximately $69,000 per month or $828,000 per year. Continuing the CYFD partnership with NMSU's Center of Innovation (COI) the cost will be approximately $1,500,000 a year. (Attachment 6 contains infrastructure budget categories for the COI.)

If allowed by the Centers for Medicare and Medicaid (CMS), these costs may be included in the Per Member Per Month (PMPM) paid to the provider. Otherwise, the state must utilize state general funds as grant funding has terminated. HSD is exploring ways to assure federal CMS funding is able to help pay these costs. In FY2020, there were 286 children and youth in NM who received Wraparound, breakout below.

Fiscal Year '20 Wraparound Enrollment Data - CYFD involvement				
TOTAL	PS	JJ	Both	NO
	42%	17%	2%	39%
286	121	48	5	112

The benefit of the partnership between CYFD and NMSU's Center of Innovation, is that as the model becomes sustainable for providers, administrative costs can be required for application, training, and continued education. The COI can employ coaches and trainers to continue to seed the system of care with high quality subject matter experts.

Billing Methodology

HSD met with the Centers for Medicare and Medicaid (CMS), the regulatory body that approves state's Medicaid program design, to discuss our options to build High Fidelity Wraparound capacity. There are a variety of options the state can utilize to operationalize this effort and HSD sought guidance on the fastest and most effective way to request approval for the payment of services as outlined in this report. The options evaluated include waivers as well as state plan amendments. Because HSD has an approved 1115 waiver through which we operate our managed care program, and currently has efforts underway to submit an amendment to this waiver before the end of the calendar year, this is likely the fastest vehicle to achieving this implementation. Additionally, applying for a waiver should allow HSD to address current provider limitations on which

providers can provide HFW, provide payment for services not otherwise billable, and continue to expand the population of children served overtime.

Rates for wraparound can be structured in a number of ways, including as case rates paid daily, monthly, annually, or per episode of care to the provider or managed care organization. The most common rate structure for Wraparound is a PMPM, with case rate also represented in other states.

HSD will utilize its actuary, Mercer, to develop an actuarially sound rate for HFW. HSD is currently considering a couple of reimbursement methodologies for HFW. One option is to utilize the current PMPM reimbursement methodology that was implemented for the Medicaid HFW Health Home providers which are provider specific and require much more time and effort to develop. A second and much more preferred option is to establish a single reimbursement rate based on Mercer's assessment of the two current HFW providers. HSD has researched reimbursement rate in other states and has found them to differ based on the model. A recommended process will be included in the 1115 waiver amendment which requires HSD to ensure budget neutrality.

Provider Type

New Mexico is proposing to expand provider types eligible to provide High Fidelity Wraparound, , by explicitly including, in addition to Health Homes, the Behavioral Health Agency (BHA) 432 provider type with Wraparound as sub-specialty, Federally Qualified Health Centers (FQHC) and Tribal Providers with designation as either a BHA or FQHC . Providers of one of the above types, with documented experience with SED children and families, as well as care coordination, case management, care coordination, or resource management will be allowed to enroll as a Medicaid HFW provider when also found to be ready for Hi Fidelity Wraparound by the NMSU Center of Innovation.

Provider Certification Process

(See Attachment 7: Wraparound Provider Process Flow Chart.)

Providers will send a letter of interest to NMSU's Center of Innovation. COI will request information and once received and the agency meets criteria, the process flows through an Interagency Council consisting of CYFD, BHSD, and Medicaid representatives will review and determine if a provider may proceed with the next steps to enroll as a Medicaid provider and contract with Managed Care Organizations (MCOs). MCO's will receive contracted provider list from HSD/CYFD and will only authorize payment for providers endorsed by Interagency Council to ensure fidelity to the model.

CYFD and NMSU have created a provider implementation manual, which will need to be amended once this process is confirmed.

Role of MCO

The role of the Managed Care Organizations (MCOs) is under development and will be dependent in part on CMS approval of the state's 1115 waiver amendment. HSD is currently considering requirements for the MCOs including reimbursement rate(s),, care coordination, ensuring and monitoring access to HFW, assessment and oversight of medical necessity, monitoring of quality of services, data collection, paying for start-up or training costs. HSD will not require a prior authorization process for HFW but will require the providers, as in the current model, to continue determination of whether the child/youth meet the criteria for the service. The provider manual will include expectations about educating children and youth and their family on their rights to appeal denial of access to this service.

Referral Process

Current Status of Structured Referral System/Process

The current process for providers receiving referrals is dependent on CYFD-Protective Services and Juvenile Justice, community stakeholder (Providers, Schools, etc.), or the MCOs. Formal outreach such as Wraparound 101 presentations and informal outreach in the form of one on one meetings are necessary to ensure a steady flow of referrals. Lack of awareness of the availability of Wraparound services is one barrier as is a lack of understanding of the value of Wraparound within those potential referral sources. While the NM Wraparound CARES program provides guidance and requires certain components be a part of any referral processes there are differences with each current provider in how they receive referrals and what the process is for enrolling new clients in services.

Structured Referral System/Process Development Plan

Enhancements to CYFD's information system, currently under development, will allow for direct referrals when eligibility criteria are met. This will ensure equity and consistency to access services as opposed to the CYFD workers making subjective decisions. The Child & Adolescent Needs and Strengths (CANS) Tool will be an essential component of a screening system for Protective Services to refer automatically to Hi Fidelity Wraparound. Screening criteria based on a CANS score and other assessment tools need to be developed. CYFD will also develop a procedure and a system of accountability to ensure referrals occur in all instances in which they are indicated. CYFD and HSD, through the Interagency Council, will develop internal protocols as well as guidance for external referral sources to understand when and how to refer to Hi Fidelity Wraparound.

Appendix D, Targeted Outcomes 3.1 and 3.1a **ATTACHMENT 1**

Generally accepted essential ingredients for Trauma Informed Care

- Addressing the difficulty of adjusting to past trauma
- Acknowledging the impact of trauma on key developmental timeframes
- Assisting in shifting perspective to bring a new reality
- Utilizing sensory strategies to address the lower brain
- Creating resiliency building key strong relationships
- Building an understanding of true meaning for an individual; their reason for waking up in the morning
- Assuring caregiver capacity-taking care of self; work/life balance, identifying limits

Wraparound addresses these ingredients by:

- Eliciting a personal or family vision of a future.
- Building a safe and trusting relationship
- Recognizing and listening for level of past trauma and its current effects
- Building a strengths based personal / family narrative to create new perspective
- Listening and building upon functional strengths
- Listening for needs vs. problems
- Providing real help in a real way
- Assisting families in rediscovering a dependable, community-centered support system
- Encouraging self-care of Wraparound facilitators

Appendix D, Targeted Outcomes 3.1 and 3.1a **ATTACHMENT 2**

Evidence of Wraparound Success in Getting Youth and Family to Engage in Their own Care

This success of Wraparound getting youth and family to engage in their own care is evidenced in the following:

- Youth and families demonstrate an increased accessing services while in Wraparound (Coldiron, Bruns, & Quick Studies, 2017)
- Youth had fewer placement changes compared to youth not enrolled in Wraparound
    - (Evidence Base and Wraparound, Bruns, 2010)
- Overall functional improvement as rated by the CAFAS and CANS ((Evidence Base and Wraparound, Bruns, 2010)
- In a New Mexico study on the demonstration of the efficacy of Wraparound 56% of youth demonstrated an increase in community supports (CYFD-Coop Consulting 2019).
- A meta-analysis of research and an update in 2010 found studies in multiple sites that document both improved outcomes and reduced costs when wraparound is implemented with fidelity (Bruns & Suter,2010):
- A study of youth in the juvenile justice system in Clark County WA found that a group receiving Wraparound had 58% fewer days of detention, 57% fewer days served, and lower recidivism rates than a comparison group receiving conventional mental health services.
- A study in Los Angeles county CA found that youth in the Wraparound group experienced fewer out-of-home placements and fewer mean days in out-of-home placements than a matched comparison group that had graduated from residential care
- A study in Massachusetts found that youth receiving Wraparound had 74% lower inpatient expenses and 32% lower ER expenses than a comparison group.
- Overall there was less use of less of out-of-home placements and general use of less restrictive settings (Evidence Base and Wraparound, Bruns, 2010)
- Overall Maintenance of youth in community residential placements (Suter & Bruns, 2009).
- More rapid closure of child protective services cases (Evidence Base and Wraparound, Bruns, 2010)
- Improved Juvenile Justice outcomes (Suter & Bruns, 2009).
- Youth in Wraparound had fewer days incarceration when compared to another group (Evidence Base and Wraparound, Bruns, 2010)
- Improvement in school functioning (Suter & Bruns, 2009)
- Improvements in school grade point average (Evidence Base and Wraparound, Bruns, 2010)

- Improvement in mental health outcomes (Suter & Bruns, 2009)
- Youth showed "significant improvement in behavioral and emotional problems, increases in behavioral and emotional strengths, and improved functioning at home at school, and in the community (Pullman et al.,2006)

Appendix D, Targeted Outcomes 3.1 and 3.1a **ATTACHMENT 3**

Elements of Fidelity

In order to support the fidelity of implementation of the Wraparound approach, training in wraparound implementation and fidelity assessment measures have increasingly become recognized as essential to the process (Sather & Bruns, 2016).

Since 2014 New Mexico, through the Behavioral Health Services of the Children Youth and Families Department, has been dedicating resources to developing a High Fidelity implementation practice in our state. This has culminated in the development of a NM Wraparound CARES Readiness Assessment and Provider Application process and the High Fidelity Wraparound Program Manual and Provider Implementation Guide.

The existing provider application and readiness assessment process provides orientation on the philosophy of Wraparound and asks the behavioral health provider to demonstrate their readiness or willingness to make changes in order to align their entire practice to the Wraparound approach. Upon acceptance of a behavioral health provider's application, NM Wraparound CARES, via the NMSU COI, provides technical assistance to the provider in hiring, onboarding, structuring of their wraparound program.

The Wraparound Program Manual outlines the Facilitator in Training (FIT) certification track for new facilitators. This track requires a combination of 100 hours of training and coaching, a minimum case load requirement, competency assessments, and fidelity assessments. For a complete description of the certification process please see the full manual. https://bhs.nmsu.edu/files/2020/03/1.-NM-WRAPAROUND-CARES-implementation-Guide.REVISED12.1.19.pdf

New Mexico Wraparound CARES has partnered with the University of Washington's Wraparound Evidence Research Team (WERT) for the use of three fidelity evaluation tools: The Wraparound Fidelity Index (WFI-EZ), The Team Observation Measure (TOM) and The Documentation and Assessment Review Tool (DART).

As a fidelity measurement system, these tools were designed to support both program improvement as well as research. With respect to program improvement, these tools can generate profiles, organized by the prescribed activities of the Wraparound process or the 10 principles of Wraparound, to illuminate areas of relative strength and weakness. This information can be used to guide program planning, training, and quality assurance (Quality Assurance and Fidelity Monitoring Tools, WERT).

With respect to research, data from these instruments can help evaluate whether the Wraparound process has been adequately implemented, and thus aid interpretation of outcomes. In addition, researchers on youth and family services may wish to use these evaluations to measure the relationship between adherence to the Wraparound model and outcomes, as a way to explore which aspects of service delivery are most important to child and family well-being (Quality Assurance and Fidelity Monitoring Tools, WERT).

Program Manual and Implementation Guide: https://legacy.nmsu.edu/bhs/files/2020/03/1.-NM-WRAPAROUND-CARES-implementation-Guide.REVISED12.1.19.pdf

Provider Application (not yet updated with new process/parameters): https://legacy.nmsu.edu/bhs/files/2020/11/NMWraparound-CARES-Provider-Application-FINAL-07.18.pdf

Overview of WERT Fidelity Monitoring Tools

Fidelity data is collected through three tools, the Team Observation Measure (TOM), Wraparound Fidelity Index (WFI), and the Documentations Assessment Review Tool (DART).

The TOM tool collects information through the observation of team meetings by a Wraparound coach. A team meeting is observed with the objective of measuring to degree to which the facilitator facilitated the team meeting according to Wraparound principles:

- Team composition
- Effective team work
- Driven by Strengths and families
- Based on priority needs
- Use of natural & community supports
- Outcome based process
- Skilled facilitation

The WFI collects information through a survey of youth, caregiver, team members and Wraparound facilitators. The survey is conducted after a team meeting and it asks team members to rate their experience/perspective in the following areas:

- Basic demographic information from the family including custody,
- Use of a team based approach
- Level the family voice and choice in the development of a plan
- How the Wraparound process has brought the appropriate support, and outcomes
- A Strength based approach
- Crisis planning by the team
- Satisfaction with the Wraparound Process
- Outcomes through progress in the home, school, social, and community domains

The DART collects information from case files. It is designed to identify critical elements in documentation that match fidelity and practice standards. This information includes:

- Basic information about the circumstances of the document review, and the youth enrolled in Wraparound. This information provides necessary context for interpreting results and can help internal or external program evaluators detect trends in fidelity
- Timely engagement
- Wraparound Key Elements
- Safety Planning

- Crisis Response
- Transition Planning
- Outcomes (Assesses whether or not various potential adverse events (hospitalization, placement, arrest) have occurred since the youth enrolled in Wraparound and whether or not their mental health, interpersonal and school functioning has changed)

Appendix D, Targeted Outcomes 3.1 and 3.1a **ATTACHMENT 4**

Wraparound Service Definition

*** Currently being Updated**

Appendix D, Targeted Outcomes 3.1 and 3.1a ATTACHMENT 5

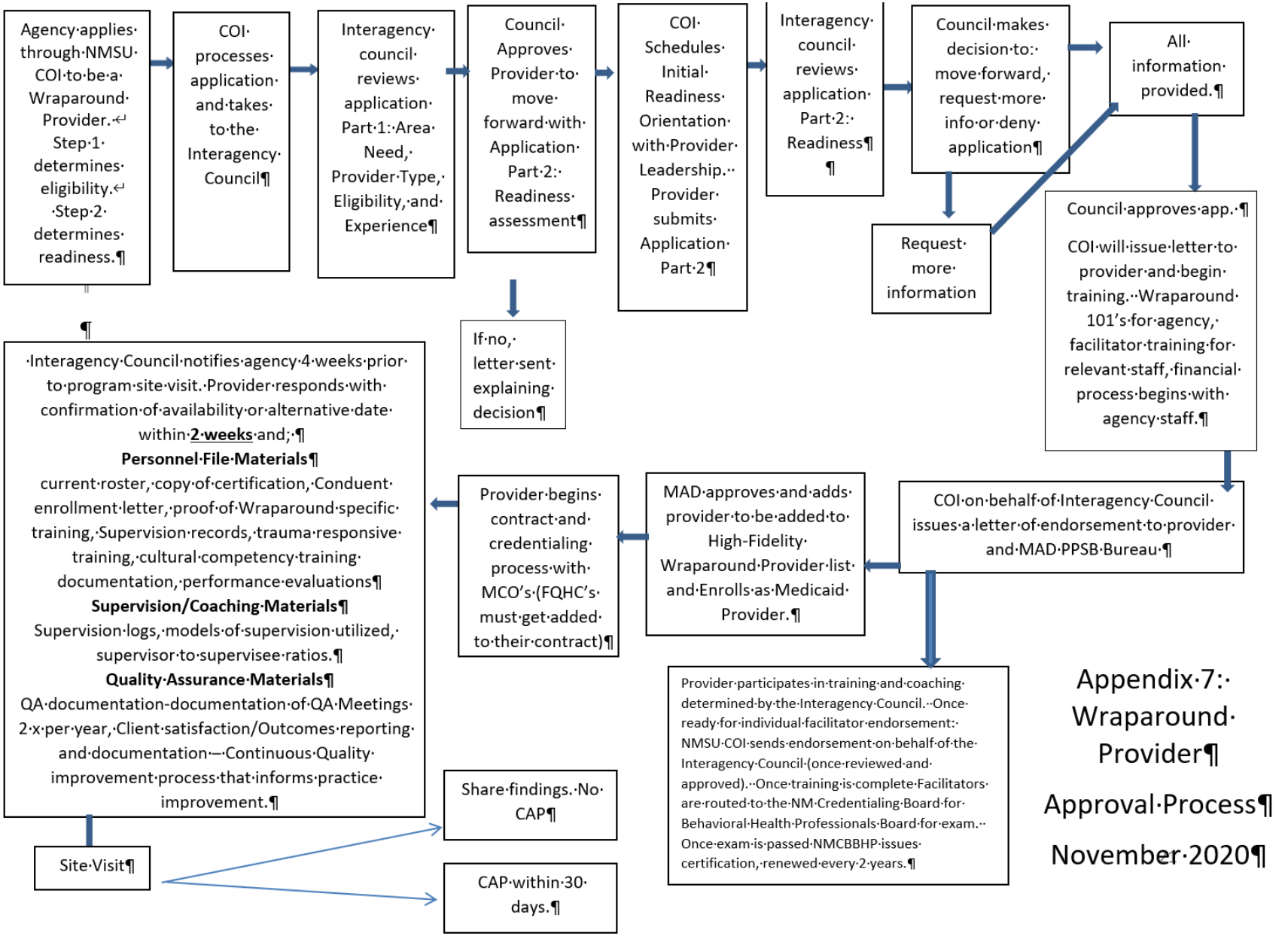
Children in custody by county, # of facilitators current and needed, in counties with over 40 children

County			Children	Facilitators	Current	Need
Bernalillo			**682**	50	20	30
Chaves			**118**	8	3	5
Cibola			**54**	4	0	4
Curry			**71**	5	0	5
Dona Ana			**162**	12	2	10
Eddy			**111**	8	0	8
Lea			**132**	10	*14	
Otero			**75**	5	0	5
Rio Arriba/Los Alamos			**74**	5	0	5
San Juan			**111**	8	3	11
San Miguel/Guadalupe/Mora			**96**	7	0	7
Santa Fe			**83**	6	0	6
Taos			**45**	2	0	2
Valencia			**88**	6	4	2
Roosevelt			**11**		7	
Sandoval			**39**	3	2	1
McKinley			**30**	2	2	
Totals			1982	141	43	101

Appendix D, Targeted Outcomes 3.1 and 3.1a **ATTACHMENT 6**

Budget Categories for Sustaining High-Fidelity Wraparound with a Center of Innovation.

Center of Innovation/CYFD Wraparound Costs
Personnel
Director
Curriculum Training and Data Manager
Specialist
Training and Certification Program Coordinator
Fiscal Program Coordinator
Graduate Assistants
Admin Assistant
Provider Coordinators/Coaches/Trainers @ CYFD
Clinical Manager @ CYFD
Evaluation and Quality Service Review Manager
Provider Support and TA
Contractors & Consultants
Wraparound Coaches/Coach the Coaches- Contractors
Consultant/Content Expert Annual
Certification Board
Program Expenses
Annual Training Costs
Fidelity & CANS Fees- WERT & Praed
COI Website and Tracking System
Travel & National Conference Trainings, etc.


Agency·applies·through·NMSU·COI·to·be·a·Wraparound·Provider.·Step·1·determines·eligibility.·Step·2·determines·readiness.¶
COI·processes·application·and·takes·to·the·Interagency·Council¶
Interagency·council·reviews·application·Part·1:·Area·Need,·Provider·Type,·Eligibility,·and·Experience¶
Council·Approves·Provider·to·move·forward·with·Application·Part·2:·Readiness·assessment¶
If·no,·letter·sent·explaining·decision¶
COI·Schedules·Initial·Readiness·Orientation·with·Provider·Leadership.··Provider·submits·Application·Part·2¶
Interagency·council·reviews·application·Part·2:·Readiness¶
¶
Council·makes·decision·to:·move·forward,·request·more·info·or·deny·application¶
Request·more·information
All·information·provided.¶
Council·approves·app.·¶
COI·will·issue·letter·to·provider·and·begin·training.··Wraparound·101's·for·agency,·facilitator·training·for·relevant·staff,·financial·process·begins·with·agency·staff.¶
·Interagency·Council·notifies·agency·4·weeks·prior·to·program·site·visit.·Provider·responds·with·confirmation·of·availability·or·alternative·date·within·2·weeks·and;·¶
Personnel·File·Materials¶
current·roster,·copy·of·certification,·Conduent·enrollment·letter,·proof·of·Wraparound·specific·training,·Supervision·records,·trauma·responsive·training,·cultural·competency·training·documentation,·performance·evaluations¶
Supervision/Coaching·Materials¶
Supervision·logs,·models·of·supervision·utilized,·supervisor·to·supervisee·ratios.¶
Quality·Assurance·Materials¶
QA·documentation-documentation·of·QA·Meetings·2·x·per·year,·Client·satisfaction/Outcomes·reporting·and·documentation·—·Continuous·Quality·improvement·process·that·informs·practice·improvement.¶
Provider·begins·contract·and·credentialing·process·with·MCO's·(FQHC's·must·get·added·to·their·contract)¶
MAD·approves·and·adds·provider·to·be·added·to·High-Fidelity·Wraparound·Provider·list·and·Enrolls·as·Medicaid·Provider.¶
COI·on·behalf·of·Interagency·Council·issues·a·letter·of·endorsement·to·provider·and·MAD·PPSB·Bureau·¶
Provider·participates·in·training·and·coaching·determined·by·the·Interagency·Council.··Once·ready·for·individual·facilitator·endorsement:·NMSU·COI·sends·endorsement·on·behalf·of·the·Interagency·Council·(once·reviewed·and·approved).··Once·training·is·complete·Facilitators·are·routed·to·the·NM·Credentialing·Board·for·Behavioral·Health·Professionals·Board·for·exam.··Once·exam·is·passed·NMCBBHP·issues·certification,·renewed·every·2·years.¶
Site·Visit¶
Share·findings.·No·CAP¶
CAP·within·30·days.¶
Appendix·7:·Wraparound·Provider¶
Approval·Process¶
November·2020¶