

Differences in Wraparound training and coaching outcomes as a function of system context

3 Case Studies

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Wraparound fidelity is important, and needs system support to achieve

- Two recent randomized trials of Wraparound have found that low-fidelity Wraparound does not produce better outcomes than usual care
 - Bruns, Pullmann, Sather, et al., 2014
 - Browne, Puente-Duran, Shlonsky, et al., 2016
- Research has also shown that more robust system and organizational supports lead to higher-fidelity practice
 - Bruns, Suter & Leverentz-Brady, 2006
 - Effland, Walton, & McIntyre, 2011
 - Snyder, Lawrence, & Dodge, 2012

The context in which Wraparound is implemented varies across states

- Community Mental Health Centers (CMHCs)
 - Typically out-patient services providers
 - Provide an array of mental health services across populations (including adults and children) and settings (home based, schools, etc,)
 - Non-profit or government entities
- Care Management Entities (CMEs)
 - A non profit organization or public agency that serves as the “locus of accountability” for defined populations of youth with complex challenges and their families who are involved in multiple systems
 - Accountable for improving the quality, outcomes, and cost of care for populations historically experiencing high-costs and/or poor outcomes

CMEs provide specialized support

- Centralized locus of accountability
- Intensive care coordination utilizing high quality Wraparound
- Real time information management
- Commitment to outcomes monitoring and continuous quality improvement around specific populations served:
 - Children and adolescents with serious emotional and behavioral challenges at risk of or returning from out-of-home placement in residential treatment, group homes and other institutional settings and hospitals
 - Youth at risk of incarceration or placement in child serving systems
- Supervisory support around one practice model

NWIC trains and coaches in a variety of contexts

- NWIC provides technical assistance and workforce support to a variety of states, the centerpiece of which is a suite of training, coaching, and CQI
 - Training topics include
 - Introduction to Wraparound
 - Engagement in the Wraparound Process
 - Intermediate Wraparound
 - Advanced Wraparound Practice
 - Supervision in Wraparound
- Currently providing in 11 states

We collect data to monitor fidelity and facilitate coaching via the COMET

- The Coaching Observation Measure for Effective Teamwork (COMET) is an instrument used to assess skill attainment in facilitators and subsequently used in supervision/coaching
- Completed by an external NWIC expert
- Items provide detailed descriptions of Wraparound skills, which are coded as Demonstrated/Not Demonstrated
- Scores are organized into “Key Elements”

Each COMET item has a detailed description of high-fidelity practice

S2. Ability to identify and extract functional strengths from the story told from multiple perspectives (Ph1)



Family story or narrative, timeline, strengths list

Skilled wraparound staff should be prepared to gather a variety of perspectives in identifying strengths. This may include speaking with a variety of family members, system partners or other team members. Regardless of how the story is told care coordinators should identify functional strengths that could be deployed as part of a Wraparound plan.

Scoring:

'Demonstrated' if the practitioner is able to integrate the perspectives of all team members in terms of relationships and patterns and expresses the added perspectives in terms of strengths of the family. This should also be reflected in the strengths list on the POC.

'Not Demonstrated' if the practitioner is caught up in behaviors and only sees deficits of the family. If they only include events or information related to the youth referred. They are not able to identify strengths gathered from other team members. It is not reflected in the strengths list on the POC.

T2. Ability to reach agreement with families about how all of the important people in the family's life should be part of the process (Ph1)



Family story or timeline, team list

Wraparound is a team-based approach in an individually based service system. As a result, family members as well as other service providers may be cautious about a team-based approach. Families who have participated in a range of other services may very well be expecting a sole practitioner and a range of interventions to be delivered to family members. Effective wraparound practitioners should be prepared to make the point about collective action from the first point of contact with families. Without a team and collective action there is no wraparound process. This means staff should be prepared to respectfully and frankly push the issue of team participation. The skilled practitioner can identify ways that constructing a team composed of key players will be in the family's benefit and is likely to increase the possibility the family's stated desires will be achieved.

Scoring:

'Demonstrated' if the practitioner can explain wraparound in a way that reflects the team process and generates buy-in from family members in the creation of a team. This would be reflected in team composition that includes both formal and informal supports.

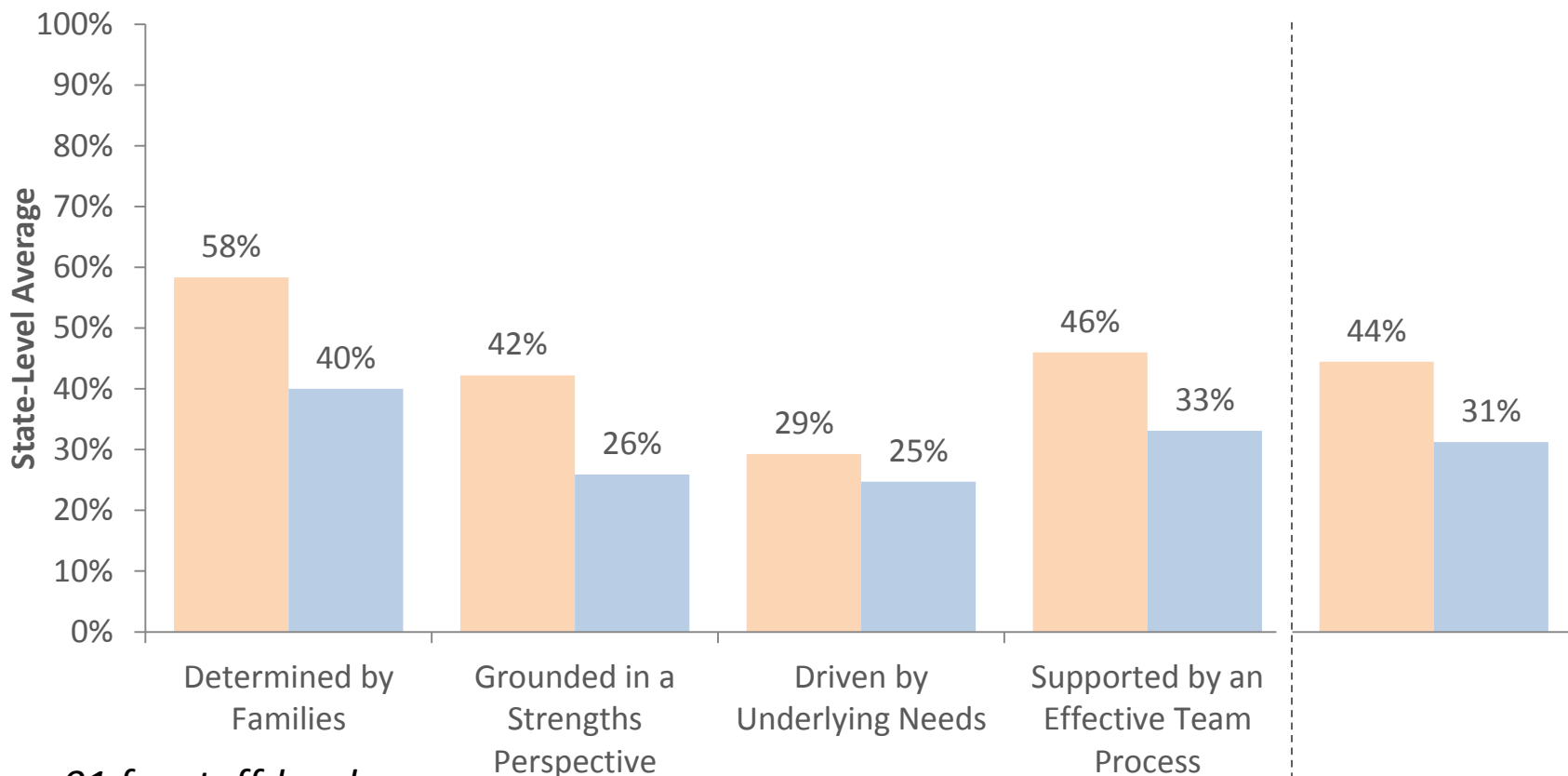
'Not Demonstrated' if the team only consists of the wraparound staff and the family.



NWIC

National Wraparound
Implementation Center

Staff in CMEs implement Wraparound at significantly higher fidelity than staff at CMHCs



p < .01 for staff-level comparisons of all scores

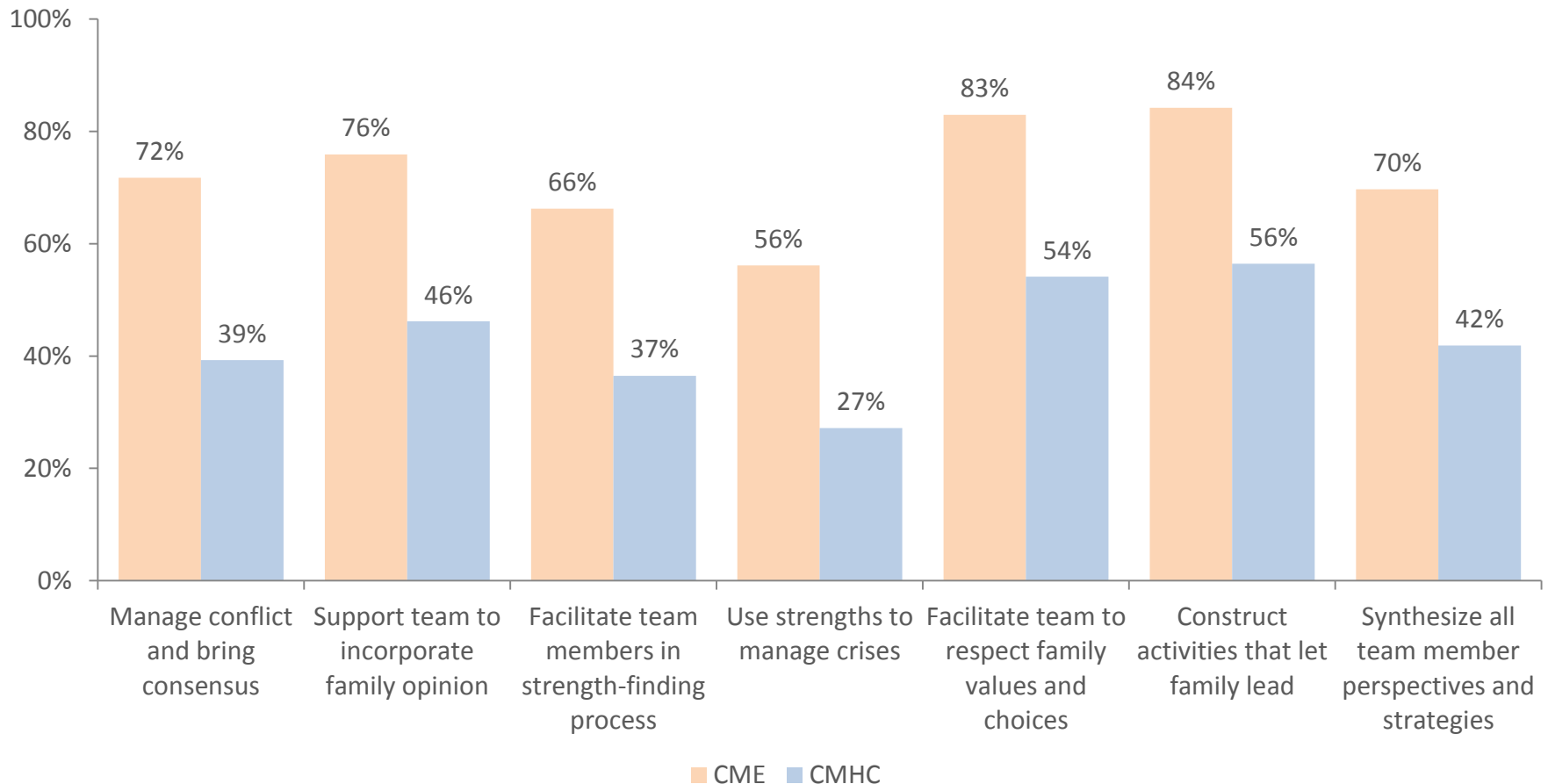
Key Element Scores

Total Score

■ CME (n=4) ■ CMHC (n=4)

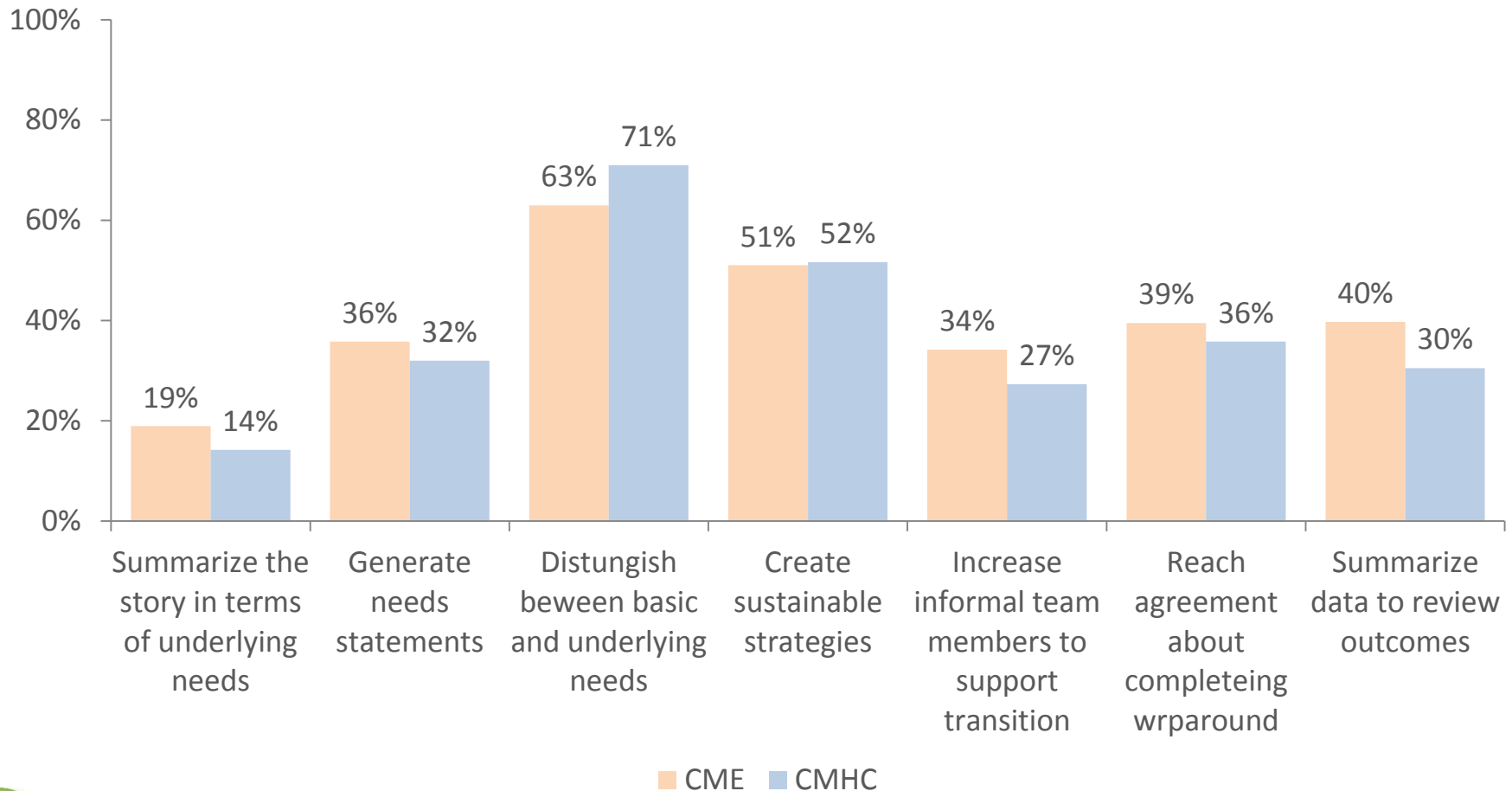
Many of the largest differences are in skills related to team facilitation and utilization of strengths in the process

Percent of sessions in which the following skills were demonstrated

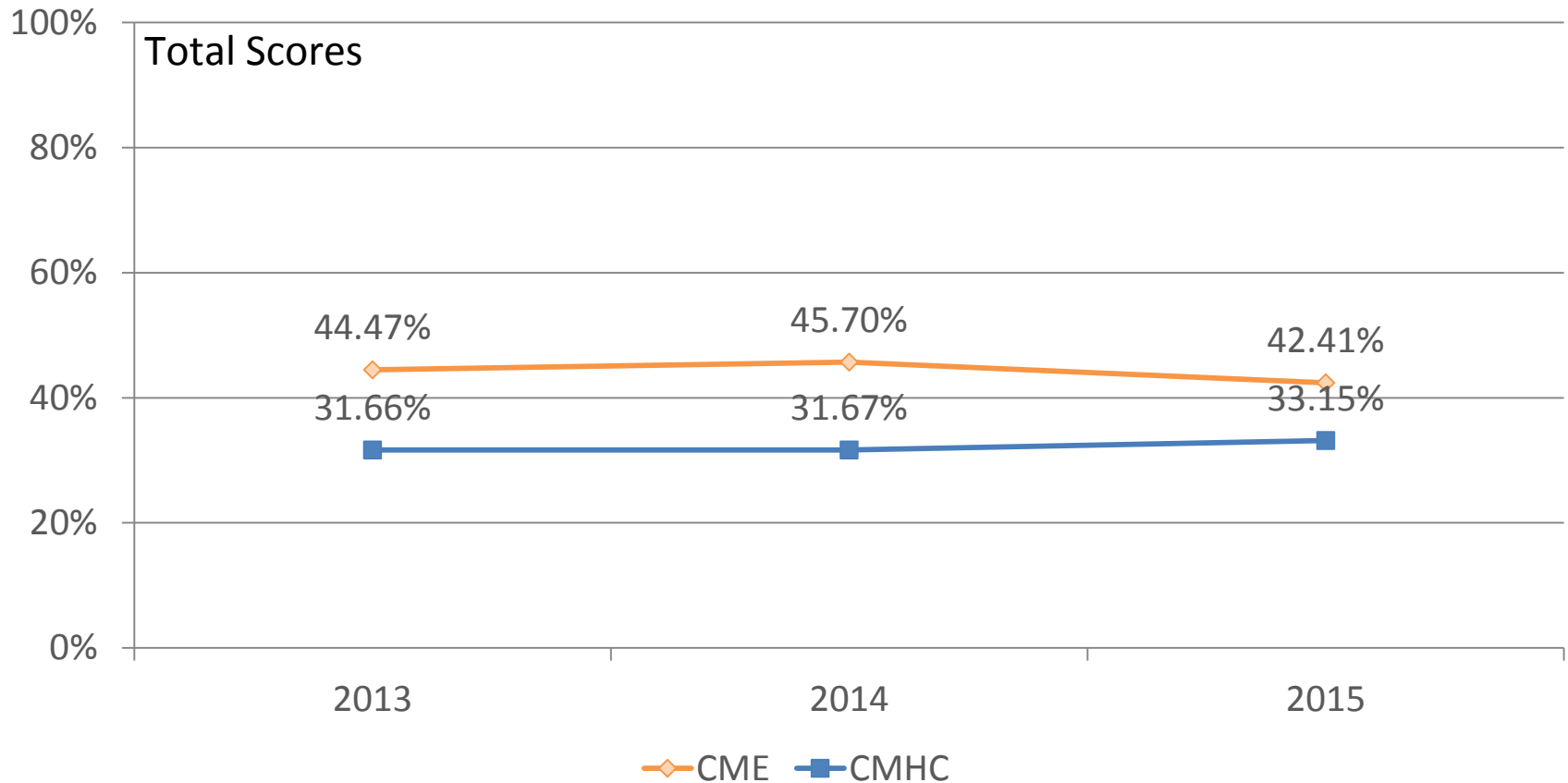


Implementation looks more similar for skills related to underlying needs and transition activities

Percent of sessions in which the following skills were demonstrated

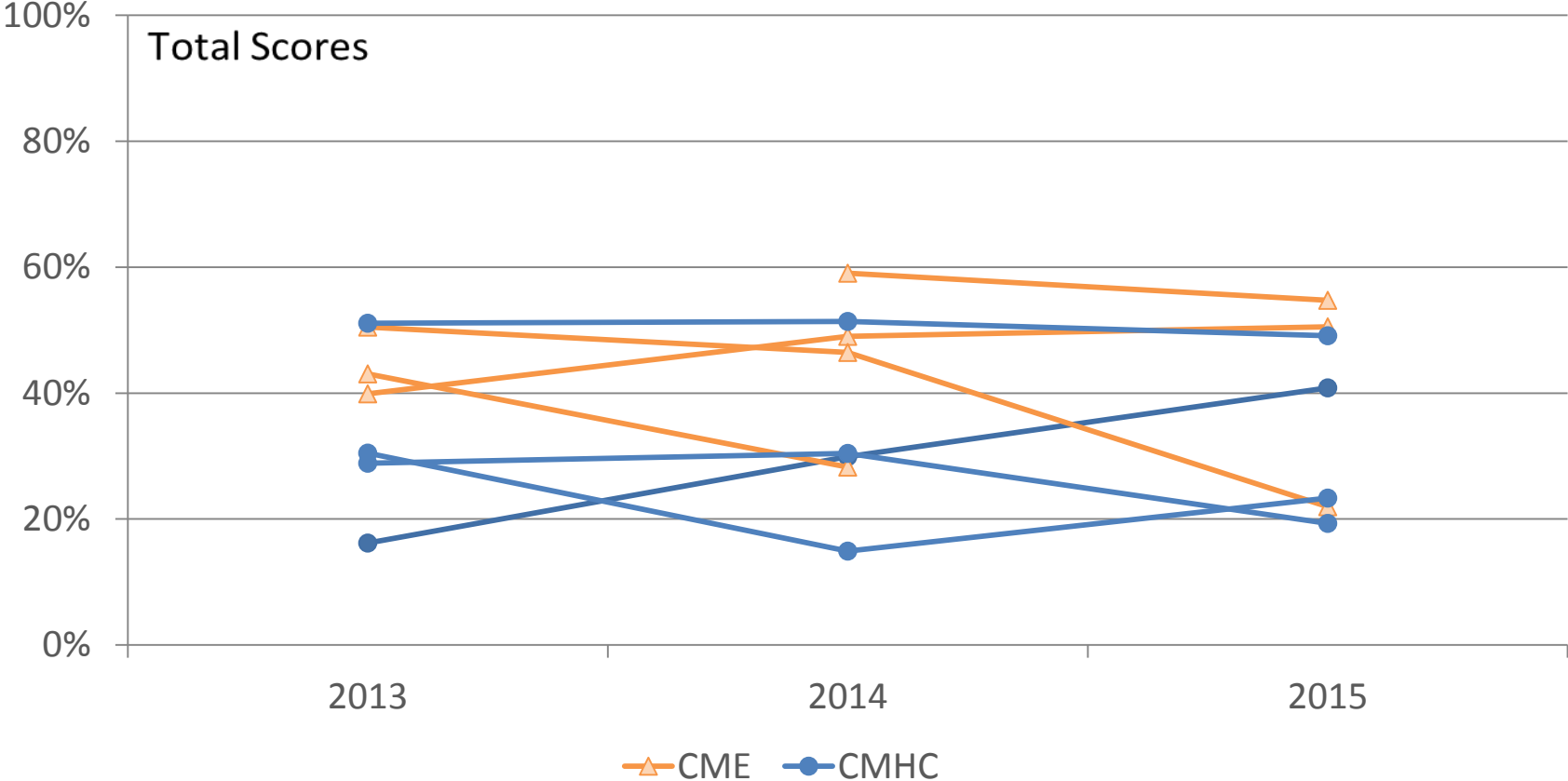


The difference between structures has held over time



$p < .01$ at all time points.

But there is some variation among states



Case Study 1

STATE A



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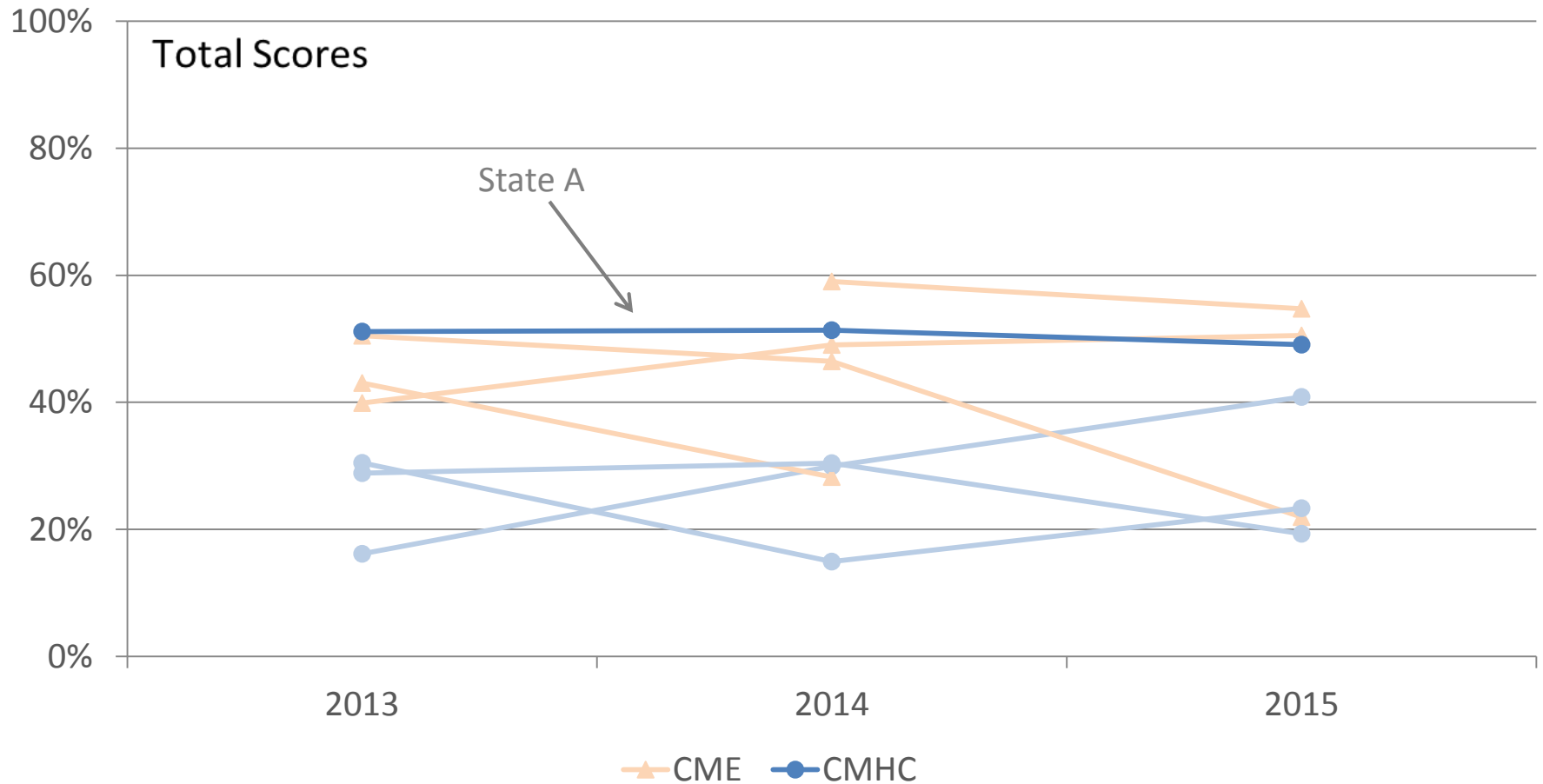
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Although not a CME state, Wraparound is implemented at higher quality than other CMHC states



State A shares many characteristics of CMEs

- Very strong and involved state leadership
- Clear state policy around implementation factors
 - Staffing ratios
 - Invest in evaluation, fidelity, and outcomes monitoring
- Developed in-state expertise to maintain ongoing workforce development
 - Training
 - Coaching

Case Study 2

STATE B



Portland State
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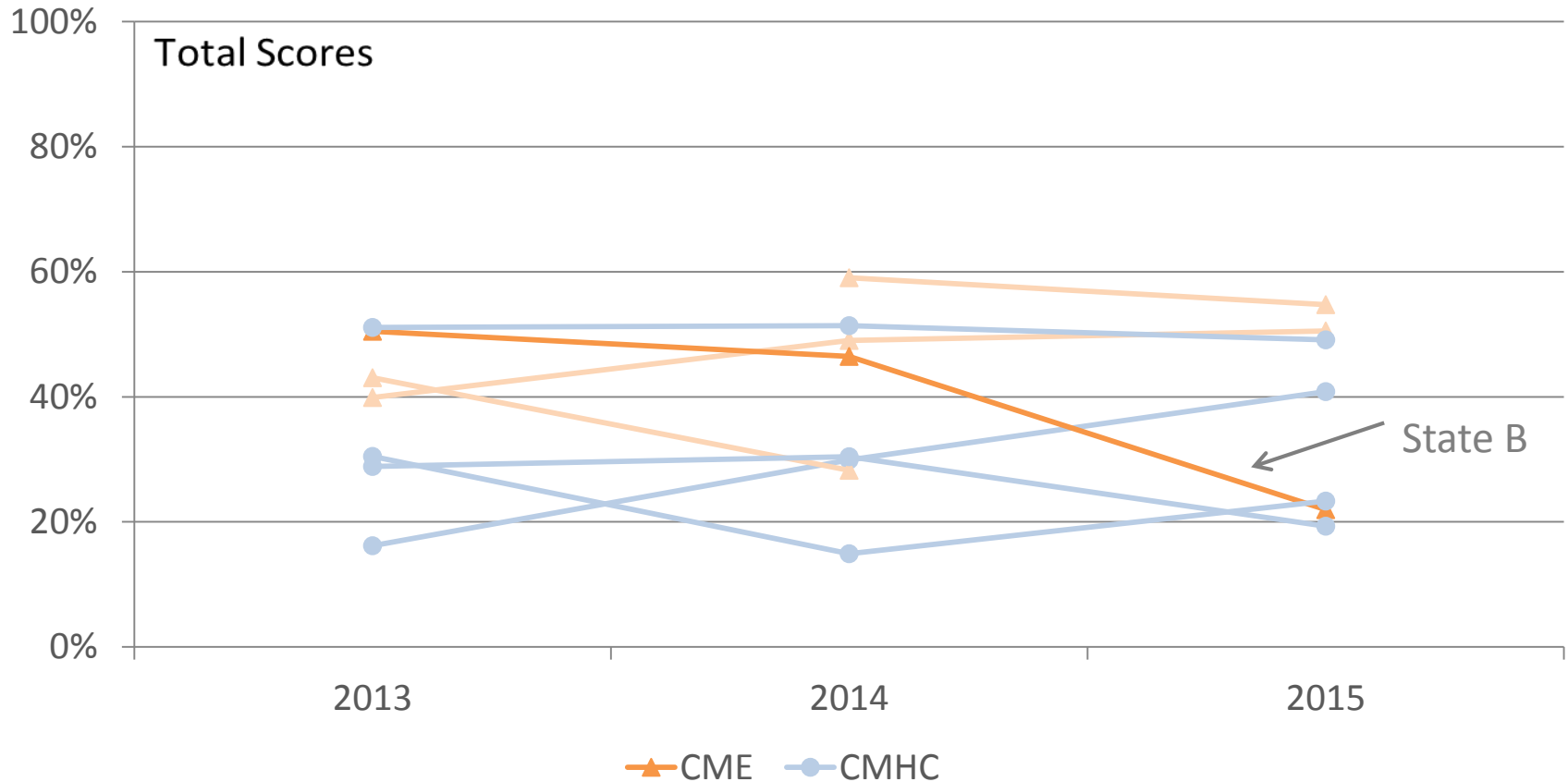
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After two years, supports and structure associated with workforce development fell away, and fidelity slipped



Changes made by State B in 2014

- In 2014, training and coaching activities ended abruptly
- State oversight and evaluation slipped once start up structures were in place and implementation went statewide
- This suggests that ongoing workforce development, evaluation, and fidelity assessment is important in any structure

Case Study 3

STATE C



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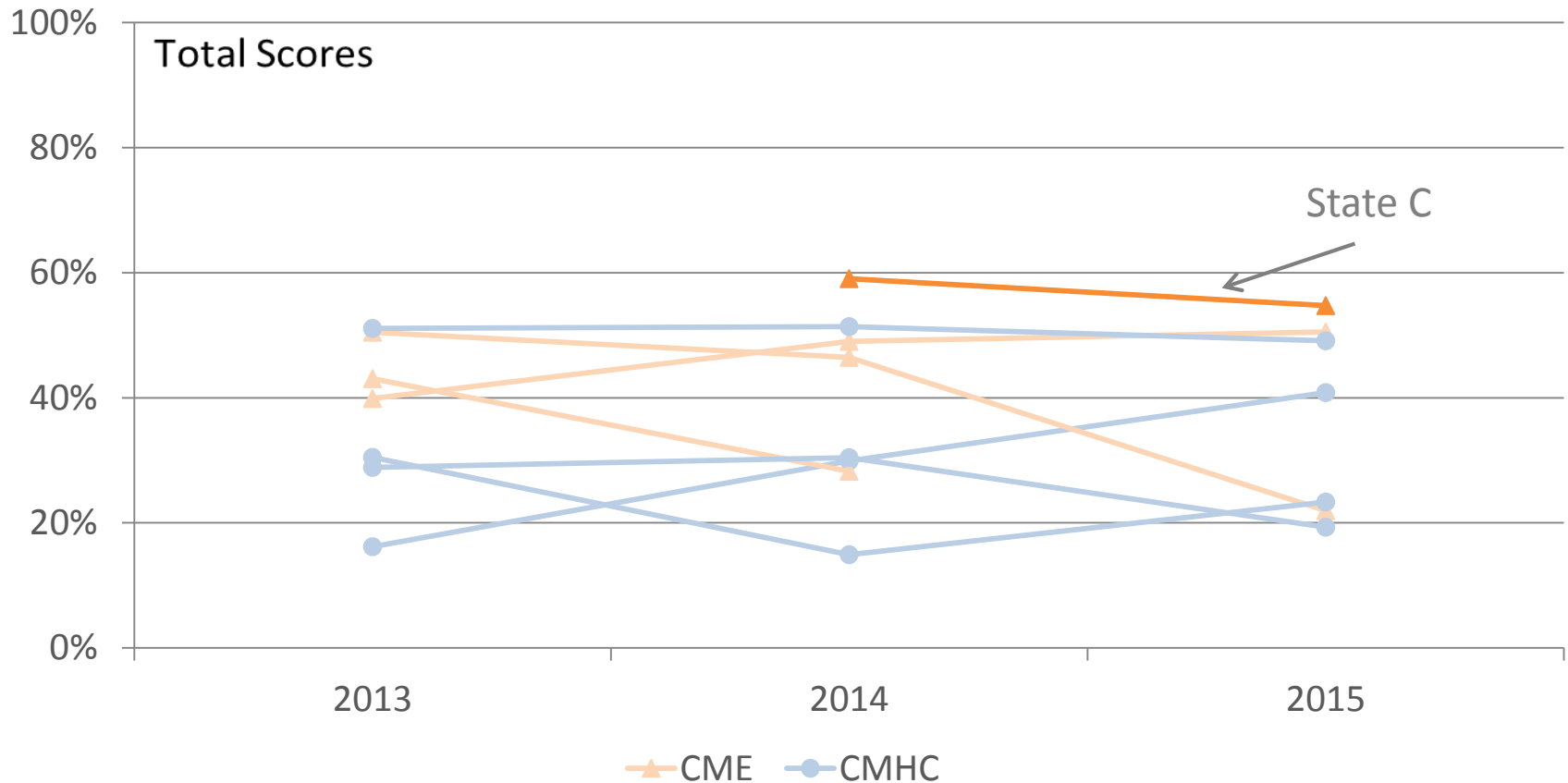
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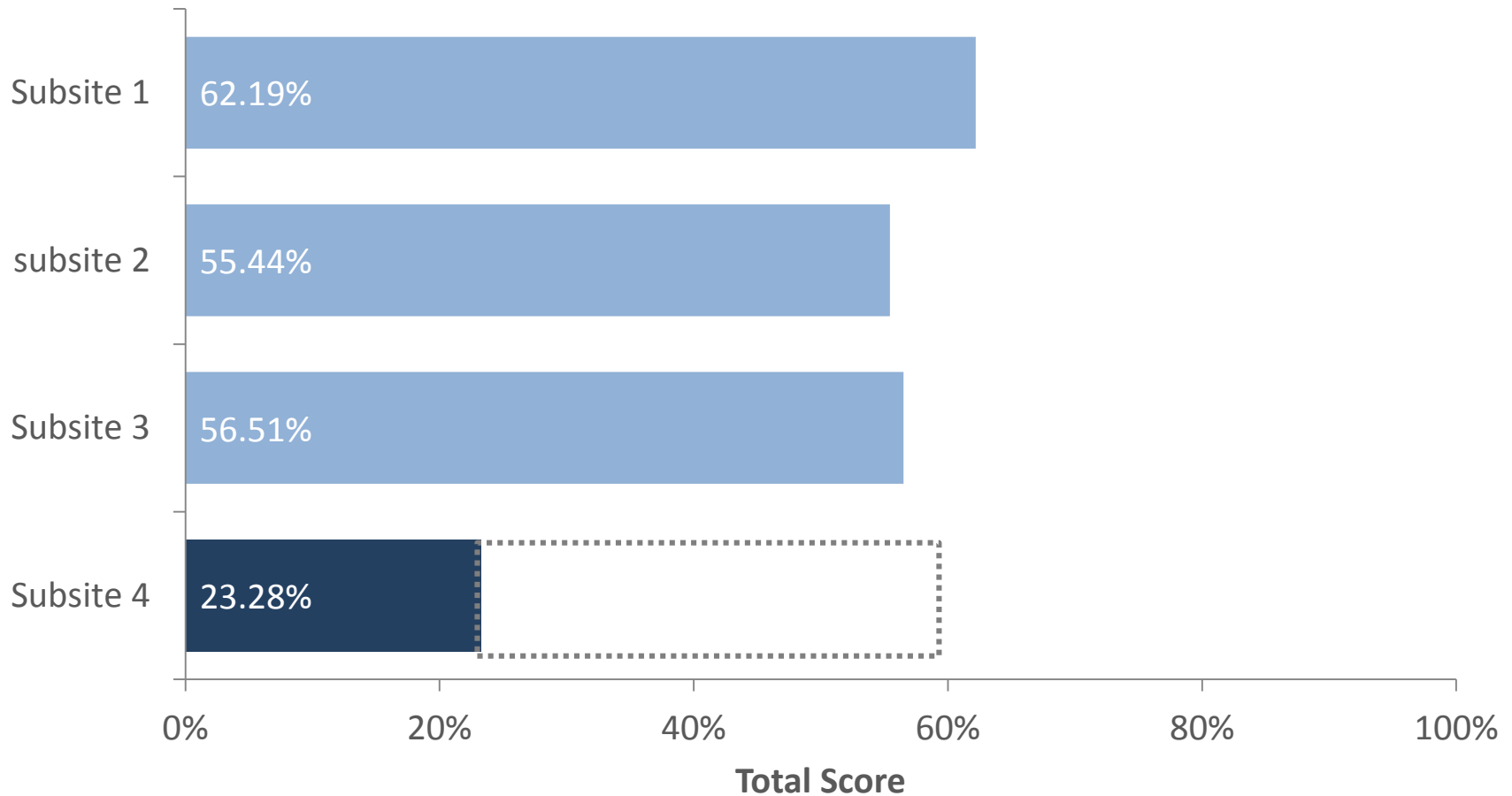
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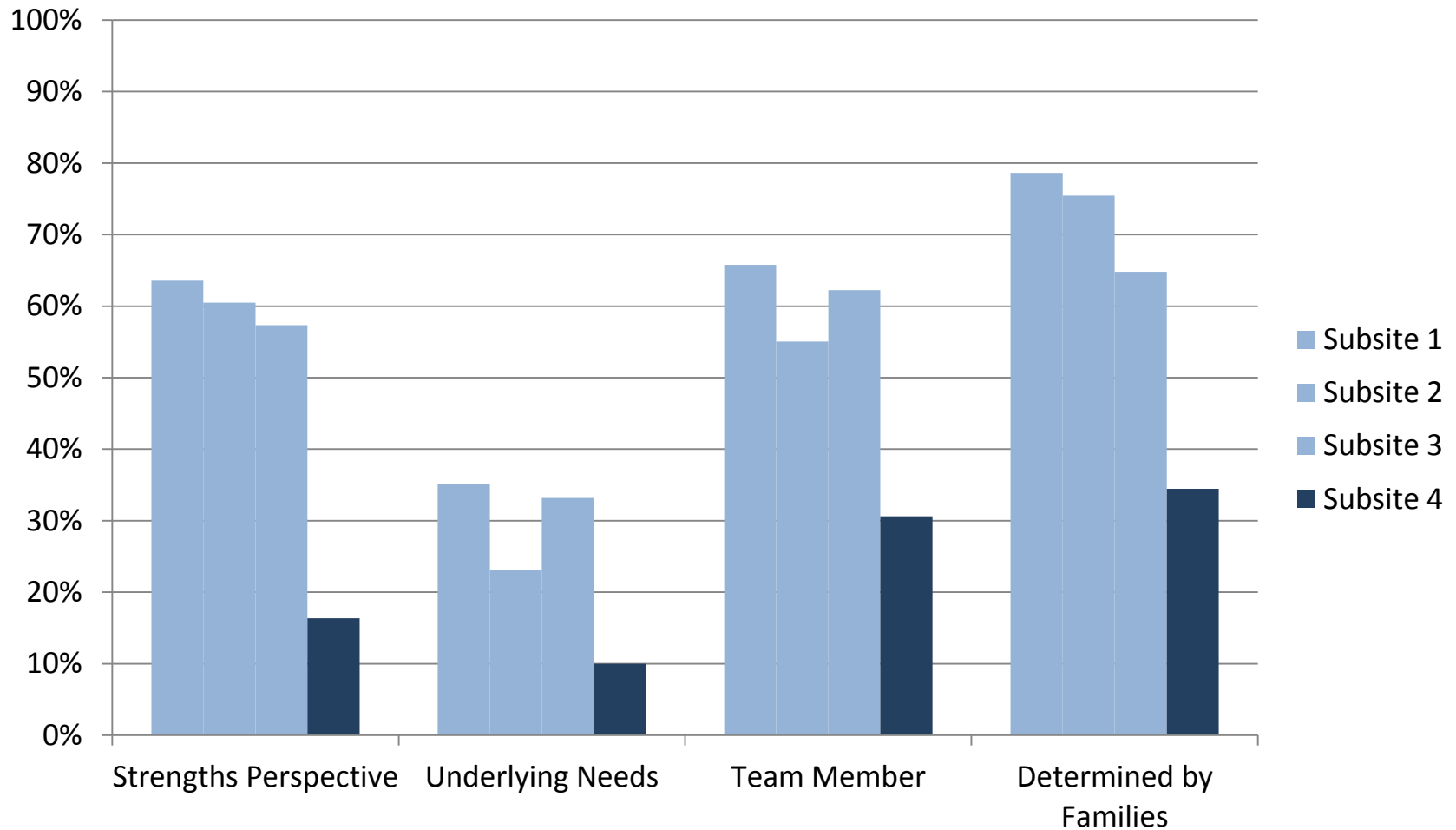
State C, a CME state, appears to be a top-performer



However, even within high-performing CMEs, regional differences in implementation matter



Even within high performing CMEs, regional differences in implementation matter



Even within high performing CMEs, regional differences in implementation matter

- Within a CME structure, strong leadership, oversight, and consistent support for frontline staff are critical
 - Staff retention
 - Hiring practices
- Collection and use of data to make leadership decision allows for targeted intervention when things are not working

Conclusions

- The features that make up Care Management Entities seem to be associated with increased fidelity to the Wraparound model, as measured by experts, when compared to CMHCs
- These features:
 - are not exclusive to CMEs (State A)
 - require maintenance (State B)
 - can vary within the context of a state (State C)