STANDARDS SHEET

WRAPAROUND SERVICES

Effective February 23, 2018 – Refresh on February 23, 2020

Good	Excellent	Outstanding
"Good stewards of taxpayer dollars"	"Excellent stewards of taxpayer dollars"	"Outstanding stewards of taxpayer dollars"
4	5 – 6	7 – 8

Master Formula	$Score = X1 + X2 + X3 + X4$	
Intermediate Outcome Category	**(X1)** = 100% - (Justice System Interactions/ Total Population Served (YTD))	Requirement: **84.7%** Standard Deviation: 12.71%
	(X2) = 100% – (Psychiatric Hospitalizations/ Total Population Served (YTD))	Requirement: **81.38%** Standard Deviation: 11.15%
	(X3) = 100% – (More Intensive Residential Placements/Population Served (YTD))	Requirement: **80.85%** Standard Deviation: 7.92%
	(X4) = 100% - (Suspensions or Expulsions from School / Total Population Served (YTD))	Requirement: **78.99%** Standard Deviation: 4.6%
Data Sources	**Variable**	**Public Source**
	X1-X4	San Diego County and FSP Reports
Scoring Rules	-1 = Greater than one SD below category requirement 0 = Less than category requirement +1 = Meets requirement but does not exceed one SD above requirement +2 = Greater than one SD above category requirement	
Timing Rules	1. Data collected at end of Q4 2. Metrics revised every two years to reflect local trends	

1855 1st Avenue, Suite 201 • San Diego, CA 92101
info@sdcta.org • P: (619) 234-6423 • www.sdcta.org

KEY PERFORMANCE INDICATORS FOR WRAPAROUND SERVICES

February 2018

Background

SDCTA's Working Group on Metrics to Define Effective Performance in Wraparound Services

The County of San Diego spent close to $152 million dollars on mental health services in FY 2016-17[1]. It is important to ensure youths throughout the region receive the best possible support from such a significant taxpayer investment in behavioral health resources. The San Diego County Taxpayers Association established a public working group with regional wraparound providers as well as other healthcare professionals to develop metrics that accurately and meaningfully assess the outcomes of local wraparound services. The working group began by researching the formal objectives of successful wraparound programs.

Existing academic research as well personal testimonies of the local providers asserted that successful youth wraparound programs prevent higher, or more intensive, levels of institutional care. The working group isolated four outcome categories that, if prevented, meaningfully capture their programs' objectives. Consequently, local programs that adhere to the wraparound principles and provide high-quality services should improve the lives of their patients during the course of treatment with respect to the following four categories of outcomes.

1. Psychiatric Hospitalizations
2. Interactions with the Justice System
3. Expulsions/Suspensions from School
4. New Institutional Placements

To establish standardized metrics, the San Diego County Taxpayers Association sought external outcome data for these categories to provide a baseline for local service providers. It was the working group's recommendation to first seek longitudinal data, or data collected six months to a year out of treatment. The working group discovered that follow-up data of this kind is not routinely collected within the industry due to cost and other resource constraints.

As a result, the working group shifted its focus to assessing these outcomes during the course of treatment where data has been more consistently collected. The working group acquired data collected by the National Wraparound Initiative from various programs across the country as part of their wraparound fidelity assessments. This data was selected from National Wraparound Initiative as being "high quality" for the following reasons: at least 30 unique caregiver WFI-EZ forms were available, questions A1-A3 were positively endorsed for at least 90% of the sample, and the initiative's forms were periodically drawn from a sample of eligible

[1] County of San Diego, MHSA FY2016-17 Update Full Report. Pg. 42

families. The graph below shows the frequency with which these four outcomes occurred at the five sampled sites during the course of treatment.

The SDCTA does not assert this data is representative of outcomes for all national wraparound services; rather, it represents the best available outcome data in terms of quality. For example, the data provided is not case-mix adjusted which would control for potential differences in the treated populations (i.e. prior incarcerations). Future iterations of these metrics will include full case-mix adjustments based on locally collected data to reflect variations in the providers' referral systems. It is the objective of the Association that through the use of this assessment tool, these metrics will ensure best practices within the industry are illuminated and rewarded

Wraparound Services

Wraparound services are defined by a collaborative planning and family-driven care process, which works with parents, caregivers, community members, and educators to develop comprehensive support plans that meet a patient's unique needs. Wraparound programs have four distinct phases: engagement and team preparation, initial plan development, implementation, and transition. These programs are primarily utilized for those at risk of being placed in more intensive institutional care, which can include hospitalization, incarceration, or residential placement.[2]

Current Academic Research

The National Wraparound Initiative (NWI) is a collaboration of research institutions working to create and implement wraparound programs, standards, and support networks for service providers. It consists of the Research and Training Center for Pathways to Positive Futures at Portland State University, the Wraparound Evaluation and Research Team at the University of Washington, and the Institute for Innovation and Implementation at the University of Maryland School of Social Work. The NWI is responsible for formalizing the Ten Principles of Wraparound, which provide the philosophical underpinning of the service process.[3]

These institutions periodically conduct literature reviews of all academic research on wraparound services to keep their practices and policies informed by the latest data. The most recent review was conducted by the University of Washington in 2017, which included all research from 1986-2014. The review concluded the pace of research into wraparound services is rapidly increasing, with around 15 publications per year over the last five years relative to the nine articles per year that occurred during the 15 years prior. The review also found that wraparound programs themselves are becoming more prevalent following the federal government's endorsement of the System of Care philosophy, which emphasizes a need for community-based care.[4]

Breakdown of Publications

[2] California Evidence Based Clearinghouse; http://www.cebc4cw.org/program/wraparound/
[3] Ten Principles of the Wraparound Process; https://nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-(10-principles-of-wrap).pdf
[4]https://depts.washington.edu/wrapeval/sites/default/files/publications/Coldiron_Bruns_Quick_2017_CompReviewOfWrapCCResearch.pdf (Pg.13)

About two-fifths of the reviewed publications examined how wraparound impacts outcomes, including youth functioning (i.e., symptoms and behaviors, community functioning, academic success, criminality, interpersonal interactions), service usage, youth's living situation, family functioning, client satisfaction, and/or youth engagement in the wraparound process.

One controlled experimental study found that wraparound resulted in improved functioning and decreased problematic behaviors for youth who had "clinically significant" problems at enrollment. A majority of the other controlled experimental studies examined were largely conducted as comparisons with other treatment methods finding mixed results on functional, school, residential, and child welfare outcomes using ultimate outcomes such as number of arrests.

Five of the 13 controlled quasi-experimental studies examined found that wraparound services provide consistent, positive results in the following areas: criminal recidivism, living situation, hospitalizations, and clinical functioning. Many of the case studies and anecdotal evidence also suggest positive results for wraparound services. [5]

The current academic research suggests that wraparound services produce positive results in the lives of youth who are treated. Despite the expanding pace of research into this field, however, there is still very little data on the isolated effects of wraparound services when compared to an untreated control group. Additionally, there is inconsistency with how the positive effects have been categorized across studies. In turn, there is still significant uncertainty with regard to what results can be expected from high-quality wraparound services.

The Effect of Customization on Wraparound Analysis

While wraparound programs typically share standard support mechanisms such as community partnerships and access to behavioral health professionals, significant variation in wraparound implementation arises from the patient/family driven nature of the process. Wraparound programs are not primarily identified by a specific practice, but rather the program's adherence to a core set of principles that underline and guide the care process.

This does not suggest that no common planning and care practices exist within the wraparound community, but rather that programs are best distinguished from other behavioral health services by their fidelity to these wraparound principles. Programs with higher fidelity scores, as measured by the WFI, adhere more closely to these principles throughout the care process again keeping in mind potential variation in treatment practices.

The tenth principle of the wraparound process asserts the goals/strategies of a wraparound plan should be observable/measurable indicators of success and progress should be monitored in terms of these indicators.[6] Inherent customization within wraparound process fosters a greater need for standardized outcome metrics to assess the success of these practices.

Data regarding isolated wraparound outcomes is relatively limited due to the extremely personal nature of the treatment as well as inconsistencies with how treatment results have thus far been captured as

[5] Aboutanos et al. 2011; Carney and Buttell 2003; Clark et al. 1996; Ferguson 2005

[6] Ten Principles of the Wraparound Process; https://nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-(10-principles-of-wrap).pdf

indicated above. Additionally, there are no current assessment tools that specifically track what are referred to as "ultimate outcomes", such as arrests or hospitalizations, for patients receiving wraparound services in San Diego following their discharge.

Existing Outcome Metrics

National:

Wraparound Fidelity Index - A set of four interviews (caregivers, youths, wraparound facilitators, and team members) that measure a program's fidelity to the Wraparound Principles. The interviews are aligned with the four phases of the wraparound process (Engagement and Team Preparation, Initial Planning, Implementation, and Transition) assessing both conformance to the wraparound practice model as well as adherence to the principles throughout service delivery. The index is graded on a scale from 1 to 8.[7]

State of California:

CANS - In November of 2017, the State of California's Department of Healthcare services announced it will be implementing the Child and Adolescent Needs and Strengths (CANS) assessment beginning in 2018 to measure child and youth functioning. The CANS will be completed at intake, during the course of treatment, and at discharge to identify youth and families' actionable needs and useful strengths.[8]

Full Service Partnership (FSP) - In collaboration with patients and their families, FSP programs provide comprehensive county health services beyond the scope of traditional clinic-based outpatient mental health facilities. Through the FSP database, participating wraparound providers periodically track a variety of data points for their respective partners, including demographic information, referral sources, residential status, school attendance, and "Key Events." The Key Event Tracking (KET) form is filled out by the providers to indicate whether during the course of treatment certain major events occur such as expulsion from school, arrests/incarcerations, psychiatric hospital visits, etc. County providers input this information into a state-administered database which then compiles a regional report for the County of San Diego.[9]

County of San Diego:

System of Care Evaluation - San Diego Children, Youth and Families Behavioral Health Services (CYFBHS) uses the System of Care Evaluation (SCE) to track a multitude of outcome assessment tools employed by the County. The SCE is a self-reported database administered by the University of California, San Diego's Child and Adolescent Services Research Center (CSARC). The SCE is designed to make services "accountable through clear outcomes, valid evaluation methods and proficient data management systems. Assessments should be strength-based and services should be outcomes-driven."[10]

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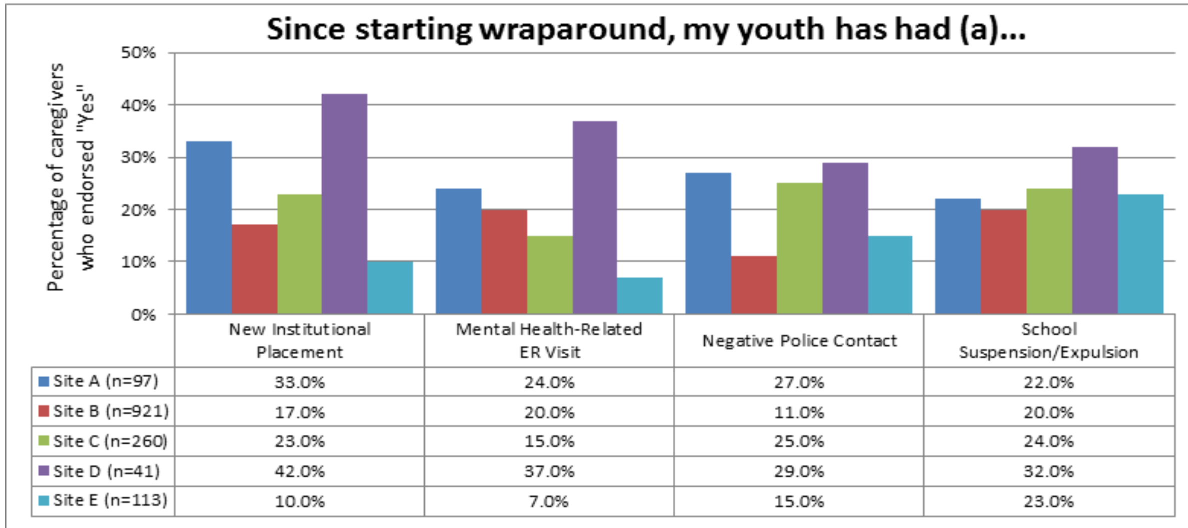
[7] https://depts.washington.edu/wrapeval/content/quality-assurance-and-fidelity-monitoring
[8] http://www.dhcs.ca.gov/provgovpart/pos/Pages/Functional_Assessment_Tools.aspx
[9] County of San Diego Children, Youth & Families FSP Report July 1, 2016 - June 30, 2017
[10] https://healthsciences.ucsd.edu/som/psychiatry/research/CASRC/resources/SOCE/Pages/Background.aspx

The SCE's assessment tools include the following:[11]

- Child/Adolescent Measurement System (Y-CAMS); designed to measure a child's social competence, behavior, and emotional problems.
- Child Functional Assessment Rating Scale (CFARS); designed to gauge the patients level of functioning utilizing a scale of 1 to 9.
- Personal Experience Screening Questionnaire (PESQ); measures potential substance abuse problems and evaluate changes in substance use following treatment.
- Eyberg Child Behavior Inventory (ECBI); assesses conduct problems, such as noncompliance, defiance, aggression, and impulsivity.

[11] https://healthsciences.ucsd.edu/som/psychiatry/research/CASRC/resources/SOCE/Pages/Data-Entry-System.aspx

National Sites:



	New Institutional Placement	Mental Health-Related ER Visit	Negative Police Contact	School Suspension/Expulsion
Site A (n=97)	33.0%	24.0%	27.0%	22.0%
Site B (n=921)	17.0%	20.0%	11.0%	20.0%
Site C (n=260)	23.0%	15.0%	25.0%	24.0%
Site D (n=41)	42.0%	37.0%	29.0%	32.0%
Site E (n=113)	10.0%	7.0%	15.0%	23.0%

Site	Sample (Collected January 1, 2015 – June 30, 2017)	% or Families Sampled	Average Months in Wraparound when sampled	Estimated Families Served Per Year
A	97	N/A	8.88	Not Reported
B	921	26.31	6.39	3500
C	260	26	8.79	1000
D	41	11.7	6.96	350
E	113	7.53	9.02	1500

WFI-EZ Sample Demographics										
Site	Site A (n=97)		Site B (n=921)		Site C (n=260)		Site D (n=41)		Site E (n=113)	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Youth Age	14.76	2.27	10.70	3.95	14.49	3.33	13.17	2.64	11.92	3.86
Youth Gender	N	%	N	%	N	%	N	%	N	%
Male	74	76.3	595	64.6	152	58.5	27	65.9	76	67.3
Female	23	23.7	320	34.7	107	41.2	14	34.1	37	32.7
Transgender	0	0.0	6	0.7	1	0.4	0	0.0	0	0.0
Missing	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Youth Race	N	%	N	%	N	%	N	%	N	%
White	20	42.6	0	0.0	40	87.0	0	0.0	0	0.0
Black or African-American	26	55.3	0	0.0	6	13.0	0	0.0	0	0.0
American Indian or Alaska Native	1	2.1	0	0.0	0	0.0	0	0.0	0	0.0
Asian American	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Unknown/Missing	50	N/A	921	N/A	214	N/A	41	N/A	113	N/A
Hispanic	N	%	N	%	N	%	N	%	N	%
No	92	94.8	587	63.7	254	97.7	41	100.0	111	98.2
Yes	5	5.2	334	36.3	6	2.3	0	0.0	2	1.8

SAN DIEGO COUNTY TAXPAYERS ASSOCIATION

Response Data:

The following charts show the number of respondents from each site that provided an answer for each of the four outcome categories.

D1: New Institutional Placement							
Site	**Forms**			**No**		**Yes**	
	N Forms	N Responses for Item	% Missing for Item	No	%	Yes	%
A	97	93	4.1	62	66.7	31	33.3
B	921	892	3.1	743	83.3	149	16.7
C	260	239	8.1	183	76.6	56	23.4
D	41	38	7.3	22	57.9	16	42.1
E	113	111	1.8	100	90.1	11	9.9

D2: School Suspension or Expulsion							
Site	**Forms**			**No**		**Yes**	
	N Forms	N Responses for Item	% Missing for Item	No	%	Yes	%
A	97	93	4.1	73	78.5	20	21.5
B	921	895	2.8	716	80.0	179	20.0
C	260	241	7.3	182	75.5	59	24.5
D	41	38	7.3	26	68.4	12	31.6
E	113	111	1.8	86	77.5	25	22.5

D3: Negative Police Contact							
Site	**Forms**			**No**		**Yes**	
	N Forms	N Responses for Item	% Missing for Item	No	%	Yes	%
A	97	93	4.1	68	73.1	25	26.9
B	921	890	3.4	792	89.0	98.0	11.0
C	260	236	9.2	177	75.0	59	25.0
D	41	38	7.3	27	71.1	11	28.9
E	113	108	4.4	92	85.2	16	14.8

D4: Mental Health Related ER Visit							
Site	**Forms**			**No**		**Yes**	
	N Forms	N Responses for Item	% Missing for Item	No	%	Yes	%
A	97	93	4.1	71	76.3	22	23.7
B	921	893	3.0	718	80.4	175	19.6
C	260	241	7.3	204	84.6	37	15.4
D	41	38	7.3	24	63.2	14	36.8
E	113	111	1.8	103	92.8	8	7.2