

YOUTH EMPOWERMENT SERVICES PROGRAM EVALUATION



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Table of Contents

Overview of Evaluation and Design	1
Results from Analysis of Administrative Data	4
Potential Limitations	4
Inquiry List	4
Time to Intake Assessment.....	5
Referral Sources	5
Enrollment in YES Waiver.....	6
Services to YES Waiver Participants.....	7
Outcomes in the YES Waiver.....	8
State Psychiatric Facility Utilization.....	10
Survey Results for Caregiver and Youth Participants.....	10
Results of Documentation Reviews	14
Wraparound Plan	14
Wraparound Team Composition.....	14
Crisis and Safety Planning	15
Identification of Strengths and Individualized Goals.....	15
Family Voice and Choice	16
Identification of Needs and Provision of Services.....	16
Transition Planning.....	16
Results of Stakeholder Interviews	18
Overview	18
Biggest Contributions of the YES Waiver to the Mental Health System.....	18
“If You Could Change One Thing”	20
Community Program Administration.....	20
Outreach, Eligibility and Enrollment	22
Provider Networks	24
YES Waiver Service Array	26
Participant Feedback (Caregiver and Youth Surveys)	28
Conclusions and Recommendations	30
State-Level Program Administration	30
Community-Level Program Administration.....	30
Youth and Family Outcomes	31
Outreach, Eligibility and Access to Services.....	31
Wraparound Approach.....	32
YES Waiver Services.....	33
References	34
Appendix: Recovery Self-Assessment for Caregivers	
Recovery Self-Assessment for Youth	

Overview of Evaluation and Design

In July 2012, the Department of State Health Services (DSHS) contracted with The Texas Institute for Excellence in Mental Health at The University of Texas at Austin to perform an external evaluation of the Youth Empowerment Services (YES) Waiver. The YES Waiver is a 1915(c) Medicaid waiver targeting children and youth at risk of psychiatric hospitalization and out-of-home placement. A description of the YES Waiver is available on the [DSHS YES Waiver website](http://www.dshs.state.tx.us/mhsa/yes/) (<http://www.dshs.state.tx.us/mhsa/yes/>). The evaluation focuses on the YES Waiver implementation and operation in Bexar County and Travis County from March 2010 to July 2012.

The primary aims of the evaluation were:

- 1) to identify strengths and challenges related to service access, utilization, quality, and outcomes;
- 2) to identify issues that remain a barrier to making the YES Waiver as effective as possible for high-need youth and families;
- 3) to provide recommendations that may impact the structure of the YES Waiver or associated processes;
- 4) to identify potential enhancements that could be incorporated into future amendments to the YES Waiver; and
- 5) to share “lessons learned” with other communities as the YES Waiver expands.

The evaluation focused on the following key questions:

Access:

- Are children and youth who are eligible for the program enrolled in a timely fashion?
- What barriers exist to timely access to the YES Waiver?
- Are existing outreach efforts effectively engaging potential referral organizations?
- What characteristics of the YES Waiver program or system implementation lead to eligible youth not accessing the YES Waiver?

Utilization:

- Are adequate service providers available to ensure full provision of the service array?
- Are enrolled youth receiving timely access to the YES Waiver services?
- What barriers exist to accessing services?
- What are the most and least beneficial YES Waiver services? What service characteristics put them in that category?
- What other services are not currently available through the YES Waiver but are critical to achieving youth and family goals and preventing hospitalization?
- Are service providers effectively engaged in service planning and implementation?
- Are service providers perceived as competent and adequately trained?

Outcomes:

- Do youth and families report that the care system is engaging, culturally responsive, strengths-based, individualized, and focused on developing an on-going support network?
- Do youth and families report improved symptomatology and functioning?

Both qualitative and quantitative research methodologies were used. The evaluation team collected information and data through the following activities:

Review of Existing Documentation – To gain more knowledge about the scope of the YES Waiver and existing implementation practices, the evaluation team reviewed the Centers for Medicare and Medicaid

Services (CMS) YES Waiver Application, YES Waiver Policies and Procedures Manual, and information available on the DSHS YES Waiver website. Understanding the intended YES Waiver design was critical for identifying potential differences with actual implementation and identifying recommendations for enhancement.

Quantitative Data Analysis – Administrative data was obtained to further explore issues around access, service utilization, and outcomes. Sources of data included databases maintained by DSHS YES Waiver administrators and DSHS’s statewide record system. Sources are summarized in Table 1.

Table 1. Administrative Data Resources

Data List	Data Source	Timeframe
Inquiry List Database	DSHS Program	February 2010 – October 12, 2011
Enrollment Database	DSHS Program	March 2010 – July 2012
YES Service Encounter Database	DSHS Program	April 2010 – July 2012 <i>All encounters submitted for this time period as of October 2012.</i>
Other Service Encounters	CARE	April 2010 – July 2012
State Hospitalizations	CARE	For each youth: Pre-waiver one year, during waiver
Assessments	CARE	For each youth: Pre-waiver one year and during waiver

Caregiver and Youth Survey – A survey of all youth and caregivers who received YES Waiver services within the past year (July 2011 – July 2012) and could be reached by the Local Mental Health Authority (LMHA) was conducted. Youth and caregivers received a modified version of the Recovery Self-Assessment (O’Connell, Tondora, Croog, Evans, & Davidson, 2005). This instrument measures the extent to which a service system is perceived to be engaging, strengths-based, supportive of individual recovery goals, and encouraging of youth and family voice. In addition, a subset of questions from the Youth Services Survey (Riley, Stromberg, & Clark, 2005) was also included. Caregivers and youth were presented with the assessment by their case manager and asked to return it in the pre-paid envelope. The survey packet also included a form that allowed families to indicate if they were willing to participate in a follow-up interview by phone to gather additional information about their YES Waiver experience.

Case Documentation Review - Client records were also reviewed on-site in each county with a focus on the wraparound process and the provision of case management and YES Waiver services. Documentation reviews included treatment plans, wraparound plans, crisis and safety plans, and service provider progress notes. A sample of six to eight youth was selected at each location and a review tool was developed by the evaluation team.

Key Informant Interviews – Interviews of key stakeholders were conducted to gather information and perceptions from a variety of relevant parties that included:

- Youth and caregivers currently participating in the YES Waiver;
- State YES Waiver staff at DSHS;
- Bexar County and Travis County community program administrators;
- Bexar County and Travis County community program supervisors and staff; and
- YES Waiver service providers.

Youth and caregivers who withdrew from or declined to participate in the YES Waiver were also invited to participate in an interview; however, no response was received from this group. Interviews were semi-structured with some standard questions, but allowed for further follow-up and tailoring for the stakeholder's role.

Results from Analysis of Administrative Data

Potential Limitations

The evaluation utilized a number of existing datasets for the analyses, with varying quality control mechanisms. Some potential issues that may influence results slightly were noted; however, general findings are thought to be accurate. In some cases, it was necessary to modify the data based on available notations. For example, entries to the inquiry list that were listed as information calls only were removed from inquiry list counts.

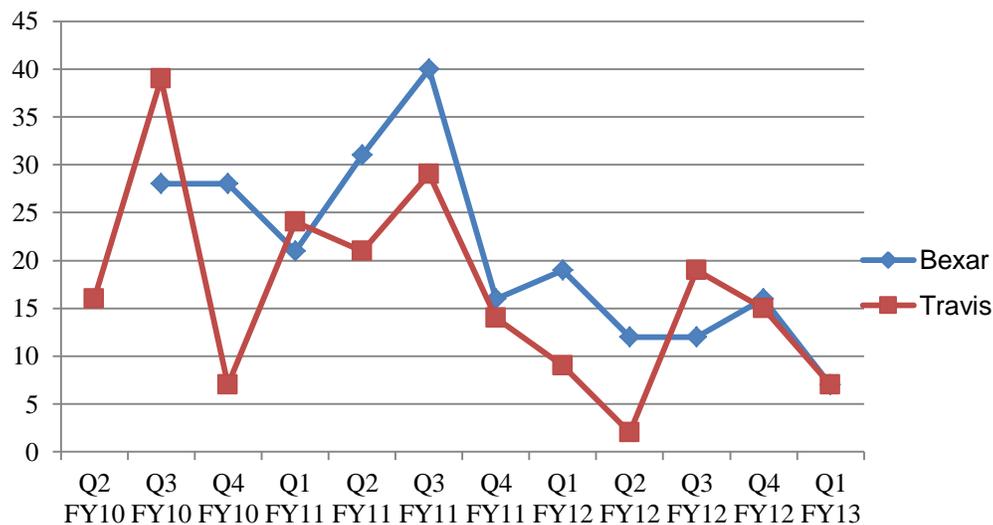
Inquiry List

The Inquiry List began in February 2010 in Travis County and in April 2010 in Bexar County. In the early stages of implementation, a steady flow of youth were registered on the Inquiry List each quarter; however, the numbers began to drop in both counties about one year post implementation (Q4 FY11). Most recently, registration has increased slightly during spring and summer months (Q3 FY12 and Q4 FY12); however, not enough data is available at this time to determine if any change will be evident during Q1 FY13 when school is back in session.

Inquiry List Registration – Quarterly Count, Unduplicated

*Q1 FY13 only contains September

	Q2 FY 10	Q3 FY 10	Q4 FY 10	Q1 FY 11	Q2 FY 11	Q3 FY 11	Q4 FY 11	Q1 FY 12	Q2 FY 12	Q3 FY 12	Q4 FY 12	Q1 FY 13	Total
Bexar		28	28	21	31	40	16	19	12	12	16	7	230
Travis	16	39	7	24	21	29	14	9	2	19	15	7	202
Total	16	67	35	45	52	69	30	28	14	31	31	14	432



Time to Intake Assessment

Overall, 52.8% of youth registered on the Inquiry List received an eligibility assessment (Bexar County = 56.4%, Travis County = 48.8%). Youth who had not had an eligibility assessment by 10/12/12 were counted as not having received an assessment. The average time from registration on the Inquiry List to the Intake assessment was 93 days (*standard deviation (sd)*=82.1). The time to assessment varied by site and over the program period and average time is provided in Table 2. Of those who had received an assessment, 59.3% met clinical eligibility criteria in Bexar County and 59.0% in Travis County.

Table 2. Average Length of Time (in days) Before Eligibility Assessment Occurred

*Q1 FY13 only contains September

	Q3 FY10	Q4 FY10	Q1 FY11	Q2 FY11	Q3 FY11	Q4 FY11	Q1 FY12	Q2 FY12	Q3 FY12	Q4 FY12	Q1 FY13	Mean
Bexar	24	55	81	72	48	195	143	235	287	133	86	107
Travis	52	128	125	70	48	43	28		8	21	13	74

During the first three quarters (Q3 FY10 – Q1 FY11), both counties experienced an increase in the length of time between the date of registration on the Inquiry List and the date of eligibility assessment as the number of individuals on the Inquiry List grew. Because the YES Waiver was brand new, both counties had a limited number of service providers and the general practice was to schedule eligibility assessments only when there was the ability to serve eligible youth. Other factors can influence the timeframe between registration and eligibility assessment. For example, some families have a tendency to not show for, or reschedule, their eligibility assessment appointment multiple times. In other instances, youth were being served in Juvenile Detention, Residential Treatment Programs, or were hospitalized at the time they were initially contacted for an eligibility assessment. These youth were kept on the Inquiry List until discharge from these programs occurred and then scheduled for an eligibility assessment at that time, which in some cases was several months later.

It is also important to note that between Q3 FY11 and Q4 FY 11, the length of time between registration and assessment became significantly greater in Bexar County primarily due to a turnover of internal service providers and the loss of external service providers. In Q4 FY11 only 4 eligibility assessments took place and then it took several months to catch up on scheduling assessments for the number of youth on the Inquiry List. During this same timeframe, Travis County’s network of external service providers was growing and consequently the length of time before eligibility assessments occurred was decreasing.

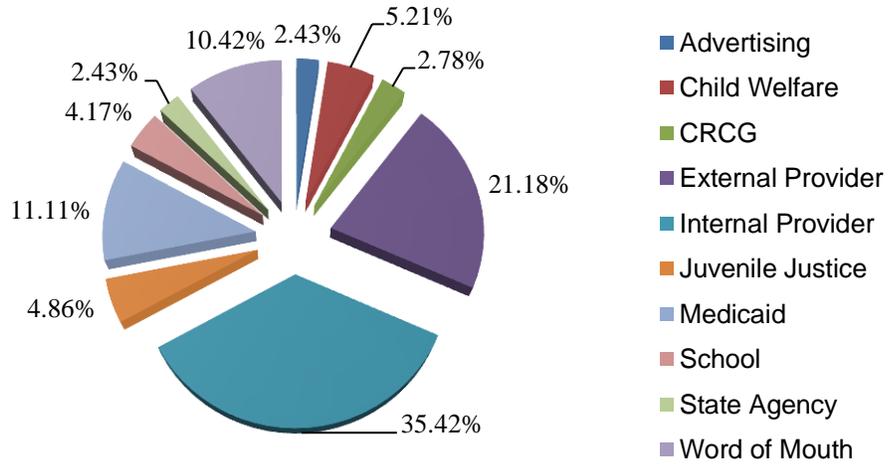
In May 2012, a clarification in policy occurred that no longer allowed counties to have youth waiting on the Inquiry List for an eligibility assessment while the YES Waiver was below capacity (300 youth). Currently both counties report that eligibility assessments can be scheduled within one week of registration on the Inquiry List.

Referral Sources

The Inquiry List reflects referral sources; however, standardized categories are not utilized. Of those youth reflected on the Inquiry List, 65.3% (288 of 431) had a referral source listed. Each referral source was assigned one of the following categories: Advertising, Child Welfare, Community Resource Coordination Groups, External Provider, Internal Provider, Juvenile Justice, Medicaid, School, State Agency, and Word of Mouth. Referral sources are illustrated in Figure 1. The majority of referrals (56.6%) came from Internal and External Providers. Word of mouth and Medicaid representatives (e.g.,

case managers) were also significant sources of referral. There were relatively few referrals from other child-serving systems, such as school, juvenile justice and child welfare.

Figure 1. Referral Source



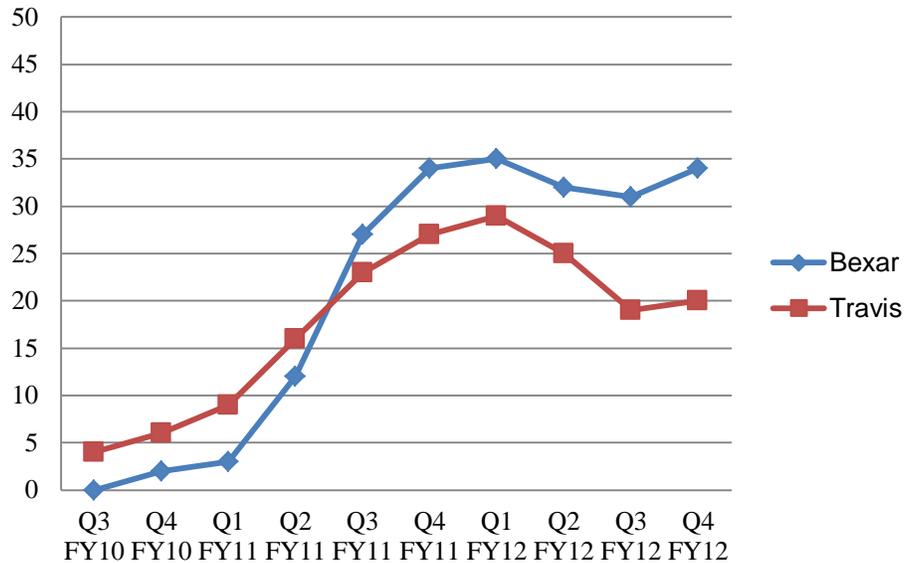
Enrollment in YES Waiver

Quarterly enrollment in the YES Waiver is shown in Table 3. Following the first year of the YES Waiver, enrollment has averaged 32 youth in Bexar County and 24 youth in Travis County. Enrollment into the YES Waiver occurred on average 93.8 days (*sd*=138.3) after the intake assessment. There was significant variability in this delay to enrollment, with the greatest delays occurring in the first two years of YES Waiver implementation. The average time between the intake assessment and enrollment in Fiscal Year 2012 was only 31.3 days (*sd*=27.3). However, incidents of lengthy delays occurred in all fiscal years. Once enrollment to the YES Waiver occurred, it was an average of 23.2 days (*sd*=49.6) until the first YES Waiver service was provided.

Table 3. YES Enrollment – Quarterly Count

*Q4 FY12 contains only June and July

	Q3 FY10	Q4 FY10	Q1 FY11	Q2 FY11	Q3 FY11	Q4 FY11	Q1 FY12	Q2 FY12	Q3 FY12	Q4 FY12
Bexar	0	2	3	12	27	34	35	32	31	34
Travis	4	6	9	16	23	27	29	25	19	20
Total	4	8	12	28	50	61	64	57	50	54



The participant sample included the 103 unique children and youth enrolled in the YES Waiver between March 31, 2010 and July 31, 2012. The participants were 55% male and had an average age of 13.2 years ($sd=3.1$). Participants were 50.5% Hispanic, 31.3% Caucasian, 14.1% African American, and 4.0% other race/ethnicities. The most common primary diagnosis for youth was Bipolar Disorder (32.0%), followed by Mood Disorder NOS (19.6%), Attention Deficit Hyperactivity Disorder (17.5%), Depressive Disorders (11.3%), and Schizophrenia or Psychotic Disorder NOS (8.2%). Most youth (73.8%) were enrolled in Medicaid prior to involvement in the YES Waiver.

Services to YES Waiver Participants

Youth were enrolled in the YES Waiver for an average of 234.4 days ($sd=129.7$). Youth enrolled in the YES Waiver received both traditional mental health services through the LMHA as well as YES Waiver services. Services traditionally available through the LMHA are illustrated in Table 4. As would be expected, intensive case management (wraparound planning) was provided to virtually all youth. A significant number of youth also received screening or assessment, medication services, counseling, flexible funds, and crisis services. Other services were negligible.

Table 4. Services Provided through the LMHA

Services	Total Youth Receiving	Total Events	Total Hours	Total Cost
Screening or Assessment	47 (47.5%)	101	49	\$10,548
Benefit Eligibility	10 (10.1%)	14	9	\$714
Routine Case Management	6 (6.1%)	6	4	\$695
Intensive Case Management (Wraparound)	98 (99.0%)	3,190	3,504	\$480,459
Medication Services	34 (34.3%)	145	63	\$15,887
Medication Training	2 (2.0%)	2	1.5	\$176

Skills Training or Rehabilitation	3 (3.0%)	10	12.5	\$1,803
Counseling	23 (23.2%)	457	381	\$57,618
Family Partner Services	0 (0.0%)	0	0	\$0
Flexible Funds	27 (27.3%)	106	49	\$20,618
Crisis Services	27 (27.3%)	116	51.27	\$21,759

Note: Costs are determined through the Cost Accounting Methodology (CAM).

YES service utilization is summarized in Table 5. Community Living Supports and Family Support Services were widely used by participants. Recreational Therapy, Licensed Nutritional Counseling, Paraprofessional Services and Adaptive Aids and Supports were also commonly provided services. Respite, Music Therapy, and Art Therapy were used by less than one-fifth of participants, while Transitional Services, Minor Home Modifications, and Non-Medical Transportation were never utilized. Although data indicated that Supportive Family-Based Alternatives were not utilized, DSHS program staff report that they have been utilized at least once.

Table 5. Services Provided through the YES Waiver

Services	Total Youth Receiving	Total Events	Total Hours	Total Cost
Community Living Services	81 (82.7%)	1,662	2,299	\$81,150
Family Support Services	66 (67.4%)	1,129	1,497	\$23,803
Professional Services:				
Animal-Assisted Therapy	0 (0%)	0	0	\$0
Nutritional Counseling	26 (26.5%)	372	326	\$18,007
Music Therapy	17 (17.4%)	207	199	\$14,012
Art Therapy	13 (13.3%)	248	232	\$14,796
Recreational Therapy	37 (37.8%)	1,122	1,432	\$97,019
Paraprofessional Services	28 (28.6%)	546	1,560	\$25,852
Respite	8 (8.2%)	76	varies	\$9,206
Adaptive Aids and Supports	22 (22.5%)	64	N/A	\$11,228
Supportive Family-Based Alternatives	0 (0%)	0	0	\$0
Transitional Services	0 (0%)	0	N/A	\$0
Minor Home Modifications	0 (0%)	0	N/A	\$0
Non-Medical Transportation	0 (0%)	0	N/A	\$0

Outcomes in the YES Waiver

Outcomes in the YES Waiver were measured utilizing the Texas Recommended Authorization Guidelines (TRAG), with the primary outcome measurements being the Ohio Problem and Ohio Functioning Scales. Changes in outcomes occurring while the youth was enrolled in the YES Waiver were measured by

examining change from the first available assessment (occurring up to two weeks prior to enrollment) and the last available assessment within one year from enrollment. To provide a comparison of YES Waiver outcomes, the outcomes of the same youth in the year prior to enrollment in the YES Waiver were also measured.

The outcomes for youth while enrolled in the YES Waiver are reflected in Table 6. Youth enrolled in the YES Waiver demonstrated significant improvements in emotional and behavioral problems as measured by the Ohio Problem Scale and significant improvement in functioning as measured by the Ohio Functioning Scale. The size of the change demonstrated in the Ohio Problem Scale is considered a “medium” effect and the change in the Ohio Functioning Scale is considered a “small” effect. In addition to these primary outcome measures, significant improvement was also seen in ratings of Danger to Self and Danger to Others (both “small” effects). Significant changes were not seen on other TRAG ratings.

Table 6. Changes in Outcome Measures during YES Waiver

Note: Significant differences noted in pink.

Outcome Measure	Mean at First Assessment	Mean at Last Assessment	Significance	Effect Size
Ohio Problem Scale	46.8 (16.5)	35.4 (14.8)	t=5.38; p<.0001	<i>d=.640</i>
Ohio Functioning Scale	31.1 (13.4)	38.0 (15.5)	t=-3.55; p=.0007	<i>d=-.425</i>
Danger to Self	1.9 (1.0)	1.4 (0.8)	t=2.98; p=.0039	<i>d=.480</i>
Danger to Others	3.4 (0.9)	2.9 (1.1)	t=3.60; p=.0005	<i>d=.452</i>
School Problems	2.9 (1.4)	2.8 (1.3)	t=.76; p=.45	<i>d=.067</i>
Juvenile Justice Involvement	1.6 (1.1)	1.5 (0.9)	t=.85; p=.40	<i>d=.116</i>
Family Resources	3.1 (1.0)	3.1 (0.9)	t=.38; p=.71	<i>d=.000</i>
Days of School Missed in Last 90 Days	4.4 (7.4)	4.4 (11.2)	t=.04; p=.97	<i>d=.000</i>

The outcomes of the same youth prior to enrollment in the YES Waiver were used as a comparison. In the year prior to YES Waiver enrollment, youth demonstrated significant worsening on the two primary measures, the Ohio Problems Scale and Ohio Functioning Scale. Prior to YES Waiver enrollment, youth also demonstrated significant worsening on ratings of Danger to Others and Family Resources. No change was demonstrated on School Problems, Juvenile Justice Involvement, Danger to Self, or Days of School Missed.

A comparison between the outcomes demonstrated prior to and after YES Waiver enrollment is summarized in Table 7. Significantly more improvement was demonstrated in both primary outcome variables – problem severity and functioning – during enrollment in YES than in the year prior to YES participation. Greater improvement in Danger to Self and Danger to Others during YES participation was also found. No differences were found in any other outcome measures prior to and after YES Waiver enrollment. However, differences consistently favored the YES Waiver and effect sizes were large, suggesting possible significant differences with a larger sample of youth.

Table 7. Comparison of Outcomes Prior to and after YES Waiver Enrollment

Note: Significant differences noted in pink.

Outcome Measure	Change Prior to YES M (SD)	Change During YES M (SD)	Significance of Difference	Effect Size
Ohio Problem Scale	-5.45 (2.18)	11.39 (2.12)	$t=3.59; p<.0007$	$d=-5.02$
Ohio Functioning Scale	5.23 (1.83)	-6.97 (1.96)	$t=-3.58; p=.0007$	$d=4.54$
Danger to Self	-0.12 (0.11)	0.42 (0.14)	$t=2.60; p=.0117$	$d=-2.84$
Danger to Others	-0.27 (0.11)	0.48 (0.13)	$t=2.95; p=.0046$	$d=-3.77$
School Problems	-0.16 (0.18)	0.14 (0.18)	$t=.35; p=.73$	$d=-1.20$
Juvenile Justice Involvement	-0.08 (0.12)	0.09 (0.10)	$t=.67; p=.50$	$d=-1.00$
Family Resources	-0.52 (0.14)	0.05 (0.13)	$t=1.33; p=.19$	$d=-2.53$
Days of School Missed in Last 90 Days	-0.73 (1.63)	0.06 (1.54)	$t=-2.07; p=.047$	$d=-.342$

State Psychiatric Facility Utilization

Analysis of the utilization of psychiatric hospitals or residential treatment centers was limited to facilities operated by DSHS. This analysis represents only a portion of the possible use of residential care and should not be considered conclusive. Facility use was based on the 365-day period prior to YES Waiver enrollment as well as the 365 days following YES Waiver enrollment. If a facility stay began prior to a cut-off date or ended after a cut-off date, the length of stay was limited to that portion falling within the year of interest.

Of the 103 youth in the sample, 16 (15.5%) had been served in a state facility in the year prior to enrollment in the YES Waiver. Fourteen had only one stay and two participants had two stays. Seven (6.8%) youth were served in a state facility in the year after YES Waiver enrollment, with three having one stay, two having two stays, one having three, and one youth with four stays. Youth averaged 7.4 ($sd=32.2$) days in a state facility in the year prior to YES Waiver enrollment and 4.1 ($sd=22.2$) days in a state facility in the year after YES Waiver enrollment. Although more state facility days occurred prior to YES Waiver enrollment, these differences were not statistically significant ($t=0.97, p=.33$), in part because relatively few youth had stays in state facilities.

Survey Results for Caregiver and Youth Participants

Youth and their caregivers who were served in the YES Waiver during the past year were surveyed using an adaptation of the Recovery Self-Assessment (RSA; see Appendix). The instrument is intended to measure perceptions of a program or agency, focused on the extent to which the program is oriented around the principles of system of care, resilience, and recovery. Items are rated from 1 (Strongly Disagree) to 5 (Strongly Agree), with 5 representing the most positive responses.

A total of 21 caregivers responded to the RSA questionnaire. Mean scores across content-based scales are reported in Table 8. Parent responses across all domains were very high, indicating respondents believed

the YES Waiver and service providers to be strength-based, culturally and linguistically competent, and focused on individualized life goals. Respondents also perceived the YES Waiver to be engaging, to foster hope, to provide families choice and voice, and to assist with the development of a sustainable support network. A comparison sample is not currently available, but statewide norms for the instrument should be available in the near future.

Table 8. Mean Scale Scores on RSA – Parent Version

Domain	Items	Mean
Individualized Life Goals	1,6,9,12,26,28	4.88
Cultural and Linguistic Competency	2,11,13,16,31,35,47	4.89
Engaged and Hopeful	3,7,20,22,24,30,44,51	4.88
Strength-Based	4,8,14,43,48	4.91
Choice and Voice	5,10,15,27,29,32,42,	4.86
Effective Individualized Services and Supports	18,33,36,37,38,39,41,45,49	4.83
Sustainable Support Network	17,21,25,46,52	4.78
System Involvement	19,23,34,40,50	4.74

Youth 10 or older were also asked to complete a modified version of the RSA. The System Involvement subscale was limited to youth 14 or older. A total of 14 youth responded to the RSA survey questionnaire, and mean scale scores are presented in Table 9. Similar to their caregivers, youth had very positive impressions of the YES Waiver, reporting that services were engaging and instilled hope, strength-based, focused on individual family goals, and culturally and linguistically competent. Although still very positive, perceptions were slightly lower for building sustainable support networks.

Table 9. Mean Scale Scores on RSA – Youth Version

Domain	Items	Mean
Individualized Life Goals	9,12,17,28,38	4.88
Cultural and Linguistic Competency	1,15,18,25,29,31	4.94
Engaged and Hopeful	5,6,11,20,23,33,35	4.92
Strength-Based	2,3,22,24,36	4.91
Choice and Voice	7,13,14,19,26,30	4.74
Effective Individualized Services and Supports	4,10,16,21,27,32,37	4.77
Sustainable Support Network	8,34,39,40,41	4.50
System Involvement	52,53,54,56,57	4.83

In addition to the RSA survey questions, caregivers and youth were asked a subset of questions from the Youth Services Survey for Families (YSS-F) and Youth Services Survey (YSS), a satisfaction questionnaire utilized by the Health and Human Services Commission (HHSC) to assess the quality of public mental health services. These questions were included to allow comparisons between the YES Waiver and traditional public mental health services. Comparisons between mean responses from YES participants and state comparisons from the 2012 HHSC survey are provided in Table 10. YES participant responses to questions related to satisfaction with services are consistently higher than statewide means. Questions related to outcomes for the youth also demonstrate perceptions of better outcomes in the YES Waiver, although differences are not at large. One question reflecting satisfaction with the family's life is slightly lower for YES participants than the statewide mean.

Table 10. Youth Services Survey for Families (YSS-F)

Note: Significant differences noted in pink.

Item	YES Mean	Statewide Mean	Significance of Difference
Overall, I am satisfied with the services my child received.	5.00	4.20	<i>t=3.71; p=.0002</i>
I participated in my child's treatment.	4.95	4.36	<i>t=3.44; p=.0006</i>
The services my child and/or family received were right for us.	4.86	4.09	<i>t=3.52; p=.0005</i>
The location of services was convenient for us.	4.95	4.14	<i>t=3.90; p=.0001</i>
Services were available at times that were convenient for us.	5.00	4.10	<i>t=4.08; p=.0001</i>
My family got as much help as we needed for my child.	4.84	3.91	<i>t=3.86; p=.0001</i>
My child is better at handling daily life.	4.05	3.71	<i>t=1.33; p=.18</i>
My child gets along better with family members.	3.85	3.60	<i>t=0.99; p=.32</i>
My child gets along better with friends and other people.	3.79	3.63	<i>t=0.67; p=.50</i>
My child is doing better in school and/or work.	3.84	3.66	<i>t=0.72; p=.47</i>
My child is better able to cope when things go wrong.	3.55	3.38	<i>t=0.64; p=.52</i>
I am satisfied with our family life right now.	3.42	3.60	<i>t=0.74; p=.46</i>

Similar results were found in youth responses to the YSS, although statewide means are not available (see Table 11). Youth in the YES Waiver rated their satisfaction with services very high, with somewhat lower ratings of improvements in personal outcomes. Notably, youth were less confident in their interactions with family members and their ability to cope when things go wrong.

Table 11. Youth Services Survey (YSS)

Item	YES Mean
Overall, I am satisfied with the services I received.	4.92
I participated in my own treatment.	4.92
I received services that were right for me.	5.00
The location of services was convenient.	5.00
I am better at handling daily life.	4.46
I get along better with family members.	3.77
I get along better with friends and other people.	4.42
I am doing better in school and/or work.	4.50
I am better able to cope when things go wrong.	3.67

Results of Documentation Reviews

Documentation of assessments and family history, wraparound plans, care management and service provider notes were reviewed at each site. Document reviews focused on the extent to which records reflected the wraparound team process and service provider documentation reflected services and supports toward the identified goals.

Wraparound Plan

The YES Waiver does not require the use of a specific format for treatment and/or wraparound planning and therefore notable differences exist between communities. Austin Travis County Integral Care (ATCIC) uses both an agency-wide treatment plan and a separate wraparound plan for YES Waiver participant. In general, the agency treatment plan appears more inclusive of strengths and individualized goals than the wraparound plan. The Center for Health Care Services (CHCS) has a single comprehensive wraparound planning document that includes a family mission statement, strengths, strategies, goals, objectives, crisis and safety plans, a list of team participants with contact information, and time sensitive tasks.

Communities differ with respect to frequency of team meetings and approach to treatment plan updates. The YES Waiver Policies and Procedures Manual specifies that the treatment plan must be reviewed every 90 days or more frequently when necessary (Section I. Treatment Planning Process). It appears to be standard practice at CHCS to have monthly team meetings (as recommended in the National Wraparound Initiative model), which includes a review of the treatment plan and updates to relevant sections such as strengths, goals, and outcomes. The frequency of team meetings at ATCIC varies case by case. It appears that case managers use a six-month wraparound plan and it is not apparent if the plan is reviewed and updated at team meetings. In some cases, it appeared that separate meetings with the youth and parent were held to engage in standard treatment plan reviews, along with getting TRAG updates. This process seemed separate from the wraparound process and likely confusing to families. On occasion, notes indicated a team meeting, when it appeared that the contact was for a different purpose, such as introducing a service provider to the family or preparing for school meeting.

Wraparound Team Composition

The YES Waiver Policies and Procedures Manual specifies the treatment team should include, at minimum, the Targeted Case Manager, Waiver participant, Legally Authorized Representative, and the Waiver Provider (Section I. Treatment Planning Process). To clarify, in the manual Waiver Provider refers to a representative from the provider organization that is contracted with DSHS to manage the provision of services, not the actual individual Waiver service providers). It should be noted that this definition of team participants does not fully match with those associated with wraparound models, which are generally limited to individuals directly supporting the youth and family.

The majority of wraparound meeting case notes reviewed identified the participation of these key individuals in team meetings, with the exception of a few that occurred without the caregiver or YES Waiver provider representative present. Service providers, in particular providers of Community Living Supports, Paraprofessional Services, and Family Supports, were clearly included in the team meetings on several occasions. Other service providers, such as Music Therapists and Recreational Therapists, rarely attended. Evidence reflected the involvement of formal supports, such as school personnel, parole officers, Child Protective Services, adoption case manager, occupational therapist, speech therapist, psychiatrist, and counselors; however this seemed to occur more frequently with particular cases and under the coordination of particular case managers. Similarly, documentation showed that families were

encouraged to include informal supports on their team, such as the participation of pastors, babysitters, family friends, significant others of the youth, grandparents, and siblings at team meetings. It is important to note both formal and informal supports were not included in several instances. In one case, the lack of a team resulted in the parent questioning what the Paraprofessional Services provider did with the youth suggesting a lack of communication and coordination. In another case, the therapist threatened to quit because he/she felt there was too much overlap with Community Living Supports. It was clear consensus about the overall plan and goals of each service provider working with the family was not achieved, causing some confusion among the various service providers that could have been resolved if a team had been formed. Some case managers clearly extended effort in communicating with relevant individuals, but this could have been more efficient and effective within a wraparound framework. In some cases, there was no evidence that the case manager interacted with the other service providers and appeared to get all information through the family.

Crisis and Safety Planning

Crisis and safety plans were included in the documentation. However, most plans were very limited and team participation in the development of the crisis and safety plans appeared lacking. Most plans included at least one crisis prevention strategy for use by the family or youth, but generally only one strategy was identified along with a listing of emergency contact numbers. For example, a common safety plan was to allow for a cool down period, call 911 and request a mental health deputy, or call the crisis hotline. In another example, the intervention was to “Continue working on client on boundaries, pull over calmly and take proper action.” In one instance the case manager note for the team meeting included a statement to the family that “these usually aren’t discussed during wraparound.” Sometimes it was noted that a short-term plan was developed at the initial team meeting but further review showed little or no changes made to that short-term plan over time. In other instances, service providers (e.g., Community Living Supports and Family Supports) were assigned the task of working with the youth and family outside of the team meeting to develop a crisis and safety plan prior to the second team meeting which was typically scheduled to occur in 4-6 weeks. A few cases showed detailed crisis and safety plans developed over time.

Identification of Strengths and Individualized Goals

In both communities, the wraparound plans included strengths of the youth and usually one caregiver. Generally, multiple strengths were identified. The use of a pre-determined set of strengths in one community seemed to limit the individualization of these strengths and may limit the extent to which youth or caregivers can identify with these strengths. The plans did not regularly include strengths of all family members or other team members. While plans were structured for the incorporation of strengths into the strategies, this generally did not seem to occur. However, the progress notes from service providers showed that youth and caregiver interests and strengths were incorporated into the goals of the individual services; these were just not captured in the wraparound plan.

The approach to documenting goals, strategies, objectives, and interventions differed between communities and among case managers. At ATCIC, the plan appeared to incorporate the YES Waiver services in a superficial way. For example, the plans listed “Intensive Wraparound Needs” as the domain, “utilize wraparound process” as the goal, and then listed the YES Waiver services as the intervention or strategy to address the goal. Many plans did include some evidence of individualized goals that went beyond symptom or behavior management. However, strategies generally consisted of the service definition and summary of core components (from fidelity manuals) rather than indicating how a service might assist in meeting the goal. Little to no individualization at the strategy level was obtained. For example, for one child the goal was to “graduate high school and have a job” with the strategies being “intensive case management” and “child and family wraparound”. ATCIC also utilizes a “Provider

Intervention Sheet” that appeared to have more individualized detail than the treatment or wraparound plans. There was some documentation about whether progress was being made, but it did not include agreed upon outcome measures to be regularly tracked or discussed within the team. At CHCS, generally two to three goals were identified for each youth and goals appeared to be individualized to each youth and family. Each goal had its own measurable objective(s) listed; however, the interventions were typically standardized and sometimes not clearly related to the specific goal or objective. The interventions generally included the service name and a brief description of what the staff will do to assist the family including frequency of contact and target start dates. Measurable objectives typically include a timeframe (ex. 90 days) and frequency of desired behavior (ex. 5 or 7 days per week), or the use of a 1-10 rating scale on progress. Progress was clearly identified at each team meeting for each goal. Goals were modified over time as progress was made.

Family Voice and Choice

In both communities, there was some evidence that the case manager was staffing the family with a service provider and then subsequently talking with the family about possibly receiving that service, suggesting that at least preliminary decisions were occurring without the family and youth being involved. In a few cases, DSHS had already approved the Individual Plan of Care prior to the first team meeting and in one case YES Waiver services had already been delivered.

The cases reviewed at CHCS showed evidence of youth and caregiver’s involvement in team processes, such as the development of a family mission statement, goals, strategies, and team composition. In one case, the case manager used language such as “client wants and client states” suggesting youth involvement as well. Time sensitive tasks were identified at each team meeting and included the youth and family as responsible parties when appropriate. At ATCIC, it was less clear that the youth and caregiver were involved in team activities, such as the identification of goals, strategies, and team composition. It appears that the caregiver’s interest in select services was taken into consideration. It was less clear that the youth played an active role in planning, other than attending the meetings.

Identification of Needs and Provision of Services

The documentation demonstrated that plans of care incorporated both YES Waiver services and non-waiver services and supports. For example, a probation officer suggested a youth could benefit from a social skills group provided through a different program, and this was incorporated into the plan. In another case, several family members on the team identified the need to get training on diabetes testing so they could assist in managing the youth’s diabetes, and this was incorporated into the plan.

Five YES Waiver services were reflected in the cases reviewed at ATCIC, including Community Living Supports, Paraprofessional Services, Recreational Therapy, Respite, and Adaptive Aids and Supports. In general, progress notes were detailed and focused on individualized goals, as well as documenting progress toward goal achievement. Service providers appeared to incorporate youth interests in the strategies, such as assisting with the care of animals or preparing for job searches at locations of interest to the youth. Services were increasingly youth-driven, with the youth taking responsibility for determining the activities that were undertaken. Several cases included a tour of the respite facility in preparation for the service. The service provider notes for Recreational Therapy were generally very detailed and identified youth-driven activities such as rock climbing. Adaptive Aids and Supports was used to purchase Rock Climbing equipment and gym memberships. In one case, the youth was denied purchase of a bike as a part of recreation therapy, with goals toward stress reduction and increased independence. DSHS indicated that this decision was due to liability issues and alternatives (e.g., bike safety equipment) were discussed.

At CHCS, every case reviewed had Community Living Supports and Family Supports and most had the addition of one or more Professional Services (Music Therapy, Recreational Therapy, or Nutritional Counseling). Service provider notes were detailed and tied back to the associated goals from the treatment plan. The activities identified under each service seemed congruent with service definitions. One safety plan identified that the caregiver would get a door alarm, however it was unclear whether this was purchased through Adaptive Aids and Supports.

Transition Planning

Overall, little evidence of transition planning within the wraparound team was found at either site. In one case, a discharge plan was present but did not include conversation or notes in the reviews about planning for transition. In another, the youth expressed concern about turning 18 soon and moving out of the house, but no goals related to transitioning and no transition plan was identified. This was only discussed between the case manager and youth, not as a part of a team meeting. In a different instance, a young adult (age 18) and parent were having conflict and the young adult refused to attend the team meeting. The facilitator indicated a need to discharge the client unless he/she attended. When the client opted to remain in the program, stating he/she valued one of the YES Waiver services, several stipulations were made at the next meeting, including requiring that the youth maintain contact with his/her therapist who the youth wanted to stop seeing. The youth did not return.

Results of Stakeholder Interviews

Overview

A total of 33 interviews were conducted and included the following stakeholder groups:

- YES Waiver participants – 12 (9 Caregivers and 3 Youth);
- YES Waiver service providers – 8 (2 internal, 6 external; Community Living Supports, Paraprofessional Services, Family Supports, Respite General Residential Operation, Art Therapy, Music Therapy, and Recreational Therapy);
- Community program directors, supervisors, and staff at Austin Travis County Integral Care (ATCIC) and The Center for Health Care Services (CHCS) – 12 (2 Directors, 1 Case Manager Supervisor, 5 Case Managers, 1 Contract Manager, 2 Intake Workers, 2 Inquiry List Coordinators) *one person is listed for two categories*; and
- Community Agency/Referral Source - 1 (Travis County).

Additionally, YES Waiver staff at DSHS were interviewed to provide context to information gathered in other stakeholder interviews. Staff also attended a stakeholder forum hosted by the Hogg Foundation for Mental Health in September, 2012, which provided additional input.

Feedback to stakeholder interviews is organized around two primary questions: “What is the biggest contribution of the YES Waiver to the mental health system?” and “What would you most like to see changed about the YES Waiver?”. Responses to additional questions are organized by content area, including county level administration; outreach, eligibility and enrollment; provider networks; and the service array. Feedback from interviews of families and youth participants is summarized separately.

Extensive overall support for the goal of the YES Waiver (i.e., providing intensive, individualized community-based services and supports) was voiced by all stakeholders participating in interviews. Feedback indicated that in general, the YES Waiver has had a positive impact on the mental health systems that serve youth and families in Bexar County and Travis County. Stakeholders consistently indicated that the YES Waiver offered increased flexibility to meet the needs of youth and families.

Biggest Contributions of the YES Waiver to the Mental Health System

When select stakeholders at the community program level were asked what they thought was the biggest contribution of the YES Waiver to the mental health system, three key elements of the YES Waiver design were highlighted – access to Medicaid, wraparound planning, and the availability of nontraditional services and supports. Similar responses were voiced during the forum hosted by the Hogg Foundation, which included state and local program administrators and advocacy organizations. When additional follow-up questions related to each of these categories were asked, stakeholders also presented a variety of associated challenges and limitations.

Access to Medicaid

Stakeholders indicated that an important benefit of the YES Waiver was the ability for youth to have access to Medicaid and increased access to mental health services. These youth also gain access to health benefits through Medicaid, such as dental care and medication coverage. Stakeholders noted that the short-term nature of the YES Waiver and the loss of this benefit when youth are transitioned from the YES Waiver could be a limitation. Some respondents noted that the potential loss of Medicaid could influence caregiver reports of outcomes on annual eligibility assessments and participation in transition planning because they do not want to be discharged from the YES Waiver.

Stakeholders expressed the desire for the YES Waiver to include a step-down process or transition period that allows for youth to remain enrolled in the YES Waiver, or rolled over to another Medicaid plan, for a period of time after YES Waiver services end. Stakeholders expressed concern that youth would be unable to sustain gains when no longer able to access services or medications through Medicaid.

The Wraparound Model

In both counties, stakeholders expressed support for the use of the Wraparound process and reported that it's important to continue to strive for fidelity within the model. Service providers reported that they appreciated the opportunity to work collaboratively with youth to develop treatment goals and to collaborate as a part of a team. However, each county pointed out design limitations, as well as local practices or barriers to implementing high fidelity wraparound.

Potential barriers to wraparound or implementation issues that were shared included:

- Case managers tend to develop an initial individual plan of care prior to establishing a child and family wraparound team (this is likely due to case management billing requirements and following YES Waiver enrollment policies and procedures);
- Service providers are not reimbursed for attendance at wraparound team meetings, particularly the providers of Professional Services (Recreational Therapy, Art Therapy, Music Therapy, and Nutritional Counseling);
- Services identified in the wraparound plan are driven by provider and service availability rather than what is needed to meet the family's underlying needs (Travis County);
- Local procedures for identifying or assigning service providers through agency processes limit family choice;
- Crisis and safety planning is not generally incorporated in the first wraparound meeting;
- Monthly productivity requirements for internal service providers interfere with carrying out the wraparound plan (Bexar County);
- Case load sizes for case managers are too high to support high fidelity Wraparound (Travis County);
- Differences in terminology between the YES Waiver and Resiliency and Disease Management (RDM) are confusing for case managers and service providers, especially those who serve youth in multiple programs (Travis County);
- Service providers may not feel a part of the team process and consequently establish separate goals with the family;
- Some service providers reported not being notified about team meetings; and
- When goals and objectives for each service are not identified in the wraparound process, service providers are left confused regarding their role and relationship with other services that the youth is receiving (Travis County).

Nontraditional Services and Supports

All stakeholder groups commented on the significance of the nontraditional services and supports provided under the YES Waiver. In particular, the flexibility of the services and supports was noted as an important factor in being able to meet the individual needs of youth and families. One stakeholder described it as being able to "think outside the box" and present new therapeutic options to youth, such as music therapy. Service providers also noted the importance of being able to meet with youth in the community to practice social skills and incorporate physical activity into services.

“If You Could Change One Thing”

Community program stakeholders were asked what they would like to see changed within the YES Waiver. Responses were categorized as pertaining to the design or implementation of the YES Waiver, or local community program administration. It is important to note that some desired changes would likely not be allowable under the structure of a 1915(c) Medicaid waiver.

YES Waiver Design:

- Allow a community to submit a plan to DSHS on how to use the YES Waiver as a funding stream and allow it to be used flexibly within each community to enhance or build upon existing community resources;
- Allow the ability to provide and bill for parent-only services or family services, such as parent skills training or extending respite to siblings;
- Allow some flexibility in providing a service without the child present if deemed appropriate, such as if a parent would like a portion of the team meeting to occur without the child present;
- Revise the reimbursement rate structure and billing guidelines to attract more service providers and allow for all team members to bill for Wraparound meetings;
- Revise the billing structure for YES Waiver services to be more consistent with other programs (units versus hours), decreasing the likelihood of billing errors;
- Allow for the billing of Intensive Case Management for youth who are 18 years old in the YES Waiver (currently must bill Adult Routine Case Management);
- Enhance Wraparound training and technical assistance learning opportunities by providing more role play and role specific activities so facilitators and service providers better understand their roles.

Community Program Administration:

- Have a designated person within the community program who is the central point of contact for staff to address YES Waiver related issues, policies, and procedures (Travis County);
- Hold continuous open enrollment of interested providers for YES Waiver services, rather than limiting enrollment to twice per year (internal contracting practice; Travis County);
- Reduce the amount of time taken for internal service authorization processes so that service providers can begin services in a timely way without risking not being reimbursed (Travis County).

Community Program Administration

The stakeholders interviewed at the community program level shared a sense of pride and accomplishment related to having the YES Waiver available to youth and families in their respective communities. They were interested in continuing to enhance the YES Waiver, and the opportunity to provide feedback was welcomed.

The general feedback received from community program stakeholders around communication with DSHS YES Waiver staff was positive and was noted to have continued to improve over time. Both counties indicated that questions, concerns, and day-to-day issues are responded to by DSHS YES Waiver staff in a timely manner.

Successes

Community program stakeholders within Bexar County identified youth graduating from the YES Waiver as a primary success. Wraparound teams hold graduation ceremonies as a part of the youth’s transition out of the YES Waiver and have the youth make posters highlighting what they’ve accomplished. One

individual recalled a youth stating, “Look at what I’ve learned and what I can do on my own”. Additional successes reported by respondents included reducing psychiatric hospitalizations, transitioning youth to adult services at age 19, and families implementing a “family night” at home. In one instance, the YES Waiver was able to provide services and supports to a youth and family while the caregiver experienced an extended medical hospitalization. In this case, the caregiver told staff that without the YES Waiver, the child would have been in the custody of Child Protective Services.

Stakeholders in Travis County indicated that the YES waiver has allowed them to expand their provider network and engage more providers of nontraditional services. This allows families to access services that may not normally be available. They reported that families are very grateful for the YES Waiver and express appreciation for the fact that youth remain eligible for a year at a time. Respondents indicated that helping families understand the intensive and short-term nature of the YES Waiver has resulted in better outcomes, as has ensuring that families are actively involved in the treatment process.

When asked about known challenges or barriers, the following themes were present in both communities (instances in which the identified challenge or barrier is specific to a particular community are noted).

Challenges - Administrative Funding

One of the most significant challenges to the administration of the YES Waiver was reported to be the lack of administrative funding. Counties acknowledged that there were significant resources needed when the YES Waiver was being established, and staff had to be dedicated to community outreach, development of internal procedures, network development, and provider credentialing. Although these activities have decreased as the YES Waiver has progressed, substantial on-going effort continues to ensure service provider relationships are maintained, new service providers are identified, and processes are revised as needed.

Both counties indicated that numerous administrative responsibilities are required for day-to-day operations of the YES Waiver within their respective communities. Individuals from both sites reported that they are doing the best they can with available resources and have absorbed the workload among current staff rather than hiring a dedicated YES Waiver staff or team. Stakeholders reported that this strain on resources has limited their ability to provide additional time on YES Waiver enhancement activities, such as provider recruitment and networking with referral sources. There are ongoing discussions between DSHS, HHSC, and the LMHA’s regarding strategies to document and finance these administrative costs.

Some of the most time-consuming activities are related to non-automated processes, such as billing, encounter reporting, eligibility determination approvals, plan of care development, and YES Waiver service authorizations. These activities put a strain on staff time and present challenges in terms of general management of associated documents. One person also mentioned that there is often difficulty accessing their designated SharePoint site.

Challenges - Community Collaboration (Care Coordination and Provider Networks)

It was reported that some aspects of the YES Waiver present a barrier to collaboration with community partners and the engagement of providers in a way that builds upon existing community resources. Program stakeholders reported that these factors resulted in difficulties in engaging qualified providers, engaging potential referral organizations, and engaging eligible youth and families in the YES Waiver. Some challenges noted include:

- The requirement that Case Management must be provided through the LMHA does not allow communities to utilize other providers experienced in the Wraparound model;
- Established community programs that offer similar services may offer more service options to families, or better reimbursement rates for providers, leading to “competition” amongst programs;

- Qualified providers of services receive higher reimbursement rates under different programs or funding sources, influencing whether these providers take YES Waiver youth referrals over referrals from other programs. This was reported to be particularly problematic for Community Living Supports (CLS) and Paraprofessional Services. In one case, it was reported that a contracted external provider of multiple services decided to end their contract with the YES Waiver entirely because the reimbursement was not enough to cover costs despite increases made in April 2012 for CLS and Family Supports; and
- The reimbursement rates are too low to attract new providers given the intensity of the YES Waiver target population.

Outreach, Eligibility and Enrollment

Both counties expressed the need for more marketing and outreach to referral sources. This includes providing additional education to current referral sources and connecting with new ones. In particular, both counties often receive referrals for youth with Pervasive Developmental Disorders (PDD) or Intellectual and Developmental Disabilities (IDD) who may or may not also have a co-occurring mental health diagnoses. Providers from external agencies indicated that there is confusion around what co-occurring diagnoses and circumstances are appropriate for meeting clinical eligibility criteria as some youth with PDD and or IDD are deemed eligible and some are not. It was reported that some referral sources, such as schools and Child Protective Services, may also benefit from additional education on what is considered a serious emotional disturbance and the additional clinical criteria for eligibility into the YES Waiver.

When asked if existing eligibility requirements are appropriate for targeting youth with serious emotional disturbance, community program stakeholders reported that they felt the criteria were identifying appropriate youth. However, challenges were identified relating to demographic, clinical, and financial eligibility processes. Community program stakeholders described a challenge around presenting the YES Waiver to families as a program that provides intensive services over a limited period of time rather than a program that they will continue to use indefinitely. Families who have a history of being served in the mental health system expect long-term service. Some stakeholders described that it has been helpful to tell families early in the process that no longer meeting eligibility requirements is considered successful completion of their participation in the YES Waiver.

Administratively, community program stakeholders commented on the amount of paperwork the YES Waiver requires prior to enrollment, sometimes taking more than one meeting to complete. In particular, one county expressed that the required letters such as the Offer Letter and Vacancy and Deadline Notification Forms are cumbersome and the timelines don't necessarily match up with the flow of events. This is particularly true if eligibility assessments are occurring within a short timeframe after the youth is registered on the Inquiry List. It was suggested that situations where some of the forms "do not apply" and are therefore not required could be identified (Sections D.5 – D.8 of YES Waiver Policies and Procedures Manual).

Demographic Eligibility

In some instances, youth registered on the Inquiry List are hospitalized, residing in a Residential Treatment Facility, or are in Juvenile Detention when they are contacted for an eligibility assessment. In these cases community program stakeholders describe that it is typical for these youth to remain on the Inquiry List and receive an eligibility assessment for the YES Waiver upon discharge. This limits the ability of the family to utilize the YES Waiver as a potential mechanism for youth to return to the community earlier if appropriate supports are in place. It is noted that according to the YES Waiver Policies and Procedures Manual (Section F. Waiver Participant Eligibility and Enrollment), the current process identifies demographic eligibility criteria, such as county of residence and current living

arrangement, as criteria that must be met before assessing for clinical eligibility and submitting for approval (Step 4).

Clinical Eligibility

Community program stakeholders identified specific examples where additional programmatic clarification and support is desired. The following issues were noted:

- Some respondents believed the definition of serious emotional disturbance was unclear and the requirement that youth have almost any primary Axis I diagnosis was overly inclusive (e.g., ADHD, Adjustment Disorder);
- Some respondents believed the inpatient criteria was confusing and too dependent on clinical judgment and that consistency could be improved with additional guidelines or criteria;
- Respondents in both communities discussed the challenge regarding conducting eligibility assessments on youth with co-occurring PDD or IDD, and highlighted the need for additional guidance on how to take into account intellectual or adaptive functioning when assessing youth with co-occurring disorders. It also revealed the need to collaborate across communities to ensure consistent policies;
- Some respondents indicated that criteria for elevated scores on the Family Resources Domain (Section B. Level of Care of the Clinical Eligibility Determination Form) were too broad, reporting that families could say that they are overwhelmed and this would contribute to eligibility, when family stressors may be unrelated to the youth's emotional disturbance (e.g. parental chronic illness) or services inappropriate to reduce the stressor (e.g., need for rental assistance); and
- The TRAG includes an item for *At Risk of Placement*, however the YES Waiver doesn't utilize this element as part of the eligibility criteria.

Financial Eligibility

Community program stakeholders reported that they lack clarity about what specific documentation the financial Medicaid eligibility determination process requires. They also indicated that the timeframe for processing and receiving approvals has increased, which they felt was due to changes in HHSC staffing patterns for processing YES Waiver applications. For instance, CHCS stakeholders reported up to six youth with pending applications at one time and one person who had been waiting since May 2012 (as of August 2012). Both community programs identified steps they have taken internally to decrease requests for additional documentation, such as trying to ensure all necessary paperwork is submitted at one time. In addition, a community program stakeholder at ATCIC created a letter template that summarizes service history and captures the psychiatrist's signature. It was also noted that additional training for internal Clients Benefits Office staff would be beneficial.

Transitioning Out

Community program stakeholders in both counties expressed a desire for more flexibility in options and processes related to transitioning youth out of the YES Waiver. Specifically, stakeholders identified the need for a step-down process that would allow youth to still have access to the YES Waiver for a period of time after youth problems improve to ensure continued stability.

Community program stakeholders at CHCS provided these examples of successful transition strategies:

- Several weeks prior to the annual evaluation date, youth are assessed to see if they are likely to qualify for another year of the YES Waiver. If not, adequate time is available to transition them to other services and supports, such as those available under RDM. They present this as a "success" for the youth and family to no longer qualify for the YES Waiver. Eighteen year olds are often referred to adult services. New providers are invited to attend final wraparound meetings so the youth and family can meet them.

- Two youth were “ready” prior to the annual evaluation so they both graduated from the YES Waiver after about nine months and transitioned into a lower intensity RDM package.
- One youth barely qualified at the annual evaluation and after discussing transition the youth and family decided it was time to graduate from the YES Waiver.

Community program stakeholders indicated some remaining confusion about how to handle transition of families who remain eligible for many years without significant changes to the severe or chronic issues that remain or families who prefer to remain in the YES Waiver through the full year of eligibility if clinical justification no longer remains and few services are being provided.

Families Who Decline Enrollment or Request Discharge

Community program stakeholders provided the following reasons that contributed to eligible youth and families choosing not to enroll into the YES Waiver or to request discharge from the YES Waiver while still eligible. It is important to note that this is not a common occurrence, and only applies to a limited number of families in each community. Possible reasons provided were:

- The family was not interested in the level of intensity of the service model;
- The family was not satisfied with the length of time the approach might take;
- The family was looking for different services than those offered, such as financial assistance with utilities; and
- The youth and/or family was not adequately engaged with service providers.

Provider Networks

Each community has developed a different model for ensuring providers for the YES Waiver services. Therefore the challenges are somewhat unique to each site. Consequently, information on provider network issues is presented separately for each county.

Bexar County

CHCS provides YES Waiver services through a combination of internal (Community Living Supports, Family Supports, Paraprofessional Services) and external providers for select services (e.g., Community Living Supports, Recreational Therapy, and Music Therapy). CHCS has a continuous enrollment contracting process for qualified providers and they report that they are aware that they need to continue to build the provider network externally in order to offer more choice to families. When asked about strengths and challenges associated with service provision, the following feedback was received.

Strengths:

- Care coordinators are aware of internal service providers’ strengths and can plan for good “fit” with families;
- Scheduling appointments and coordinating care is relatively easy with internal service providers; and
- All service provider progress notes (from both internal and external providers) along with the wraparound plan and approved plan of care for YES Waiver services are available electronically for all providers to access.

Challenges:

- Internal service providers have a monthly “minimum” productivity requirement of 100 hours that is difficult to meet (Community Living Supports and Family Supports);
- No service providers are currently in place for Art Therapy or Supportive Family-Based Alternatives;

- Capacity for Music Therapy (usually youth waiting for an opening) and Paraprofessional Services (limited to one service provider) is limited;
- Respite has not been readily available in the past despite requests from families, due to the lack of In-Home Respite providers, lack of interest from the community's General Residential Operation licensed by DFPS to provide emergency care, and limited availability and willingness from DFPS licensed foster families;
- The provider network is still developing for Nutritional Counseling (previous providers have not worked out) and Animal Assisted Therapy (Equine Therapy);
- One external provider agency of Community Living Supports has withdrawn due to the reimbursement rate, despite recent rate increases;
- Staff have limited time to research potential providers and follow-up with them; and
- External service providers have a lack of knowledge about youth with serious emotional disturbance and are not prepared for the "no shows" and "acting out" that sometimes occur with the youth served under the YES Waiver.

Travis County

ATCIC provides YES Waiver services solely through their external network of providers. Currently, ATCIC has two opportunities for qualified providers to enroll per year. When asked about strengths and challenges associated with service provision, the following feedback was received.

Strengths:

- Several providers are on contract for the majority of YES Waiver services;
- In a few cases, family members have provided In-Home Respite and received reimbursement through the YES Waiver; and
- ATCIC is currently in the process of contracting with two different providers of Animal Assisted Therapy (Equine Therapy).

Challenges:

- Some providers are reticent to accept referrals due to lower reimbursement rate compared to other community programs and intensity of youth served through the YES Waiver;
- Only about 20% of the network providers have actually served YES Waiver youth, in part due to case managers lack of familiarity and/or willingness to refer youth;
- Providers who come from a different service background, such as serving youth with intellectual or development disabilities and may not have the necessary skills to serve the youth and families;
- Providers may need additional training, particularly around engaging and communicating effectively with caregivers and other family members, behavior management, and parent skills training;
- Providers expressed concerns that each coordinator does things differently and communication was considered poor in some cases. One service provider offered an example where the provider wasn't informed of a change to the plan of care for a transitioning youth and the provider continued to provide the service after the youth had ended their participation in the YES Waiver and did not receive reimbursement;
- Families with higher socio-economic status are sometimes dissatisfied with service providers' level of experience or education, being unaccustomed to paraprofessional or bachelor's level providers;
- An insufficient number of Community Living Supports providers are in place who are bilingual and can provide services in the family's home;
- Non-Medical Transportation could benefit some families, but providers want reimbursement of time rather than mileage, due to the amount of time it may take to transport youth in urban areas;

- Several service providers noted problems with communication and resolution of issues with the LMHA after bringing the concern to various individuals (case manager, case manager supervisor, ombudsman, or program director); and
- Limiting enrollment of qualified providers to two contracting cycles per year makes it difficult to keep the network full and to expand. For example, the last contracting cycle ended in August and even if a provider is interested, they can't apply until January.

YES Waiver Service Array

When asked “*What are the most and least beneficial YES Waiver services?*,” the majority of stakeholders listed Professional Services, particularly Recreational Therapy and Music Therapy, along with Community Living Supports, Family Supports, and Respite (when available) as being most beneficial. CHCS stakeholders also included Adaptive Aids and Supports. Fewer examples were given for least beneficial services, but responses included Non-Medical Transportation and the various types of Respite. Stakeholder feedback regarding each specific service is outlined below.

Respite

Community program stakeholders report that it has been challenging in both communities to provide Respite, due to a lack of available providers or available settings and that available providers/settings do not always meet the needs of youth and families. Both communities also indicate they lack the resources to seek out providers and establish multiple contracts across the various settings in order to utilize them. According to encounter data, the In-Home Respite and DFPS Residential Child Care categories are the only two categories that have been utilized to date.

Stakeholders reported that the definition and qualifications for the Respite Camp category are too restrictive. A community program stakeholder did a survey of local camps that meet qualifications and were informed that none of the surveyed camps were interested in serving the YES Waiver population. Furthermore, the day camps that are available in the community that youth in the YES Waiver would like to attend do not fit the qualifications for this category of Respite because they are not accredited by the American Camping Association or licensed by DSHS. Currently, some success accessing these camps has come through Adaptive Aids and Supports funds in both communities, but this limits families' ability to use these funds for other key components of the wraparound plan.

Community program stakeholders gave several examples of families wanting Respite to be provided outside of the home rather than for a provider to come to the home. For example, it was noted that Home and Community-Based Services Waiver through the Department of Aging and Disability Services allows the community agency to certify a provider's home as a respite site rather than having to utilize DFPS licensed facilities or families. Although CHCS has utilized DFPS licensed homes for Respite in the past, stakeholders indicated that the number of DFPS families is insufficient and those who have accepted YES Waiver youth in the past aren't adequately trained. In one instance, a DFPS family sent the child back home after 12 hours because they weren't equipped to handle the level of care. Due to a recent change in leadership, it is anticipated that the relationship with and accessibility to appropriate DFPS families will improve. Currently the DFPS General Residential Operation is not interested in serving YES Waiver youth, but CHCS indicated they are continuing to pursue this option.

Community Living Supports (CLS)

Stakeholders indicated that this is one of the most beneficial and utilized services. It was reported that the distinction between Master's level and Bachelor's level providers can be confusing for providers and case managers because the service definition is equivalent and both types of providers may not be available for families to choose from. A provider is often chosen based on who is available rather than determining whether a Master's level or Bachelor's level provider is needed. Since this is a highly utilized service

category, some stakeholders expressed a preference for having the option to use Rehabilitative Skills Training for similar activities because this service is reimbursed at a higher rate and has a network of stable providers. However, other stakeholders noted a value in being able to access providers external to the LMHAs and having more flexibility in the treatment approach utilized in CLS.

Paraprofessional Services

One provider stakeholder described the Paraprofessional Service as essentially the same as Community Living Supports with the only difference being the level of qualification of the provider, rather than a distinct service.

Family Supports

Although this service is utilized often in both communities, no feedback specific to this service was provided.

Professional Services (Recreational Therapy, Music Therapy, Art Therapy, Animal Assisted Therapy, Nutritional Counseling)

Some respondents believed additional detail around the different types of Animal Assisted Therapy was needed, since therapeutic approaches, general settings, and provider qualifications can vary greatly. For example, ATCIC is currently in the process of contracting with two different equine therapy providers and each provider has distinct characteristics that might influence which one a family would choose based on their individual needs. Additional information could help families better understand the nature of this service and differences between providers.

Adaptive Aids and Supports

In general, it was observed that the community programs have different experiences related to the design and processes associated with the use of this service category. Community program stakeholders from ATCIC described barriers and challenges to using this service and expressed a need for additional clarification from DSHS on what fits within this category and what does not. Respondents recalled instances in the past where purchased items or services were not reimbursed. Other stakeholders, including service providers, reported being told by care coordinators that too much paperwork and justification was involved when requests are made from youth and families.

CHCS identified several examples of how this service has been successful in supporting youth and families in the YES Waiver by accessing weighted blankets, tutoring, lock boxes, and martial arts through this support and did not report any issues with the associated approval and reimbursement processes.

Non-Medical Transportation

This service has not been utilized through the YES Waiver to date. Stakeholders indicated that some families may be able to benefit from the service but the way it is currently designed does not meet family needs and is not appealing to providers. Respondents indicated that families may have transportation, but could benefit from assistance with the cost of fuel – rather than having someone else pick up the child and transport them to and from appointments. The main reason given for the lack of providers for this service is that mileage reimbursement isn't enough based on the amount of time spent transporting youth in urban settings. Providers of other YES Waiver services would prefer to be reimbursed for provider time rather than mileage.

Supportive Family-Based Alternatives

This service has never been used. Community program stakeholders at CHCS reported that some families may have benefitted qualified and willing DFPS families had been available.

Transitional Supports

This service has never been used. No feedback was received regarding this service.

Minor Home Modifications

This service has never been used. No feedback was received regarding this service.

Additional Services and Supports

Stakeholders were asked to report any additional services and supports they would like to see included under the YES Waiver service array. The following suggestions were given:

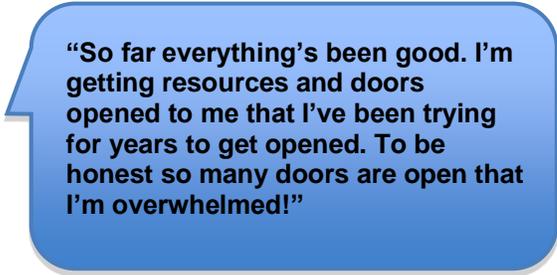
- Couples Counseling / Marriage Counseling;
- Parent Coaching / Family Skills Training;
- Crisis Respite (someone to de-escalate situations);
- Social skills groups for youth;
- Supplemental curriculum for youth on topics such as bullying, dating violence, family violence, and peer pressure; and
- Support groups for parents with youth with mental illness.

Participant Feedback (Caregiver and Youth Interviews)

Interviews were conducted with nine caregivers and three youth who were enrolled in the YES Waiver. The length of time in the YES Waiver for this group ranged from one month to two years. Comprehensive care, the wraparound model, the service array, the availability of home-based services, and Medicaid assistance were noted as appealing factors to caregivers when they first heard about the YES Waiver.

When asked about the length of time they had to wait on the Inquiry List before being assessed for eligibility, caregivers reported timeframes anywhere from immediate up to one year. Of the nine families, caregivers reported that six youth were hospitalized (four on multiple occasions) and one youth had two separate admissions to a residential treatment center during the time he/she was on the Inquiry List. Five caregivers mentioned that the youth continued receiving outside services and supports while on the Inquiry List, including seeing therapists and psychiatrists.

All but one caregiver expressed satisfaction with their treatment team and the plan of care development process. The exception to this was a family that experienced a turnover in service providers due to the provider agency ending their relationship with the YES Waiver.



“So far everything’s been good. I’m getting resources and doors opened to me that I’ve been trying for years to get opened. To be honest so many doors are open that I’m overwhelmed!”

Caregiver responses to the question of whether they were given a choice among service providers were mixed.

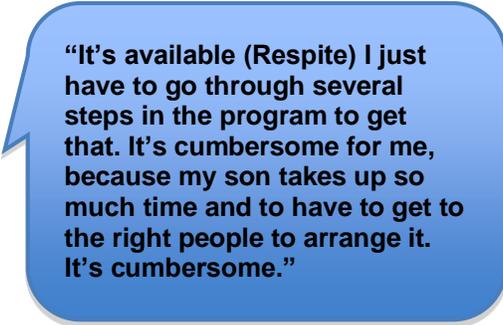
Approximately half of the respondents stated that service providers were identified by the case managers based on availability and a couple further stated that they knew they could ask for different providers if necessary. For the most part, caregivers indicated that their service providers attended team meetings, with the exception of the Professional Services providers, doctors, and psychiatrists. One caregiver indicated that he/she had to switch psychiatrists to one that only saw YES Waiver youth, which was “unfair” since they had built trust with their previous psychiatrist. Overall, caregivers reported no challenges to communicating with service providers or scheduling/attending service appointments. A few commented on the time flexibility of their providers and the benefit of having providers come to the home. One caregiver identified difficulty getting in touch with the participant’s psychiatrist. Another caregiver reported difficulty scheduling with a Professional Services provider so the family decided to try another Professional Service provider instead and that has since worked out.

Caregivers were asked what services and supports were most beneficial. The most frequent responses included Case Management or the wraparound process, but Family Supports and Adaptive Aids and Supports were also highlighted. The three youth interviewed identified Art Therapy, Recreational Therapy, and Case Management as the services that helped them the most. This coincided with the services that they enjoyed the most with one stating, “I like the fact that they can take me places, like to the park.”

Most caregivers and youth did not identify a particular service when asked what services and supports were the least beneficial, but those that did cited Music Therapy, due to scheduling problems, Case Management, due to a perceived lack of respect for the caregiver role, and Family Supports.

When asked what services or supports they would have liked or needed that weren’t available through the YES Waiver, caregivers provided the following examples:

- Respite
- Music Therapy, due to lack of available providers
- Parent Support Group, and
- Vehicle Maintenance.



“It’s available (Respite) I just have to go through several steps in the program to get that. It’s cumbersome for me, because my son takes up so much time and to have to get to the right people to arrange it. It’s cumbersome.”

When asked what sets the YES Waiver apart from other programs, caregivers identified the following characteristics:

- Services are provided in the home;
- The YES Waiver is all-inclusive;
- The availability of support for caregivers (family support service);
- Case managers take their time and ask for caregiver and youth input rather than telling you what to do; and
- The case manager and service providers are always very positive, explain everything to the youth, and make sure the goals are attainable. They communicate and interact with the youth on a level that the youth understands.

When caregivers and youth were asked about changes that they have noticed since participating in the YES Waiver, they indicated:

- Improved communication within the family;
- Increased self-awareness, understanding, and control;
- Improved ability to handle crisis situations;
- Improved behavior;
- Improved grades;
- Reduction in anger and aggression;
- Reduction in problem behaviors; and
- Reduction in hospitalizations;

One hundred percent of caregivers and youth interviewed said they would recommend the YES Waiver to other youth and families.

Conclusions and Recommendations

State-Level Program Administration

The YES Waiver has been successfully established in two communities and appropriate policies and procedures have been developed. Stakeholders report that YES Waiver staff at DSHS have been receptive to feedback from the communities about barriers to implementation and program policies have been modified when possible to reduce barriers. Staff at HHSC have adjusted reimbursement rates for YES Waiver services at the request of DSHS and stakeholders. Given the currently small scale of the program, the quality of the program management could be jeopardized if the program is expanded significantly without additional programmatic support at the state level and/or automation of some programmatic activities.

Recommendations:

1. DSHS should consider automation to support key waiver oversight activities, including transmission of eligibility documentation and plans of care for approval, service encounter submission, and billing.
2. DSHS should further standardize data entry specifications, including formats for data elements and required or optional fields, and document these requirements in the Policies and Procedures Manual.
3. As the YES Waiver expands, DSHS should consider increasing collaboration between relevant units, such as Child and Adolescent Services and Quality Management, to ensure policies are aligned and expertise can be shared.
 - a. Quality Management staff should assist with designing processes to monitor quality indicators from existing data sources and on-site reviews.
 - b. Collaboration with Child and Adolescent Services should explore issues such as shared provider training opportunities (e.g., family peer-to-peer services, skills development curriculum), consistent policies for family partner/supports certification, consistent guidelines for wraparound provision, and shared terminology across programs.
4. DSHS should consider processes to incorporate the YES Waiver into the existing (or revised) RDM framework. Communities should have clear guidelines about when youth should be served within the YES Waiver and when an intensive service package within RDM should be utilized.
5. DSHS should examine strategies to assist communities with network development, especially to the extent that collaboration with other state agencies may be beneficial.
6. HHSC should continue to examine ways of streamlining the Medicaid Eligibility process, including making documentation requirements clear and attempting to ensure communities have access to knowledgeable, accessible staff.
7. HHSC and DSHS should explore options for maintaining Medicaid eligibility for youth during a step-down period (e.g., one year following YES completion) to ensure adequate access to services and supports to maintain progress and prevent relapse.

Community-Level Program Administration

Both Travis and Bexar Counties have established procedures for implementation of the YES Waiver with their community, including outreach to community stakeholders, maintenance of an inquiry list, eligibility assessments, establishment of provider networks, and processes for accessible documentation. These activities, including day-to-day management of the program, have been incorporated into the duties of existing staff. Although both communities are supportive of the YES Waiver and proud of their accomplishments, both noted that management of the program is a significant strain on financial and staff resources. Each county has structured the program in different ways, and administrative challenges are sometimes unique to each community.

Recommendations:

1. HHSC should explore opportunities to reimburse LMHAs for administrative tasks associated with local operation of the YES Waiver program. In addition, LMHAs are likely to have increased resource needs during the first year of YES Waiver start-up.
2. LMHAs should have an identified YES Waiver administrator to whom case managers, YES Waiver providers, and families and youth can direct issues and concerns that are not resolved adequately through other processes.
3. Travis County should review the internal procedures for authorization of purchases for Adaptive Aids and Supports to identify potential ways to streamline the process.
4. Travis County should review internal processes for service authorization to decrease delays in service initiation or miscommunication regarding the closing of authorizations.
5. Bexar County should monitor the impact of provider productivity standards on wraparound fidelity and service quality, to ensure that fidelity and quality can be maintained with increased provider expectations.

Youth and Family Outcomes

Families and youth showed significant improvement in emotional and behavioral problems, as well as youth functioning, during participation in the YES Waiver. These results are significantly better than the outcomes seen in the same youth in the year prior to YES Waiver participation. Youth also showed improvement on ratings of risk for self-harm and risk for harming others through aggressive behavior, both critical aspects of risk of out-of-home placement and hospitalization. Both youth and their caregivers reported being very satisfied with the services and supports they received through the YES Waiver, and caregivers in the YES Waiver generally reported greater satisfaction than caregivers served through traditional public mental health services. Parents and youth responding to a survey believed the program and service providers to be strength-based, culturally and linguistically competent, and focused on individualized life goals. Respondents also perceived the program to be engaging, foster hope, provide families choice and voice, and assist with the development of a sustainable support network. Youth had fewer state psychiatric facility stays in the year following YES Waiver enrollment and had fewer days in facilities than in the year prior to their enrollment in the YES Waiver, although differences were small.

Recommendations:

1. DSHS should further evaluate the extent to which the YES Waiver has prevented psychiatric hospitalization and residential treatment by incorporating other state datasets (e.g., Medicaid, DFPS, Texas Juvenile Justice Department) as well as examining rates for placement of youth in psychiatric hospitals and residential treatment facilities within the community at large. Results could inform the identification of additional outreach opportunities and/or service gaps.
2. DSHS should further extend the evaluation to a full cost-benefit analysis of the YES Waiver when enough youth have been served to support generalizability.

Outreach, Eligibility and Access to Services

Referral and enrollment has been below expectations over the life of the YES Waiver and has declined in the last 18 months. Referrals traditionally come from internal providers and external provider organizations. Other potential referral sources, such as Children's Protective Services, juvenile justice departments, schools, hospitals, and Community Resource Coordination Groups are less common. Community administrators acknowledge that they lack the time and financial resources to focus on community outreach as much as might be desired. The amount of time between registration on the inquiry list and the eligibility assessment has been lengthy; however recent policy and staffing changes have resulted in improvements. Timely processing of Medicaid eligibility documentation for those not entering

with Medicaid has also been a recent issue. In general, stakeholders believed appropriate youth were accessing the program, but issues remain about operationalizing the eligibility criteria, particularly around co-occurring developmental delays. The issue of limited enrollment and access is multi-faceted. It is likely due in part to limited resources for outreach efforts, lengthy waits on the inquiry list, limited provider capacity, and occasional delays in eligibility processing. More recent data suggests these issues are improving, but it is unclear if delays would increase if significantly more youth and families were referred to the program.

Recommendations:

1. Community programs should consider initiating YES Waiver services immediately following the eligibility assessment, presuming eligibility for those awaiting determination. Although some financial risk is associated with initiating services, it was reported that only one denial has occurred in the history of the program.
2. Outreach to ensure appropriate referrals from community organizations should be ongoing and supported by administrative resources if possible. Outreach should include other child-serving agencies (e.g., schools, juvenile justice, and child welfare), local hospitals, and CRCGs.
3. DSHS should continue to work with communities to clarify criteria related to clinical eligibility in order to improve consistency and ensure that criteria are not too flexible or rigid in targeting youth appropriate for the YES Waiver.
4. DSHS should consider options to allow youth who are currently hospitalized or residing in a residential treatment or Juvenile Detention facility to receive an eligibility assessment prior to discharge/release. Although the YES Waiver requires youth to be residing in a non-institutional setting to be considered “eligible”, this criterion could be satisfied just prior to enrollment rather than prior to the assessment. Additional barriers related to billing and coordination of care would also need to be addressed, but changes could enhance the role of the YES Waiver in providing needed supports for youth to return to their community.

Wraparound Approach

Stakeholders valued the wraparound planning approach utilized in the YES Waiver and many families reported this was the most beneficial component of the program. Both counties are utilizing wraparound planning with families, but the quality of the approach is variable. Wraparound plans generally identified the strengths of the youth and caregivers and in most cases wraparound teams were developed, incorporating the youth, caregivers, and at least one YES Waiver service provider. In some cases, other formal and informal supports, such as probation officers or babysitters, were also included on the team. Some general weakness to wraparound implementation was found as well, including some occasions of no team meetings, identification of services and providers before the initial team meeting, limited crisis and safety plans, and lack of transition planning. Providers noted some issues with communication and coordination that could have been managed with regular team meetings. Some barriers to high quality wraparound appear to be limited training for facilitators and team members, high case manager caseloads, high provider productivity standards, and inability for professional service providers to be reimbursed for time attending team meetings.

Recommendations:

1. DSHS should examine opportunities to align YES Waiver policies and procedures with the National Wraparound Initiative recently adopted by DSHS through RDM. Areas of focus should include training requirements for facilitators, content of provisional plan and wraparound plans, the frequency of plan review, team member participation, caseload sizes, and quality monitoring processes.

2. DSHS should consider ensuring YES Waiver wraparound facilitators (i.e., case managers) receive additional training and coaching to improve the consistency and quality of wraparound implementation.
3. DSHS should consider providing additional training or guidance, perhaps through web-based training program, to YES Waiver service providers on the core principles and values underlying the wraparound approach and expectations for team members.
4. DSHS and/or LMHAs should identify approaches to regularly assess and monitor wraparound fidelity utilizing a valid fidelity measure, such as the Wraparound Fidelity Index or the Team Observation of Measure.
5. LMHAs should ensure that wraparound facilitators have access to information about all contracted providers so that key information can be shared with families when identifying potential service providers.
6. LMHAs should ensure that wraparound teams are linking family members and youth with appropriate community supports, such as family support groups.
7. DSHS should review options to allow LMHAs to utilize qualified external contractors for wraparound facilitation so that capacity can be expanded and be appropriately flexible for fluctuations in enrollment.

YES Waiver Services

In addition to intensive case management (wraparound), a variety of YES Waiver services were utilized by participants. Community Living Supports and Family Support Services were the most frequently utilized and well-liked by caregivers and youth. Recreational Therapy, Licensed Nutritional Counseling, Paraprofessional Services and Adaptive Aids and Supports were also commonly provided services. Several other services, including Respite, Non-Medical Transportation, and Supportive Family-Based Alternatives were rarely or never used. Stakeholders reported that a lack of qualified and willing providers, low reimbursement rates, and restrictive service definitions or provider qualifications were barriers to the use of some of these services.

Recommendations:

1. HHSC should continue to explore the adequacy of provider rates. In addition to provider qualifications, rate reviews should incorporate an understanding of the additional expectations of providers within the wraparound model (i.e., phone contacts, home- or community-based provision of services, participation in monthly team meetings, participation in team meetings following crises, etc.).
2. DSHS should consider revising YES Waiver services that aren't being utilized to their fullest extent, including:
 - a. Adding a Respite category to allow youth to receive respite in a provider's home, with certification of the respite home and provider conducted by the LMHA; and
 - b. Exploring the possibility of revising the Camp Respite category so that accreditation by the American Camping Association is not required, but retaining required licensure status through DSHS.
3. Consider the addition of the following new services which could be beneficial for youth with serious emotional disturbances:
 - a. Behavior analyst/specialist (with appropriate certification);
 - b. Youth peer support; and
 - c. Youth social skills group.
4. DSHS may need to provide additional clarification to community program stakeholders and YES Waiver providers on the following issues:
 - a. Clarify that CLS is inclusive of parent management skills and can be provided without the youth present;

- b. Clarify if Non-Medical Transportation can be used to support transportation by the parent if financial hardship is documented and other options are unavailable;
 - c. Clarify allowable purchases for Adaptive Aids and Supports and appropriate justification; and
 - d. Clarify differences in service definitions between Paraprofessional Services and Community Living Supports.
5. HHSC and DSHS should consider providing program development funds and technical assistance to communities to build a provider network for Supportive Family-Based Alternatives. Although stakeholders perceived this service to be potentially very beneficial, a lack of qualified providers and the complexities of cross-agency collaboration have been barriers to its development.
6. DSHS and LMHAs should consider establishing provider profiles of all contracted YES Waiver service providers to allow both case managers and families and youth opportunities to learn about the qualifications of available providers and their service approach. Provider profiles could be available online through the DSHS website or maintained locally by the LMHA (e.g., a provider book).

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Note

The Evaluation Team would like to thank the youth, caregivers/parents, program administrators, and service providers who contributed to this evaluation report. All participants were highly invested in the success of the YES Waiver and giving of their time to ensure the program meets the needs of youth and their families.