

System of Care Practice Review Regional Report of Findings: Southeast

October 2014

Completed by:
Francine Arienti, Kelly English
& Amy Horton
Technical Assistance Collaborative

Completed for:
Massachusetts Executive Office of
Health and Human Services



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Executive Summary

SOCPR overview

As part of its ongoing effort to evaluate the quality of care delivered to youth under 21 receiving MassHealth children’s behavioral health services, the state selected the System of Care Practice Review (SOCPR) process. The SOCPR, which was developed by the University of South Florida (USF), uses a multiple case study methodology to learn how important System of Care (SOC) values and principles are operationalized at the practice level, where youth and families have direct contact with service providers. A series of five regionally-based reviews of the care delivered by Intensive Care Coordination (ICC) and In-Home Therapy (IHT) providers are planned. This report presents the results from the reviews that occurred in March 2014 for providers serving the Southeast region of the state.

Trained reviewers use the SOCPR protocol to review a youth’s treatment record and to guide interviews with service providers, caregivers, and the youth. Reviewers then rate their impressions of the youth’s care according to four domain areas that map closely to the core values of a SOC as articulated by Stroul, Blau, and Friedman.¹

TABLE 1: SOCPR DOMAINS AND SUB-DOMAINS

Domain	Sub-domains
Child-centered & family focused	Individualized Full-participation Care coordination
Community-based	Early intervention Access to services Minimal restrictiveness Integration and coordination
Culturally competent	Awareness Sensitivity and responsiveness Agency culture Informal supports
Impact	Improvement Appropriateness

In addition to the standard set of questions contained in the SOCPR protocol, nine additional questions were added to the Massachusetts version of the SOCPR to assess if youth with IHT serving as their “clinical hub” are receiving all medically necessary remedial services including appropriate care coordination. A copy of the additional questions is located in Appendix C.

Southeast region review summary

The care of 24 randomly selected youth who received services from ICC or IHT providers in the Southeast region was reviewed using the SOCPR. Youth between the ages of 5-9 (n = 9) represented the largest percentage of the sample at 38%, followed by youth between the ages of 14-17 (n = 6) at 25%, youth between the ages of 10-13 (n = 5) at 21%, then youth ages 0-4 (n

¹ Stroul, B.A., Blau, G., & Friedman, R.M. (n.d). *Updating the System of Care Concept and Philosophy*. Washington, D.C.: National Technical Assistance Center for Children’s Mental Health.

= 3) at 12%; only one youth in the sample was between the ages of 18 and 21. Sixty-three percent (n = 15) of the youth were male. In terms of race, the majority of youth (n = 17) were White (71%), followed by those identified as Bi-racial at 17% (n = 4). Eight percent of the youth (n = 2) were Hispanic and one youth (4%) was African-American. English was identified as the language spoken at home for 96% of the families (n = 23).

At the time of the review, the largest number of youth (n = 9) had been receiving services between 7-9 months, with four of these youth enrolled in ICC and five youth enrolled in IHT. Of the 24 youth reviewed, fourteen youth had involvement with at least one service system (e.g. Department of Children and Families, special education, Department of Mental Health, etc.). Four youth, two in ICC and two in IHT, were involved with two service systems, and two youth with ICC were involved with three systems. The most common type of behavioral health condition reported among the youth reviewed was ADHD (58% or n = 14). Sixty-three (63%) percent of the youth reviewed had more than one reported behavioral health condition. All of the ICC youth were enrolled in two or more additional behavioral health services; this was true of only four of the 12 youth who had IHT serving as their care coordination “hub”. Apart from ICC and IHT, Therapeutic Mentoring was the most commonly utilized behavioral health service, with 54% (n = 13) of the sample participating in that service, with the majority of those youth also participating in ICC (n = 9).

Results

SOCPR scores can range from a low of 1 to a high of 7. Scores from 1 to 3 represent lower implementation of a System of Care (SOC) approach. A score of 4 suggests a neutral rating, lack of support for or against implementation. Scores in the 5 range represent good implementation of SOC principles, while those from 6 to 7 represent enhanced implementation of SOC principles. For the Southeast region, SOCPR mean domain scores ranged from 5.60 to 6.38. The overall mean score of the cases examined was 6.01.

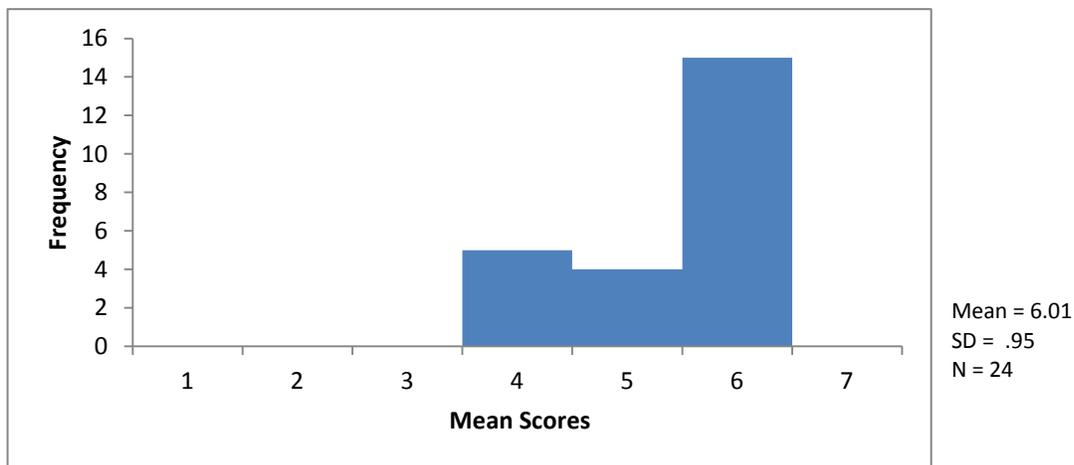
The domain of Community-Based was the highest scoring domain, followed by Child-Centered and Family-Focused, Culturally Competent, and finally, Impact. The scores indicate that in the Southeast region, provider agencies included in the sample performed best at including the Community-Based SOC value in service planning and provision. This is due in large part to the fact that ICC and IHT are services that are delivered primarily in home and community-based settings and are expected to be offered at times that are convenient for youth and families.

TABLE 2: SOCPR DOMAIN SCORES

	Min	Max	Mean	Standard Deviation	95% CI Lower Limit	95% CI Upper Limit
Overall	4.08	6.88	6.01	.95	5.63	6.39
Domain 1: Child-Centered Family-Focused	3.38	6.94	5.95	1.08	5.51	6.38
Domain 2: Community-Based	4.55	7.00	6.38	0.68	6.11	6.65
Domain 3: Culturally Competent	3.90	7.00	5.90	1.05	5.48	6.32
Domain 4: Impact	1.50	7.00	5.60	1.41	5.04	6.17

As the histogram in Figure 1 shows, sixty-three percent (15 of 24 cases) fell into the 6 range representing enhanced SOC implementation, and four cases (17%) scored in the 5 range, reflecting good SOC implementation. Five cases (21%) had means in the 4 range.

FIGURE 1: OVERALL MEAN SCORES



Identified strengths and opportunities for improvement

Overall, the findings from this review show that ICC and IHT providers in the Southeast region are generally demonstrating a system of care approach to service planning and delivery, performing best at including the Community-Based SOC value in service planning and provision. Areas of particular strength for providers in this region included:

- Thorough assessments were conducted with youth and families across life domains.
- Providers engaged families in the service planning process, supported them in influencing the planning process (e.g. respecting family voice and choice), and ensured they understood the content of their plans. By helping foster this sense of ownership over the planning process, reviewers found that families were actively participating in reaching their treatment goals.

- Services were accessible to children and families and were offered at convenient times, in convenient locations, and in the primary language of the family.
- Services were provided in comfortable settings that were the least restrictive and most appropriate environment.
- One person was responsible for successfully coordinating the planning and delivery of services and supports.
- Providers quickly clarified the youth and family's needs.
- Providers recognized that youth and families' understanding of the service requirements had an impact on their service participation.
- Providers assisted youth and families in navigating the agencies they represent.

Although ratings for the majority of youth reviewed fell in the enhanced (n = 15) or good (n = 4) range, findings indicated the greatest opportunities for growth for ICC and IHT providers in the following areas:

- Incorporating youth and family strengths into service plan goals.
- Smoothly and seamlessly connecting youth and families with additional services and supports.
- Intentionally including natural supports into service planning and delivery.

Further, important differences between IHT and ICC cases reviewed in the Southeast Region revealed the additional need for improvements among IHT providers in the following areas:

- Ensuring that the intensity of services and supports reflects the youth and family's identified needs and strengths.
- Including formal providers and natural supports in the service planning process.
- Quickly putting the appropriate combination of services and supports in place for youth and families.
- Showing a greater awareness of how IHT clinicians' culture influences the way they interact with the youth and family.
- Making services more responsive to the youth and family's values, beliefs, and lifestyle.

About this report

This report, along with the information offered at the individual provider-specific debriefings that were convened by staff from MassHealth and EOHHS following the Southeast reviews, should be used to help inform quality improvement efforts and guide discussions with staff about the development of provider-specific strategies for building upon areas of strong performance and how to improve service delivery to youth and families. The areas identified for growth could serve as important topics for in-service trainings, be given greater attention and focus in individual and group staff supervision, and/or become areas that are regularly reviewed as part of a provider's quality assurance processes. Recommendations for specific system-level interventions will be made in the final year-end report when trends across regions can be summarized and based upon a larger number of reviews.

Introduction

Overview

This report presents findings from the System of Care Practice Reviews (SOCPR) that occurred in the Southeast region during March 2014. Developed by the University of South Florida (USF), the SOCPR utilizes a multiple case study methodology to learn how important Systems of Care (SOC) values and principles are operationalized at the practice level, where youth and families have direct contact with service providers. Using the SOCPR protocol, trained reviewers conduct structured interviews with key informants including the parent/caregiver of a randomly selected youth, the youth (if 12 or older), service providers, and other helpers familiar with the care the youth and family are receiving. A review of a youth's record is also performed, which provides an additional source of information about the service planning and delivery process. During the March 2014 review cycle, the care of 24 randomly selected youth who received services from 12 provider sites² was reviewed using the SOCPR. Six of these 12 providers were randomly selected IHT providers. The remaining six represented the ICC providers that serve the Southeast region. Twelve of the youth had ICC serving as their care coordination “hub” while 12 had IHT serving in that role.

The SOCPR process is one component of the Commonwealth's quality monitoring infrastructure for services delivered to MassHealth enrolled youth with behavioral health challenges as part of the Children's Behavioral Health Initiative (CBHI). The values guiding the CBHI closely align with the domain areas assessed by the SOCPR (Table 3). This alignment served as one of the primary reasons why the SOCPR was selected by the Commonwealth to inform and guide current and future CBHI quality improvement efforts.

TABLE 3: CBHI VALUES AND SOCPR DOMAINS

CBHI values	SOCPR domains
Child-centered and family-driven	Child-centered and family-focused
Strengths-based	
Culturally responsive	Culturally competent
Collaborative and integrated	Community-based
Continuously improving	Impact

The March 2014 review represented the fourth time the SOCPR has been used by the state to gather qualitative information about the service planning and delivery process in IHT and the third time it has been used with ICC providers. See Table 4 for a summary of review dates by region. It is expected that by the end of May 2014 adherence to SOC principles by providers in each region of the state will have been reviewed.

² The twelve provider sites represented nine unique provider organizations.

TABLE 4: REVIEW SCHEDULE BY STATE REGION

Review dates	Metro/ Boston	Northeast	Southeast	Central	Western
June 3-7 2013 (training round)	X				
June 24-26 2013 (training round)	X				
October 21-22 2013		X			
January 14-16 2014 (training round)				X	
January 27-28 2014 (training round)				X	
March 17-18 2014			X		
May 12-13 2014					X

History of qualitative case reviews in Massachusetts

Between 2010 and 2012, as part of her efforts to monitor the Commonwealth’s compliance with and progress implementing the Remedial Plan approved as part of the Judgment in *Rosie D. v. Patrick*; the Federal court monitor, Karen Snyder, conducted a qualitative case review process using the Community Service Review (CSR) protocol. In the two year period that CSR reviews took place, the service delivery and planning process for 281 youth and families who received ICC and/or IHT was reviewed. Following the end of the CSR reviews, the Commonwealth chose to implement its own case review process. The Commonwealth selected the SOCPR protocol rather than continue with the CSR given its: aforementioned alignment with CBHI values, research validation, streamlined data collection processes that reduce provider and reviewer burden, and its more structured interview protocol which promotes consistency among reviewers and more reliable data collection.

In January 2013 the Commonwealth procured, the [Technical Assistance Collaborative, Inc. \(TAC\)](#), a Boston-based nonprofit human services consulting firm, to assist in managing implementation and operation of the SOCPR process over the next several years.

Methodology

Reviewer training

In early June 2013, a cadre of 12 reviewers comprised of family members, service providers, state employees, and researchers participated in one and a half days of training on use of the SOCPR protocol conducted by USF. In advance of the live training, reviewers were also expected to participate in a one and a half hour online training to familiarize themselves with the protocol. Following the training, each of the Massachusetts reviewers was paired with an expert reviewer from the USF team which included individuals from a provider agency in Tampa, the state of Arizona, and a provider agency in Ottawa, Canada. On the first day of reviews the Massachusetts reviewer shadowed their partner as he/she conducted interviews, and on the second day the Massachusetts reviewer served as the lead interviewer with their expert partner coaching them through the process. On the final day, the partners compared their ratings to arrive at a consensus score for each review. Reviewers also participated in a group debriefing at the end of the review week.

At the end of June, the newly trained Massachusetts reviewers were partnered to conduct reviews. One served as the lead reviewer while the other shadowed, switching roles on the second day. Similar to the early June review round, the teams compared ratings to arrive at a consensus score for each review and participated in a group debriefing. The USF team participated in a portion of the debriefing via conference phone to clarify any questions and address concerns raised by the Massachusetts team.

An additional five Massachusetts-based reviewers were trained during the January 2014 review cycle. The January training was conducted by the Technical Assistance Collaborative with each new reviewer partnered with an experienced Massachusetts-based SOCPR reviewer.

Provider selection

For the March SOCPR review, it was determined that the care of 24 youth from 12 provider sites in the Southeast region would be reviewed. Twelve of these youth were to have ICC serving as their “hub” provider, therefore having primary responsibility for care coordination. The other half had IHT serving as their hub. All six ICC providers in the Southeast region were selected to participate. According to the September 2013 Community Service Agency (CSA) Access Report, the Southeast ICC providers were serving approximately 865 youth, ranging from a high of 224 youth to a low of 98, with an average capacity of 144.

Data from the September 2013 MABHA report was used to randomly select six IHT providers serving the Southeast region. According to the report there were 19 IHT providers with 27 sites in the Southeast region serving 1,607 youth, ranging from 176 to zero, with an average capacity of 60. By comparison, the six selected provider sites reported serving a total of 518 youth or 32% of the youth participating in IHT in the Southeast region. The capacity of the six selected sites ranged from a high of 123 youth to a low of 53 youth, with an average capacity of 86 youth.

Youth selection

Once the providers were identified, MassHealth requested that selected ICC providers prepare a report including the names of all currently enrolled youth, and IHT providers prepare a report including only those youth who were enrolled in IHT without concurrent enrollment in ICC. MassHealth then sent the completed reports to TAC. TAC randomly selected 15 youth per provider, purposely oversampling in case some youth/families declined to participate. This list of 15 youth was then sent back to the program director with a request to supply additional information necessary to proceed with the consent and scheduling process (e.g. primary language of the family, age of youth, etc.). Program directors returned their completed lists to TAC which then randomly selected two youth per site for the providers to approach to obtain consent (see description of consent process below). If a family declined, providers were asked to contact TAC so another youth from the verified list of youth could be selected to participate. This process continued until the target of two youth from each of the selected organizations was reached for a total of 24 youth, two per provider site.

To reach the goal of 24 reviews for the Southeast review round, a total of 41 families were asked to participate in the SOCPR. Of those families who either declined or were unable to participate approximately 35% were enrolled in ICC and 65% were enrolled in IHT. The most

common reason why families declined to participate related to them feeling anxious about having “strangers” in their homes and being overwhelmed by the prospect of adding an additional task/responsibility to their already busy lives.

TABLE 5: REASONS FOR NOT PARTICIPATING

Reason	N of families
Anxious/overwhelmed	8
Unavailable/out of town	2
Medical reasons	2
Unable to be contacted	2
Other	3
Total	17

Consent process

In January 2014, TAC hosted a webinar for the randomly selected providers to educate them about the consent and scheduling processes. A copy of the presentation is located in Appendix A. Following the webinar, IHT clinicians or care coordinators for the randomly selected youth approached the youth (if 18 or older) or the parent/caregiver to ask if they would be willing to participate in the SOCPR process. Parents and youth over 18 were informed that their participation in the SOCPR process was voluntary and would not impact their service delivery if they chose not to participate. They were also informed that they would receive a gift card to Target upon completion of their interview. If the youth or parent agreed, they were asked to sign a consent form and the necessary release of information forms. Providers also explained the SOCPR process to those youth between the ages of 12-17 whose parents had agreed for them to be interviewed and obtained their written assent to participate.

Sample copies of the consent, assent, and authorization to release forms are located in Appendix B.

Scheduling process

Providers scheduled a minimum of three interviews (with a preference for four) with the following key informants: 1) the parent/caregiver; 2) the youth if 12 or older; 3) the IHT clinician or care coordinator; and 4) a second formal provider who was familiar with the care provided to the youth (e.g. family partner, DCF worker, outpatient therapist, etc.). If the youth was under 12 the provider worked with the youth/family to select an alternate provider who was familiar with the care delivery and planning process to participate in an interview. A review of the youth’s record at the provider agency preceded the interviews. It is important to note that for an SOCPR administration to be considered valid a minimum of three data points (the record review and two interviews) are necessary.

SOCPR description

The SOCPR collects and analyzes information regarding the process of service delivery to document the service experiences of youth and their families, and then provides feedback and

recommendations for improvement to the system. The process yields thorough, in-depth descriptions that reveal and explain the complex service environment experienced by youth and their families. Feedback consists of specific recommendations that can be incorporated into staff training, supervision, and coaching, and may also be aggregated across cases at the regional or system level to identify strengths and areas in need of improvement within the system of care. In this manner, the SOCPR provides a measure of how well the overall system is meeting the needs of youth and their families relative to system of care values and principles.

The reliability of the SOCPR has been evaluated, and high inter-rater reliability has been reported in its use.³ The validity of the protocol is supported through triangulating information obtained from various informants and document reviews. The SOCPR was found to distinguish between a system of care site and a traditional services site. Moreover, Hernandez et al. found in their study that the SOCPR identified system of care sites as being more child-centered and family-focused, community-based, and culturally competent than services in a matched comparison site offering traditional mental health services.⁴ System of care sites were more likely than traditional service systems to consider the social strengths of both youth and families and to include informal sources of support such as extended family and friends in the planning and delivery of services. In addition, Stephens, Holden, and Hernandez⁵ found that the SOCPR ratings were associated with child-level outcome measures. In their comparison study, Stephens and colleagues discovered that youth who received services in systems that functioned in a manner consistent with system of care values and principles compared with traditional services had significant reductions in symptomatology and impairment one year after entry into services, whereas youth in organizations that did not use system of care values demonstrated less positive change.

SOCPR method

The SOCPR uses a case study methodology informed by caregivers, youth, formal providers, and extant documents related to service planning and provision. The SOCPR relies on data gathered from interviews with multiple informants, as well as through a review of the youth's record. Document reviews precede interviews and provide the reviewer with important contextual information about the youth and family's treatment history and current treatment and planning processes. The unit of analysis is the family, with each family representing a test of the extent to which the system of care is implementing its services in accordance with system of care values and principles.

The interviews are based on a set of questions intended to obtain the youth, caregiver, and service provider's perceptions of the service delivery process. Questions related to accessibility, convenience, relevance, satisfaction, cultural competence, and perceived effectiveness are included. These questions are open-ended and designed to elicit both descriptive and

³Hernandez, M., Gomez, A., Lipien, L., Greenbaum, P. E., Armstrong, K., & Gonzalez, P. (2001). Use of the system of care practice review in the national evaluation: Evaluating the fidelity of practice to system of care principles. *Journal of Emotional and Behavioral Disorders*, 9, 43-52

⁴ Ibid.

⁵ Stephens, R.L, Holden, E.W., & Hernandez, M. (2004). System-of-care practice review scores as predictors of behavioral symptomatology and functional impairment. *Journal of Child and Family Studies*, 13, 179-191.

explanatory information that might not be found through the record review. The questions provide the reviewer with the opportunity to obtain information about the everyday service experiences of the youth and family and thereby gain a glimpse of the life experience of a youth and family in the context of the services they have received.

Ratings are supported and explained by reviewer's detailed notes and direct quotes from respondents to provide objective, evocative, and in-depth feedback. The findings are used to document the specific aspects of service delivery that are effective or that need to be further developed and improved to increase fidelity to the system of care approach. One of the strengths of the SOCPR derives from its production of both quantitative and qualitative data.

SOCPR domains

The SOCPR assesses four domains relevant to systems of care: 1) Child-Centered and Family-Focused, 2) Community-Based, 3) Culturally Competent, and 4) Impact.

Domain 1, Child-Centered and Family-Focused, is defined as having the needs of the child and family dictate the type and combination of services provided by the system of care. It is a commitment to adapt services to children and families, as opposed to expecting children and families to conform to preexisting service configurations. Domain 1 has three sub-domains: a) Individualized, b) Full Participation, and c) Care Coordination.

Domain 2, Community-Based, is defined as having services provided within or close to the child's home community in the least restrictive and most appropriate setting possible, and coordinated and delivered through linkages between a variety of providers and service sectors. This domain is composed of four sub-domains: a) Early Intervention, b) Access to Services, c) Minimal Restrictiveness, and d) Integration and Coordination.

Domain 3, Culturally Competent, is defined by the capacity of agencies, programs, services, and individuals within the system of care to be responsive to the cultural, racial, and ethnic differences of the population they serve. Domain 3 has four sub-domains: a) Awareness, b) Sensitivity and Responsiveness, c) Agency Culture, and d) Informal Supports.

Domain 4, Impact, examines the extent to which families believe that services were appropriate and were meeting their needs and the needs of their children. This domain also examines whether services are seen by the family to produce positive outcomes. This domain has two sub-domains a) Improvement and b) Appropriateness.

Taken individually, these measures allow for assessment of the presence, absence, or degree of implementation of each of the domains and sub-domains. Taken in combination, they speak to how close a system's services adhere to the values and principles of a system of care. The findings can also highlight which aspects of system of care-based services are in need of improvement. Ultimately, results provide the basis for feedback, thus allowing a system's stakeholders to maintain fidelity to system of care values and principles.

IHT supplemental questions

In addition to the standard set of questions contained in the SOCPR protocol, nine additional questions were added to the Massachusetts version of the SOCPR. The additional questions were created to assess if youth with IHT serving as their “clinical hub” are receiving all medically necessary remedial services, including appropriate care coordination. A copy of the IHT Supplemental Questions protocol is located in Appendix C.

Organization of the SOCPR

The SOCPR is organized into four major sections.

Section 1:

This section includes demographic information and a snapshot of the child’s current array of services.

Section 2:

Organizes the record review and comprises the Case History Summary and the Current Service/Treatment Plan; the Case History Summary facilitates reviewers recording key elements from the history. It also provides information about all of the service systems with which the child and family are involved (e.g., special education, mental health, juvenile justice, child welfare). It summarizes major life events, persons involved in the child’s history and current life, outcomes of interventions, and the child’s present status. Review of the treatment or care plan provides information about the types and intensity of the services received, integration and coordination, strengths identification, and family participation. The Document Review is completed prior to any interview so that the information gathered through the documents can inform and strengthen the interviews.

Section 3:

Consists of the interview questions organized by the type of informant (primary caregiver, youth, formal service provider); the interviews are designed to gather information about each of the four identified domains (Child-Centered and Family-Focused, Community-Based, Culturally Competent, and Impact). Questions for each of the four domains are divided into sub-domains that define the domain in further detail. Questions in each of the sub-domains are designed to indicate the extent to which core system of care values guide practice. Data are gathered through a combination of closed-ended and more open-ended questions. The open-ended questioning provides an opportunity for the reviewer to probe issues related to specific questions so that answers are as complete as possible. In addition, direct quotes from respondents are recorded whenever appropriate and possible.

Section 4:

Reviewers use this section to summarize and integrate the information collected in the other three sections of the SOCPR. The Summative Questions call for the reviewer to provide a rating for a statement associated with SOC core values at the level of direct practice. Reviewers rate each Summative Question on a scale from 1 (disagree very much) to 7 (agree very much) (see Table 6). SOCPR scores can range from a low of 1 to a high of 7. Scores from 1 to 3 represent lower implementation of a SOC approach. A score of 4 indicates a neutral rating, lack of support

for or against implementation. Scores in the 5 range represent good implementation of SOC principles, while those from 6 to 7 represent enhanced implementation of SOC principles.

TABLE 6: SUMMATIVE QUESTION SCALE

Disagree very much	Disagree moderately	Disagree slightly	Neither agree nor disagree	Agree slightly	Agree moderately	Agree very much
1	2	3	4	5	6	7

Starting with the Central region review, Massachusetts elected to change how reviewers organized their qualitative information in Section 4. As discussed previously, reviewers were asked to provide a narrative summary of strengths and challenges for groups of questions organized by area (e.g. assessment, intensity of services, service planning) or sub-domain (e.g. full participation, care coordination, early intervention, etc.) rather than for each individual question. This was done in order to help reviewers organize their thinking related to areas of interest and to align the qualitative data analysis more closely with quantitative data analysis. See Appendix D for how the Summative Questions were organized by area or sub-domain.

Quantitative data analysis

Mean scores were computed for the overall SOCPR score, as well as for each of the four SOCPR domains (Child-Centered and Family-Focused, Community-Based, Culturally Competent, and Impact). In addition, mean scores were computed for those sub-domains contained within the domains. Finally, each summative question was examined individually. In general, the mean score for each item of interest was an important statistic to be examined. In addition, the minimum and maximum scores, as well as the standard deviation for each item of interest, were examined.

Qualitative data analysis

As previously noted, the January and March reviews required narrative summaries of practice strengths and challenges for groups of questions organized by area (e.g. assessment, intensity of services, service planning) or sub-domain (e.g. full participation, care coordination, early intervention, etc.) rather than for each individual question.

Evaluation team members first reviewed the data without coding, allowing them to immerse themselves in the data to allow for comprehension of the “big picture,” promoting understanding of the scope and context of the region under review. Once data was reviewed and prepared for analysis (i.e. saved as Excel documents), the narrative comments were examined and coded for key themes.

Evaluation team members discussed and reconciled any differences regarding themes/trends to reach consensus. The quantitative ratings for each item were also considered in conjunction with corresponding narrative summary and any identified themes/trends to determine a general assessment for each domain.

Using these findings, this report section also highlights particular successes and challenges with regard to implementation of SOC principles for each of the SOCPR domain areas.

Results

Results of the analysis of the quantitative and qualitative data are presented below. The results are organized and presented based on the four domain areas of interest: Child-Centered and Family-Focused, Community-Based, Cultural Competence, and Impact. Findings represent the combined ratings of the summative questions and the qualitative analysis of the written responses. Demographic information that describes the characteristics of the sample is also presented.

This section also includes the results of the analysis of the IHT Supplemental Questions. Responses to these questions were analyzed separately as they are not a part of the standard SOCPR protocol but were included as part of the disengagement criteria for the lawsuit.

Demographics

Twenty-four youth participated in the Southeast SOCPR review. Twelve of the youth had ICC serving as their care coordination “hub” while 12 had IHT serving in that role. A summary of the demographic characteristics of these youth are presented in the figures below.

FIGURE 2: AGE

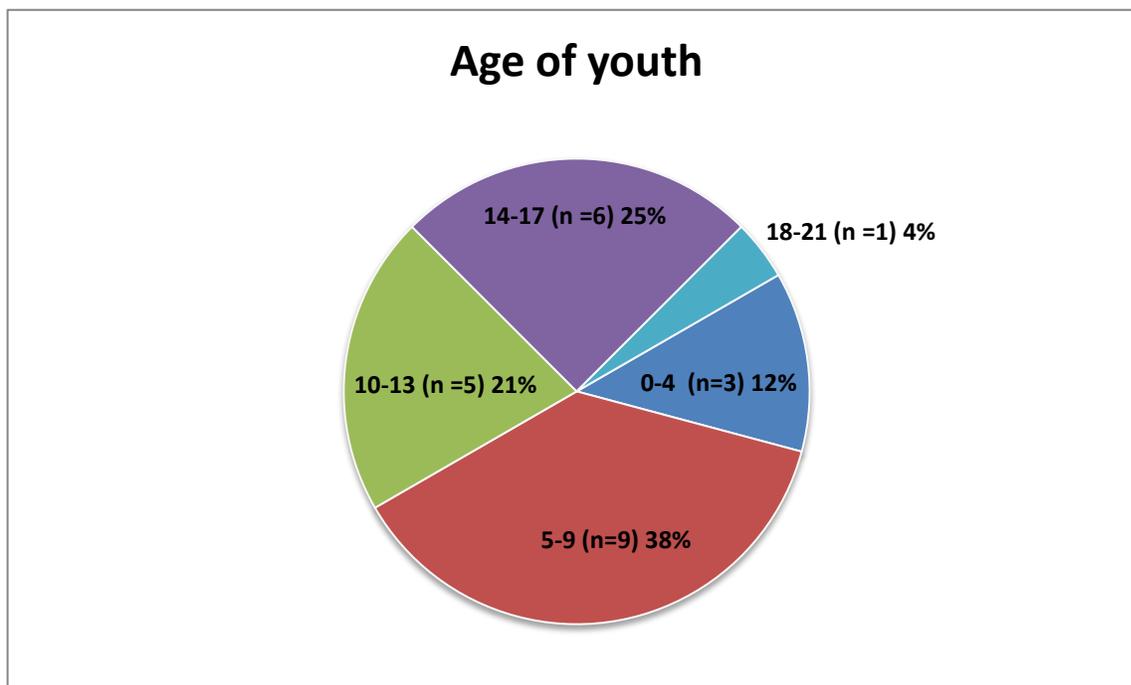


FIGURE 3: GENDER

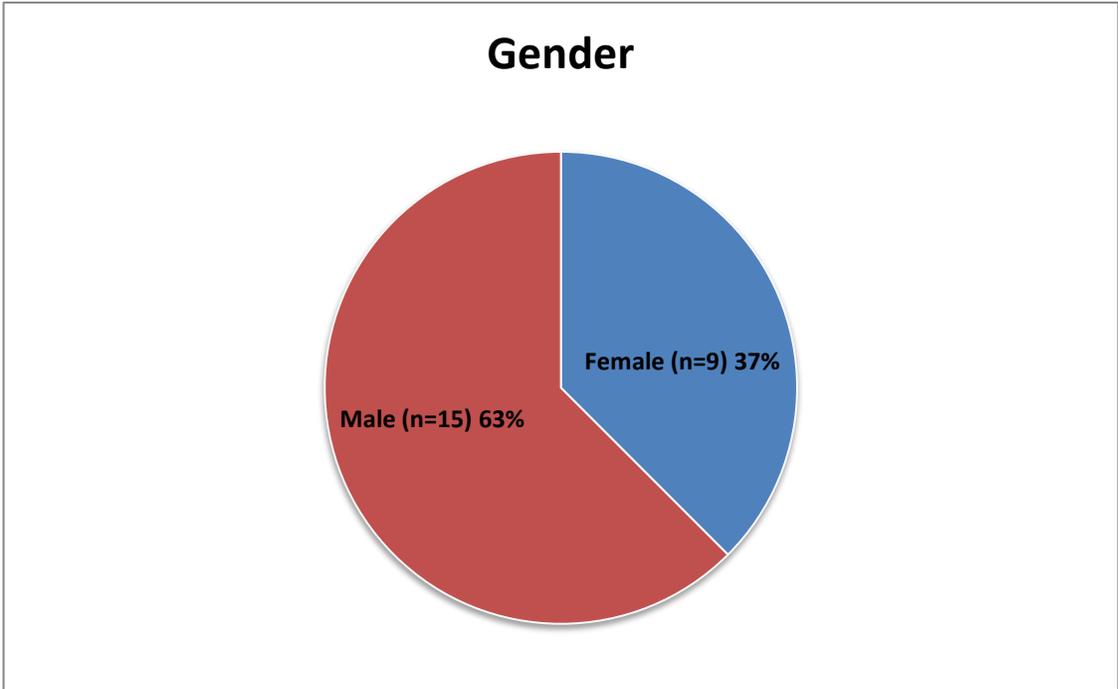


FIGURE 4: RACE

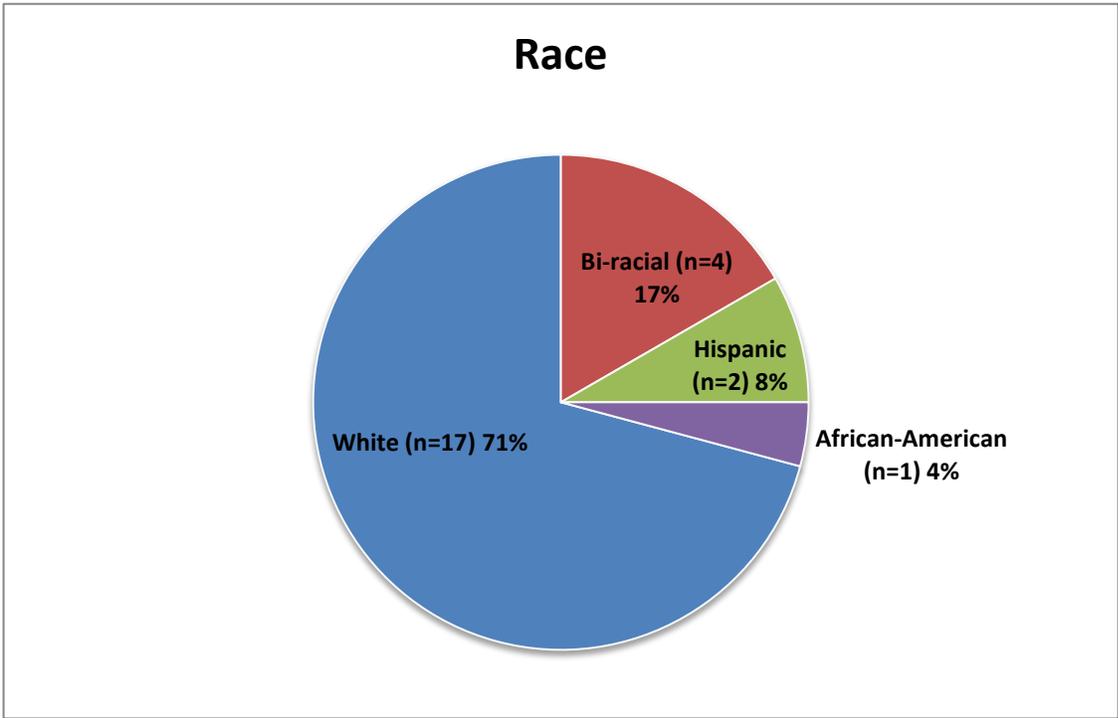
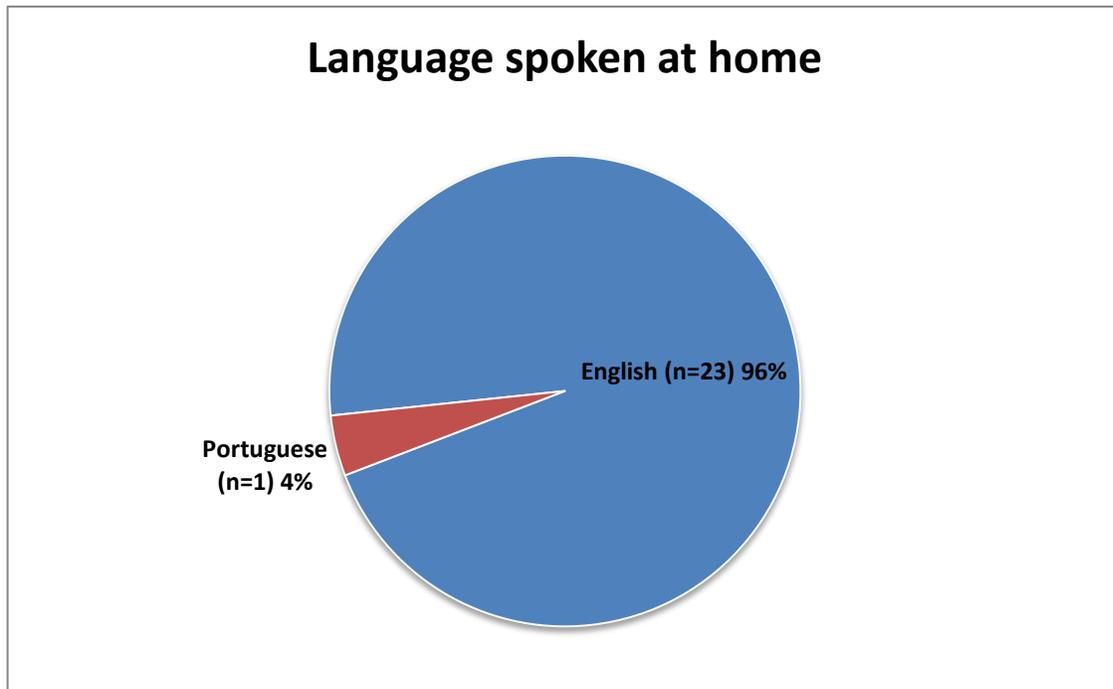
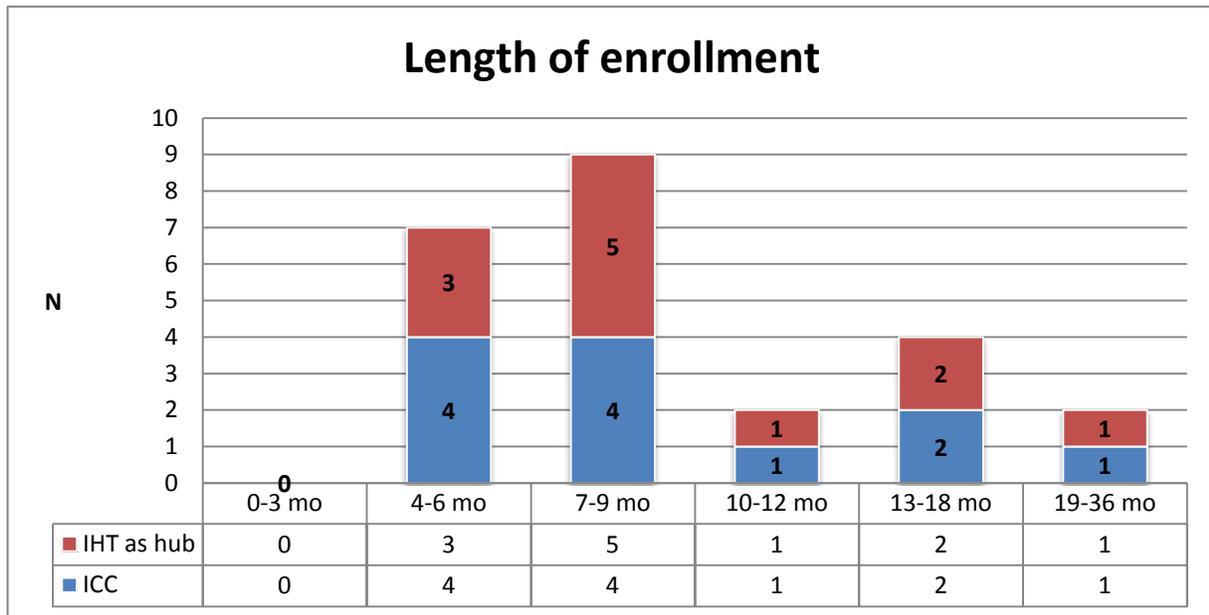


FIGURE 5: LANGUAGE SPOKEN AT HOME



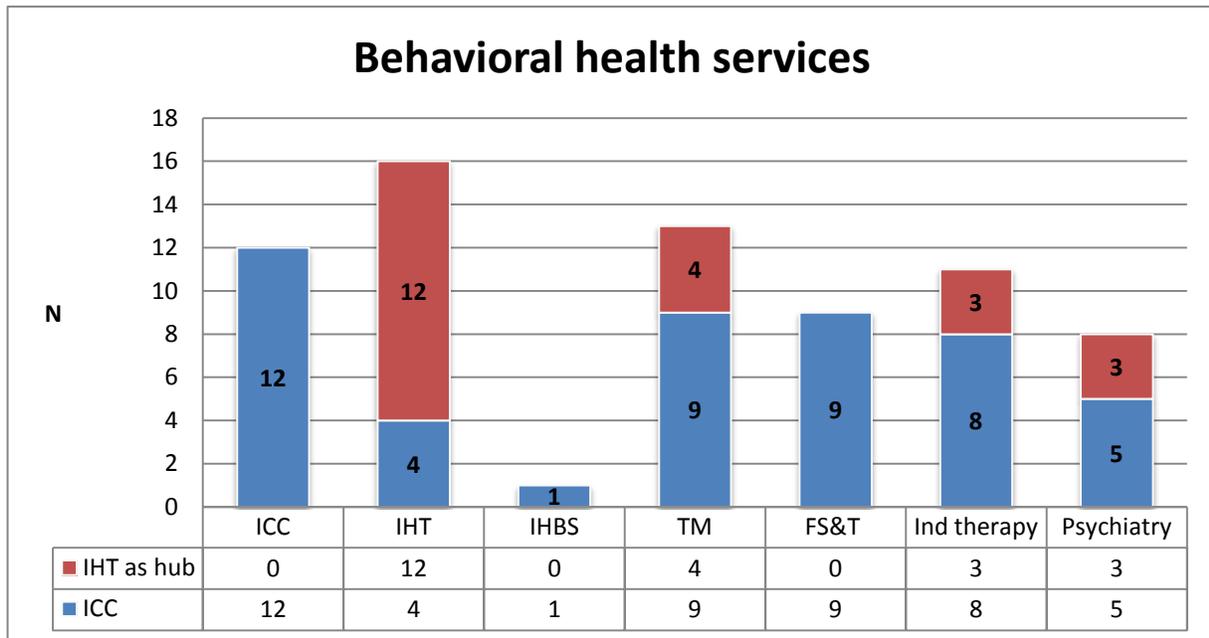
As shown above, youth between the ages of 5-9 (n = 9) represented the largest percentage of the sample at 38%, followed by youth between the ages of 14-17 (n = 6) at 25%, youth between the ages of 10-13 (n = 5) at 21%, then youth ages 0-4 (n = 3) at 12%; only one youth in the sample was between the ages of 18 and 21. Sixty-three percent (n = 15) of the youth were male. In terms of race, the majority of youth (n = 17) were White (71%), followed by those identified as Bi-racial at 17% (n = 4). Eight percent of the youth (n = 2) were Hispanic and one youth (4%) was African-American. English was identified as the language spoken at home for 96% of the families (n = 23).

FIGURE 6: LENGTH OF ENROLLMENT AT TIME OF REVIEW



At the time of the review, the largest number of youth (n = 9) had been receiving services between 7-9 months, with four of these youth enrolled in ICC and five youth enrolled in IHT. Seven youth, four youth in ICC and three youth in IHT, had been enrolled between 4-6 months and four youth, two each in ICC and IHT, had been enrolled between 13-18 months. Two youth with IHT and two with ICC were each enrolled between 10-12 months and 19-36 months. As all of the youth in the sample remained in active treatment at the time of the review, their length of stay at the time of discharge is not yet known.

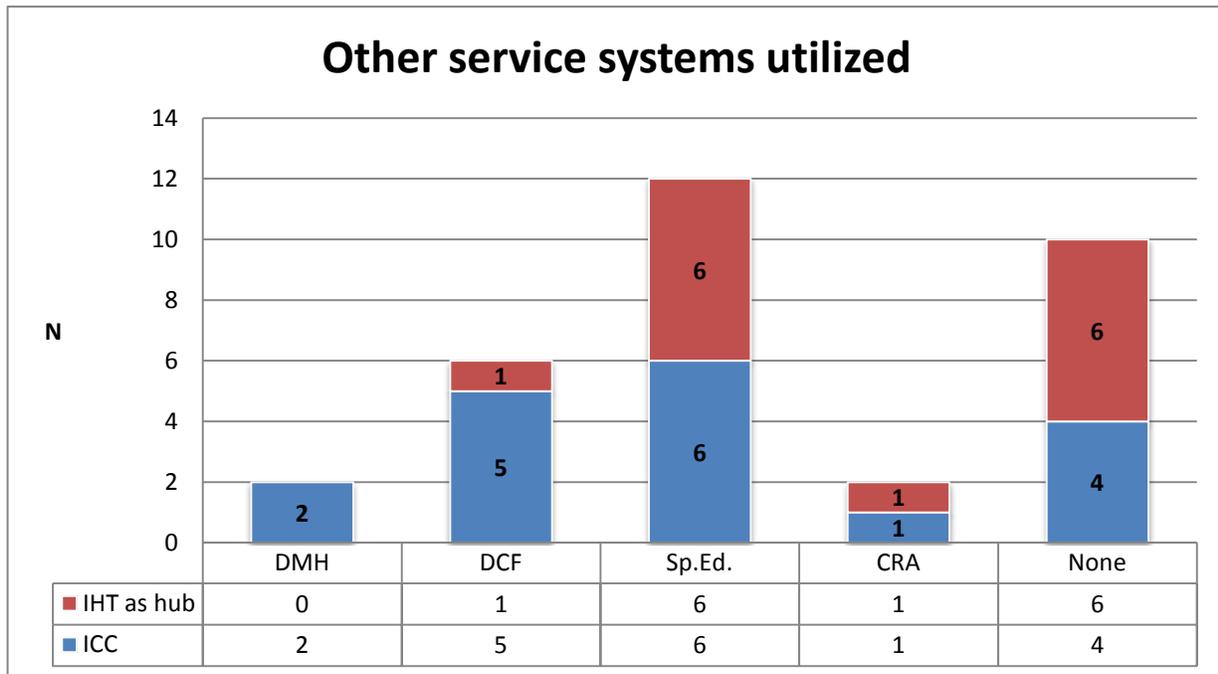
FIGURE 7: BEHAVIORAL HEALTH SERVICES UTILIZED



Note: Youth may be enrolled in more than one behavioral health service therefore the total number above is greater than 24.

The types of behavioral health treatment/interventions currently being utilized by the youth reviewed are shown in Figure 7. All of the ICC youth were enrolled in two or more additional behavioral health services; this was true of only four of the 12 youth who had IHT serving as their care coordination “hub”. Apart from ICC and IHT, Therapeutic Mentoring was the most commonly utilized behavioral health service, with 54% (n = 13) of the sample participating in that service, with the majority of those youth also participating in ICC (n = 9). Forty-six percent of the youth (n = 11) were enrolled in individual therapy, with the majority (n = 8) having concurrent enrollment in ICC. Of the twelve youth with ICC, nine of them also had a family partner (i.e. FS&T). Thirty-three percent (n = 8) were receiving medication management services from a psychiatric practitioner, with the majority (n = 5) of those being youth with ICC. One youth with ICC was also receiving In-home Behavioral Services (IHBS).

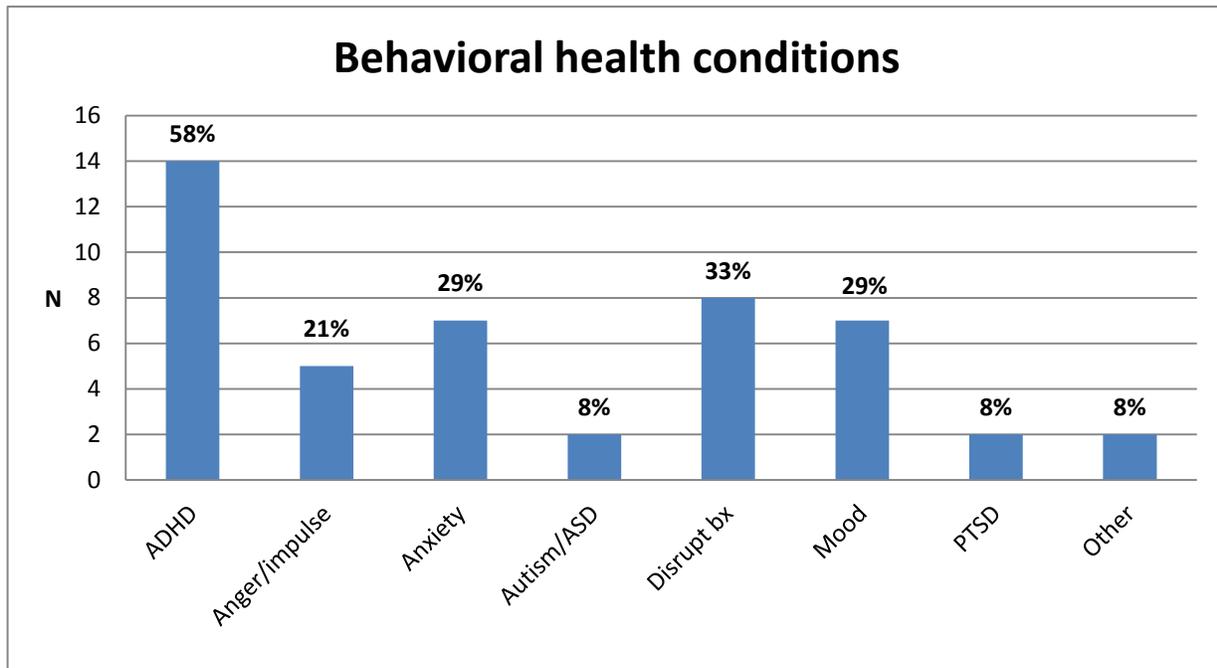
FIGURE 8: SERVICE SYSTEMS UTILIZED



Note: Youth may be involved with more than one service system therefore the total number above is greater than 24.

Of the 24 youth reviewed, fourteen youth had involvement with at least one service system. Four youth, two in ICC and two in IHT, were involved with two service systems, and two youth with ICC were involved with three systems. The largest number of youth, 12, had special education services with half of these youth enrolled in ICC and half in IHT. Of the six youth with DCF involvement, five of them were enrolled in ICC. Two youth with ICC were also involved with DMH, and two youth, one with ICC and one with IHT had informal assistance via a Child Requiring Assistance (CRA) application.

FIGURE 9: BEHAVIORAL HEALTH CONDITIONS



Note: Youth may have more than one diagnosis therefore the total above is greater than 100%.

The most common type of behavioral health condition reported among the youth reviewed was ADHD (58% or $n = 14$), followed by disruptive behavior (33% or $n = 8$), and anxiety and mood each at 29% ($n = 7$ each). The least common reported conditions were PTSD, autism, and “other” at 8% each ($n = 2$ each). It is important to note that (63%) of the youth reviewed had more than one reported behavioral health condition.

SOCPR mean domain scores

As described in the quantitative analysis section, mean scores were computed for the overall SOCPR score, as well as for each of the four SOCPR domains (Child-Centered and Family-Focused, Community-Based, Culturally Competent, and Impact). In addition, the minimum and maximum scores for families reviewed in each domain, as well as the standard deviation for each item of interest, were examined. This helped provide an understanding of the range of scores, the average score, as well as an indication of the variability from family to family. This section reports on these overall findings, and then on specific items of interest which demonstrate extreme scores.

Table 7 shows the overall score as well as those for each SOCPR domain for the entire sample of 24 families. SOCPR scores range from a low of 1 to a high of 7. Scores from 1 to 3 represent lower implementation of a SOC approach. A score of 4 indicates a neutral rating or lack of support for or against implementation. Scores in the 5 range represent good implementation of SOC principles, while those from 6 to 7 represent enhanced implementation of SOC principles.

For the Southeast region, SOCPR mean domain scores ranged from 5.60 to 6.38. The overall mean score of the cases examined was 6.01. The domain of Community-Based was the highest

scoring domain, followed by Child-Centered and Family-Focused, Culturally Competent, and finally, Impact. The scores indicate that in the Southeast region, provider agencies included in the sample performed best at including the Community-Based system of care value in service planning and provision. This is due in large part to the fact that ICC and IHT are services that are delivered primarily in home and community-based settings and are expected to be offered at times that are convenient for youth and families.

TABLE 7: SOUTHEAST REGION SOCPR DOMAIN SCORES

	Min	Max	Mean	Standard Deviation	95% CI Lower Limit	Upper Limit
Overall	4.08	6.88	6.01	.95	5.63	6.39
Domain 1: Child-Centered Family-Focused	3.38	6.94	5.95	1.08	5.51	6.38
Domain 2: Community-Based	4.55	7.00	6.38	0.68	6.11	6.65
Domain 3: Culturally Competent	3.90	7.00	5.90	1.05	5.48	6.32
Domain 4: Impact	1.50	7.00	5.60	1.41	5.04	6.17

Histograms were drawn to illustrate the range of SOCPR scores for the overall case and the four SOCPR domains. These figures are presented below. Sixty-three percent (15 of 24 cases) fell into the 6 range representing enhanced SOC implementation, and four cases (17%) scored in the 5 range, reflecting good SOC implementation.

Five cases (21%) had means in the 4 range. The lowest overall scoring case was an IHT case which also had the lowest score in the Child Centered and Family Focused Domain, primarily due to the lack of a thorough assessment combined with an outdated service plan that did not identify or incorporate any family/youth strengths, as well as lack of follow through to connect the youth with important services reflective of current needs. The second lowest scoring case was of an ICC case that was also the lowest scoring in the Cultural Competence and Impact Domains. While the family had many services in place, it was clear that more intensive services (i.e. IHBS) were necessary to stabilize the youth – all formal providers and the mother expressed frustration over the lack of progress as a result of the current services. Separate from this, there were also issues related to the ICC’s lack of awareness regarding the impact of culture on the dynamics of the helping relationship with the family.

Of the remaining two lowest scoring cases, both were IHT cases. One scored the lowest on the Community-Based Domain due to lack of appropriate integration and care coordination by the IHT clinician; this individual’s lack of experience and proper supervision translated to poor service planning, delivery, and outcomes for the youth/family. The other case reflected service planning and delivery that was not fully responsive to the needs of the family as a whole across domains.

FIGURE 10: OVERALL MEAN SCORES

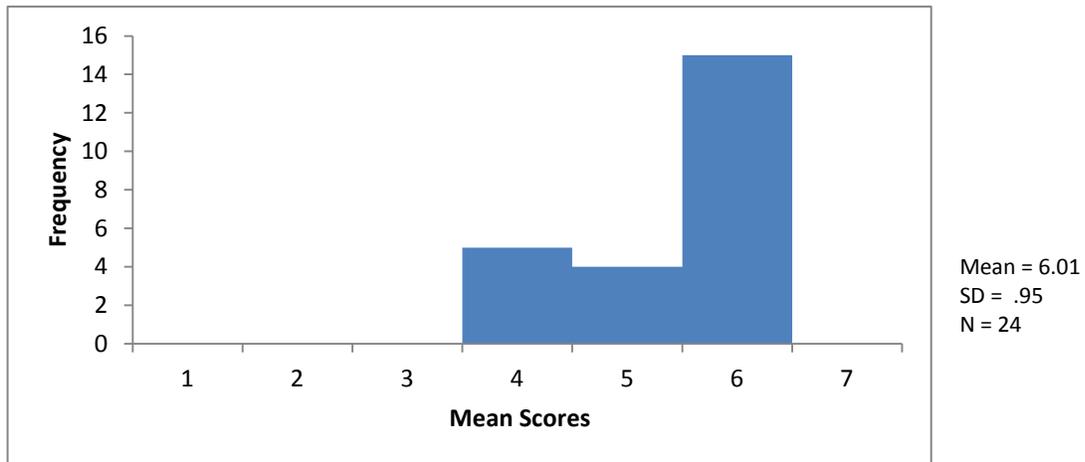


FIGURE 11: CHILD-CENTERED AND FAMILY-FOCUSED MEAN SCORES

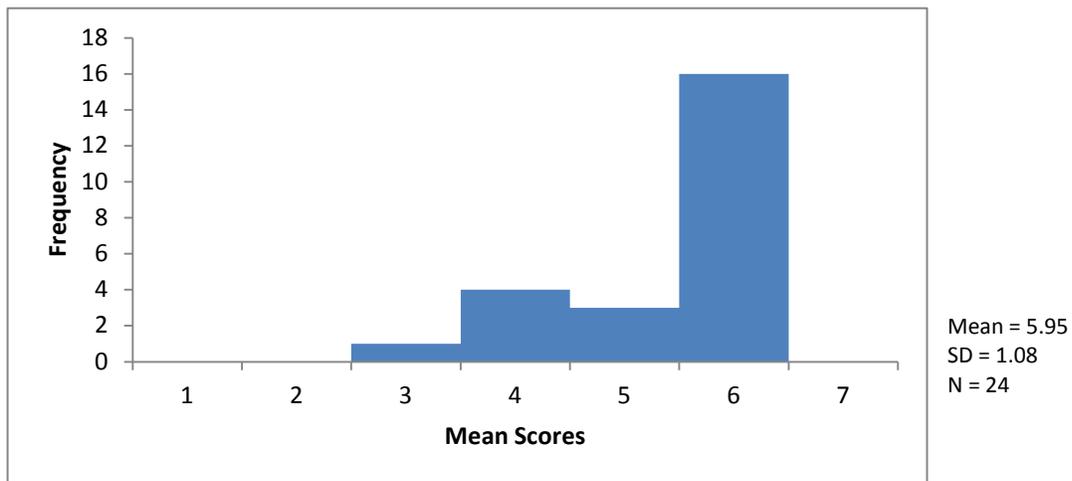


FIGURE 12: COMMUNITY-BASED MEAN SCORES

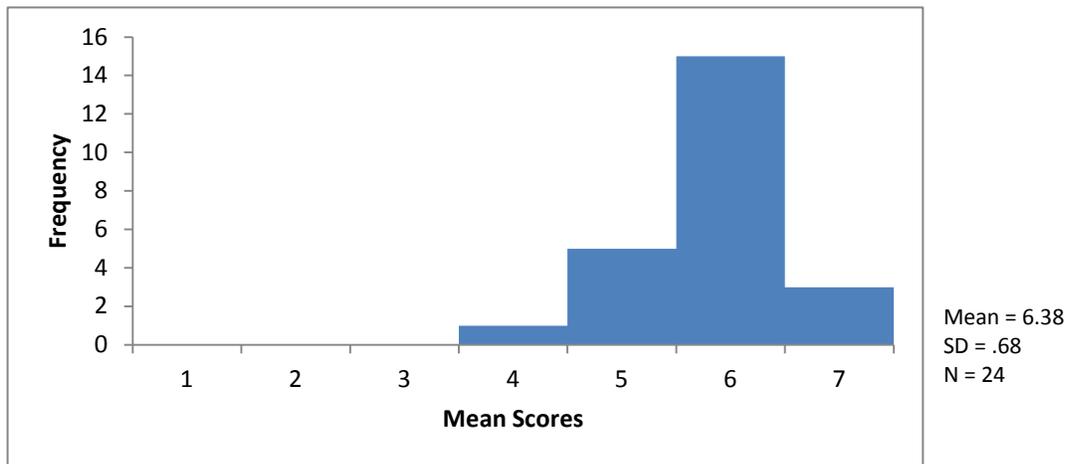


FIGURE 13: CULTURALLY COMPETENT MEAN SCORES

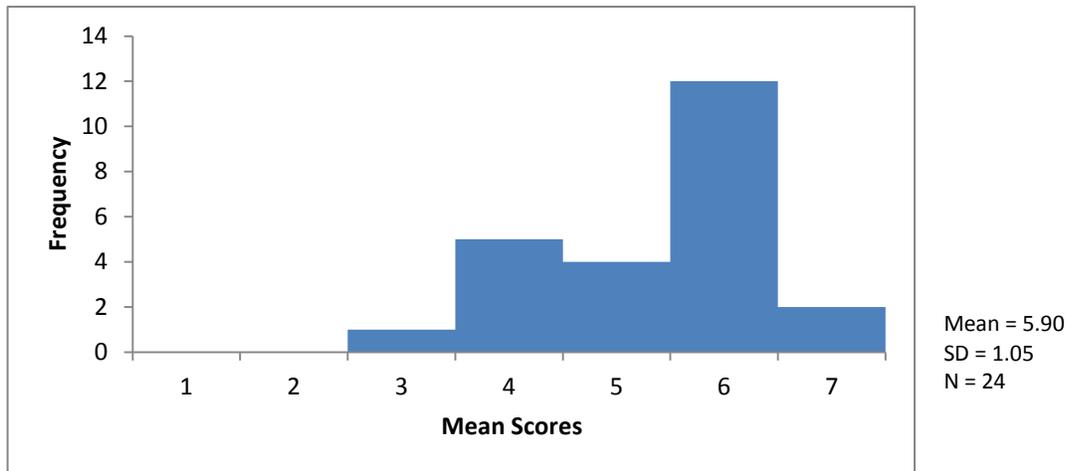
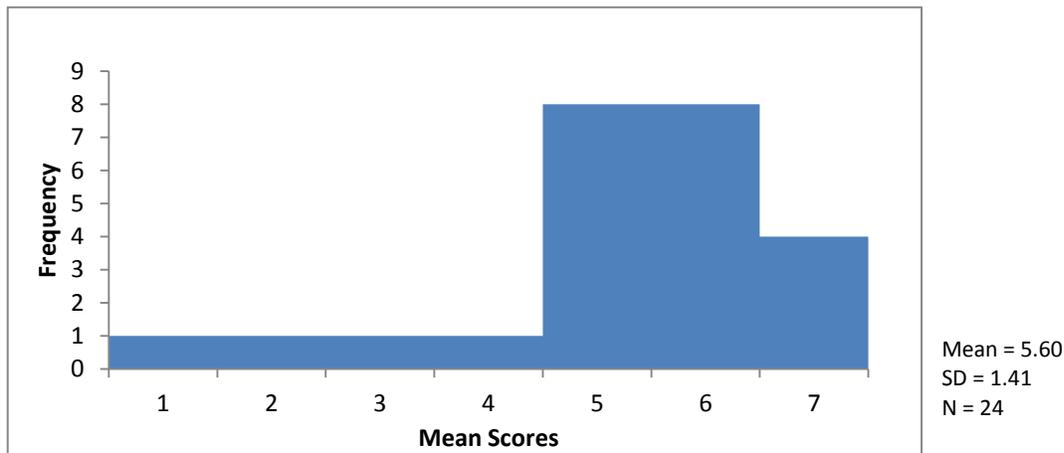


FIGURE 14: IMPACT MEAN SCORES



SOCPR individual question scores

The following data are the mean scores, frequency counts, and percentages of responses for each individual question of the SOCPR based on a sample of 24 families for the Southeast region. Data are presented by the sub-domains and areas within each domain.

Domain 1: Child-Centered and Family-Focused

The first domain of the SOCPR is designed to measure whether the needs of the youth and family determine the types and mix of services they receive. This domain reflects a commitment to adapt services to the youth and family rather than expecting them to conform to preexisting service configurations. The review reflects the effectiveness of the site in providing services that are individualized, that families are included as full participants in the treatment process, and that the type and intensity of services provided is monitored through effective care coordination. The sub-domains, which reflect system of care principles and contain measurements of practice or system of care implementation, are: *Individualized*, *Full Participation*, and *Care Coordination*.

The Child-Centered and Family-Focused domain had a mean score of 5.95 which reflects good implementation of this SOC principle. In general, analysis of quantitative and qualitative data provided by SOCPR raters suggests that Southeast providers are delivering services that are child-centered and family-focused. Mean scores for 16 youth (67%) fell in the 6 range indicating enhanced implementation of this principle, and three youth (13%) had mean scores in the 5 range reflecting good implementation. Four youth (17%) had mean scores in the 4 range and one (4%) was in the 3 range, suggesting lower implementation of this principle for these cases.

Mean scores in this domain were generally positive overall. Reviewers indicated that providers did well at completing thorough assessments across life domains, and that youth and families were actively participating in service planning and delivery. One area identified for potential improvement overall involved better incorporation of child and family strengths into service plan goals. IHT providers in particular need to pay better attention to providing service and supports at a level of intensity that is reflective of the needs and strengths of youth/families, and to overall coordination of the planning and delivery of services.

Sub-domain 1a: Individualized

The *Individualized* sub-domain includes four general areas: Assessment/Inventory, Service Planning, Types of Services/Supports, and Intensity of Services/Supports.

Assessment/Inventory: This first area contains three questions focused on the assessment conducted with the youth and family. Seventy-nine percent (79%) of reviewers agreed moderately or very much that a thorough assessment was conducted across life domains. Further, about 67% of reviewers agreed moderately or very much that the needs of the youth and family had been identified and prioritized, and 79% agreed that the strengths of the youth and family had been identified. Reviewer comments reflecting strengths in these areas included:

- “In general, the assessment was a combination of CANS and a very good Comprehensive Home-Based Assessment. Strengths of both the mother and child were well specified.”
- “Comprehensive service assessment completed and CANS. Strengths and needs of youth have been clearly identified. All appropriate domains were addressed.”
- Multiple assessment tools utilized to assess needs and strengths across all life domains.”
- “Thorough assessment using multiple instruments. All areas of assessment were covered.”
- “The records had a comprehensive assessment and contained information on the youth’s history, needs/concerns and strengths.”
- “Needs were prioritized based on assessment. The strengths section was very well done, with many strengths identified.”

In some cases, reviewers mentioned specific life domains that were assessed and being addressed in addition to mental health including education, safety, social/recreational, and legal. Nevertheless, several reviewers noted that not every life domain had been covered in the assessments, and also specifically mentioned when relevant historical information or

information from other systems (e.g., education) was missing on the youth and/or family. Attention to the needs of caregivers rather than solely focusing on the youth was also noted in a few instances as a deficit.

Service Planning: The second area of focus within the *Individualized* sub-domain is the service plan. Only fifty-eight percent (58%) of reviewers agreed moderately or very much that the service plan was integrated across providers. In many instances, reviewers reported that while the service plan is shared with other providers, there was no unified or single plan that was integrated across providers. In some cases reviewers specifically noted where other providers (e.g., schools, individual therapists, TT&S, day care providers) had input through the ICC or IHT despite not being directly involved in service planning.

Approximately 75% of reviewers agreed that the service plan goals reflected the needs of the youth and family. One reviewer stated, “service planning includes family voice about concerns and has been tailored to family’s and youth’s specific and unique needs.” A noteworthy comment from another reviewer is as follows: “The IHT service plan is one of the clearest and best thought out that I have seen...The whole team knows the plan and agrees with the priorities. As the needs have changed...the team has met to review and revise.” While another reviewer stated that “the service plan goals reflect the needs/concerns and strengths of the youth and family.” While other reviewers similarly reported that service plans goals appeared flexible and/or current based on changing needs, some felt there were goals that should have been added based on additional needs that were identified. Additionally, one reviewer noted that “service plan goals are focused exclusively on the child. No family goals have been included.”

Only 46% of reviewers agreed that service plan goals incorporated the strengths of the youth and family. One reviewer commented that “the goals in no way reflected the strengths of the family and the clinician had difficulty verbally identifying any strengths.” Another similarly stated that “the plan did not speak at all to the strengths of the youth or family and the clinician/TT&S had a hard time even expressing what the strengths were.” In one instance, a reviewer noted that goals did not appropriately represent the strengths of the family as they were reportedly “always in crisis”, making it difficult to balance addressing strengths because “the focus tended to fall on the needs of the family.” In another case, it was reported that the “plan includes strengths of caregiver but little on the youth.”

A separate question asked if there was evidence that the provider had “informally” acknowledged and incorporated strengths into the service planning and delivery process. Seventy-five percent (75%) of reviewers agreed that providers did. One reviewer commented that “use of strengths was not well articulated in plan although providers seemed to rely on caregiver strengths and extended family strengths.” Another reviewer stated that “it was not evident in the service plan that the strengths of the family were used, but upon having conversation with the parent, youth and clinician, all the parties were able to identify the strengths of the family and the ways the clinician and TT&S utilized them in individual sessions.”

Types/Intensity of Services/Supports: The final two areas in this sub-domain focus on whether the types and the intensity of services and supports provided to the youth and family reflect their needs and strengths. About 75% of reviewers agreed moderately or very much that the types of services/supports provided did reflect needs and strengths. Reviewers generally reported that services were connected to the identified needs and strengths of youth and families. One reviewer commented that “the services and supports reflect and meet the needs of this family (e.g., the TM was selected because the team identified the need for the youth to have a male role model, this has been a great match for this youth and was identified as the best support for this youth). Another reflected that “IHT has been the perfect match for this youth and family. Family and youth have been more and more comfortable with IHT in the home and they have accomplished a lot.”

One noted that while the in home aspect of the IHT service was helpful, “it did not appear to be working with the youth around some of the key need areas, e.g., education, sibling tension.” Some reviewers also noted other services which may have been beneficial for youth and families which were not being accessed (e.g., individual therapy, IHBS, TM, as well as informal supports). One reviewer wondered whether ICC was really needed commenting that “IHT said she referred to ICC because she does not have time to do care coordination – she was a large OP caseload and just a few IHT cases. Services might have been more appropriately managed by more intensive use of IHT.”

About 75% of reviewers agreed that the intensity of services/supports reflected needs and strengths, although this was true for 92% of ICC cases versus only 58% of IHT. Reviewers of ICC cases noted things like “all team members agreed that the intensity of the services/supports was just right” and “the intensity being delivered is exactly what the caregiver can handle’, although in one instance the intensity was too great for the caregiver and additional services (IHT, TT&S, TM) were discontinued.

Among IHT cases reviewed, it appeared that while the intensity of IHT services may have been appropriate, the role and/or intensity of additional services were of concern. For several youth, reviewers commented that because needed services or supports had not yet been put in place, the intensity of services/supports provided to the family did not reflect their needs and strengths.

TABLE 8: SUB-DOMAIN 1A INDIVIDUALIZED

SUBDOMAIN: 1a: Individualized	Mean	Disagree very much n (%)	Disagree moderate ly n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Area: Assessment/Inventory								
1. A thorough assessment or inventory was conducted across life domains.	6.17	0	0	2 (8.3)	0	3 (12.5)	6 (25)	13 (54.2)
2. The needs of the child and family have been identified and prioritized across a full range of life domains.	5.71	0	1 (4.2)	2 (8.3)	0	5 (20.8)	8 (33.3)	8 (33.3)
3. The strengths of the child	5.88	0	2	0	0	3	11	8

SUBDOMAIN: 1a: Individualized	Mean	Disagree very much n (%)	Disagree moderate ly n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
and family have been identified.			(8.3)			(12.5)	(45.8)	(33.3)
Area: Service Planning								
4. There is a primary service plan that is integrated across providers and agencies.	5.54	1 (4.2)	0	2 (8.3)	0	7 (29.2)	7 (29.2)	7 (29.2)
5. The service plan goals reflect needs of the child and family.	5.92	0	1 (4.2)	1 (4.2)	0	4 (16.7)	9 (37.5)	9 (37.5)
6. The service plan goals incorporate the strengths of the child and family.	5.08	2 (8.3)	0	4 (16.7)	1 (4.2)	6 (25)	3 (12.5)	8 (33.3)
7. The service planning and delivery informally acknowledges/considers the strengths of the child and family.	5.83	0	1 (4.2)	3 (12.5)	0	2 (8.3)	7 (29.2)	11 (45.8)
Area: Types of Services/Supports								
8. The types of services/supports provided to the child and family reflect their needs and strengths.	5.75	0	2 (8.3)	2 (8.3)	0	2 (8.3)	8 (33.3)	10 (41.7)
Area: Intensity of Services/Supports								
9. The intensity of the services/supports provided to the child and family reflects their needs and strengths.	5.96	0	0	2 (8.3)	0	4 (16.7)	9 (37.5)	9 (37.5)

Sub-domain 1b: Full participation

The *Full Participation* sub-domain includes questions assessing how well the youth and family, along with service providers and informal helpers, participate in developing, implementing, and evaluating the service plan. Reviewers agreed moderately or very much 92% of the time that youth and families actively participate in the service planning process. About 88% of reviewers agreed moderately or very much that the youth and family influence the service planning process, and that the family understood the content of their plans. Strengths mentioned by reviewers related to youth and family participation in the planning process included:

- “The family has been the driving force behind the plan development...they have been active partners in the plan development and identified the needs and concerns for their family.”
- “Family is open and honest and very engaged in all aspects of treatment planning, they feel that ‘they have the final say’ in goal formulation, this includes the youth.”

- “The family is integrated fully into the planning process and appears to drive the planning process and build action steps to complete goals in plan.”
- “The treatment plan and any revisions are created with the mother’s voice. The mother is given a draft copy to edit and review with the team.”

Reviewers agreed moderately or very much 79% of the time that the youth and family were actively participating in services. In the few instances where reviewers mentioned a lack of active participation, two noted that the youth had not been engaged by the provider and therefore was a reluctant participant, while another noted that some services had been terminated due to the parent not participating -- which the reviewer ascribed to the provider’s failure to engage the parent more fully in service planning.

In terms of participation by formal providers and informal helpers, 71% of reviewers agreed moderately or very much that they were involved. This represented 83% of reviewers of ICC cases versus 58% of IHT. Several reviewers mentioned informal supports as not being engaged as part of the planning process. As discussed in other sections of this report, inclusion and participation of school personnel in service planning was noted as a particular challenge.

TABLE 9: SUB-DOMAIN 1B FULL PARTICIPATION

SUBDOMAIN 1b: Full Participation	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
10. The child and family actively participated in the service planning process (initial plan and updates).	6.63	0	0	0	0	2 (8.3)	5 (20.8)	17 (70.8)
11. The child and family influence the service planning process (initial plan and updates).	6.50	0	0	0	0	3 (12.5)	6 (25)	15 (62.5)
12. The child and family understand the content of the service plan.	6.46	0	0	0	0	3 (12.5)	7 (29.2)	14 (58.3)
13. The child and family actively participate in service.	6.42	0	0	0	0	5 (20.8)	4 (16.7)	15 (62.5)
14. The formal providers and informal helpers participate in service planning (initial plan and updates)	5.58	1 (4.2)	1 (4.2)	0	1 (4.2)	4 (16.7)	12 (50)	5 (20.8)

Sub-domain 1c: Care coordination

In the *Care Coordination* sub-domain, 79% of reviewers agreed moderately or very much that one individual appeared to be responsible for coordinating youth and family services and was doing so successfully. Almost all the reviewer comments for the ICC cases described the care coordinator as successfully coordinating the planning and service delivery process, mentioning good communication with the family and team members as the hallmark of effective coordination. While many of reviewers of IHT cases described the clinicians as successfully

delivering care coordination, there were two cases where the reviewer reported a serious lack of collaboration and communication with school personnel. For example one reviewer mentioned, “It is impossible to understand why no contact between the IHT and the school occurred until the school filed a CRA for truancy.” For the other youth with IHT the reviewer commented that, “The youth was failing out of school and the clinician was not addressing this.”

About 75% of the time reviewers indicated that service planning appears to be responsive to the changing needs of the family and that plans are updated in a timely fashion. Comments in this regard included:

- “According to the mother, whenever there has been a new or changing need (emergency placement in CBAT, change in school behavior, or issues with insurance) she calls the IHT and ‘gets a call back and a response to our needs the same day.’”
- “Service emphasis has shifted as youth’s behavior has improved and mother has developed awareness and confidence in her ability to address issues appropriately.”
- “The plan is updated based on the changing or emerging needs of the family (e.g. identification of challenges in school, identification of a need for a male TM, the need of the parent to find a job).”
- “The service plan changed to meet the family need such as marital issues or housing issues that arose.”

Despite this, in a few instances reviewers felt services were not responsive to the changing needs of the youth and family. Again several reviewers mentioned emerging truancy issues or other school problems that were not being adequately addressed through the planning process. Another family had recently become homeless and the IHT had not adjusted the plan based on this crisis for the family. For another youth with ICC the care coordinator had not modified the plan despite a lack of progress for the youth; a similar issue was reported for a youth with IHT whose plan had not been changed despite a worsening of his depressive symptoms.

TABLE 10: SUB-DOMAIN 1C CARE COORDINATION

SUBDOMAIN 1c: Care coordination	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
15. There is one person who successfully coordinates the planning and delivery of services and supports.	6.08	1 (4.2)	1 (4.2)	0	0	3 (12.5)	5 (20.8)	14 (58.3)
16. Service plan and services are responsive to the emerging and changing needs of the child and family.	5.63	1 (4.2)	3 (12.5)	0	0	2 (8.3)	8 (33.3)	10 (41.7)

Domain 2: Community-Based

The second SOCPR domain is designed to measure whether services are provided within or close to the youth's home community, in the least restrictive setting possible, and moreover, that services are coordinated and delivered through linkages between providers. The sub-domains here are used to evaluate the effectiveness of the site in identifying needs and providing supports early (*Early Intervention*), facilitating access to services (*Access to Services*), providing less restrictive services (*Minimal Restrictiveness*), and integrating and coordinating services for families (*Integration and Coordination*).

As indicated earlier, of the four SOCPR domains, the *Community-Based* domain had the highest mean score (M = 6.38). Eighteen of the 24 cases (75%) fell into the enhanced implementation range with scores in the 6 to 7 range. Another five (21%) were in the 5 range, reflecting good implementation of this SOC principle. One youth had a score in the 4 range suggesting sub-optimal performance.

The sub-domains of *Access to Services* and *Minimal Restrictiveness* scored the highest overall. This indicates that services are accessible to youth and families and are offered at convenient times, in convenient locations, and in the primary language of the family. Furthermore, services are provided in comfortable environments that are the least restrictive and most appropriate. These areas represent strengths for the Southeast providers. One area highlighted for potential improvement in the *Integration and Coordination* sub-domain involves the need for a smoother and more seamless process for connecting youth and families with additional services and supports, particularly among IHT providers. IHT providers in particular could also improve in terms of *Early Intervention* by more quickly offering the appropriate services and supports to youth and families based on their assessed needs.

Sub-domain 2a: Early intervention

In the *Early Intervention* sub-domain, reviewers agreed moderately or very much 75% of the time that providers quickly assessed and clarified the youth and family's initial concerns, and that once the needs were clarified, appropriate services and supports were initiated. The rapidness of response and intervention were mentioned by almost all reviewers (approximately 21 out of the 24) as practice strengths of Southeast region providers. Reviewer comments in this area included:

- “As soon as needs/concerns regarding the identified child were emerging, the youth was immediately enrolled into the program and services began immediately. A care plan was developed very quickly following enrollment.”
- “The family began services very quickly. Once involved in services, the parent and the ICC worked on identification of needs/concerns and strengths. Team members interviewed agreed that services happened very quickly.”
- “The youth was initially involved with O/P and easily transitioned into IHT after her stay at CBAT and a TM and TT&S were brought on fairly quickly when needs around organization, social skills, behavior management emerged.”

- “It is evident that the IHT did a good job clarifying family needs right away and offered appropriate services needed at the time.”
- “The family was pleased at the quick time frame. ICC, FP, TM all started quickly to address needs of family.”

It should be noted that differences were found in this sub-domain between the ICC and IHT cases reviewed. Reviewers of youth with ICC agreed moderately or very much 92% of the time that once needs were clarified that the appropriate combination of services and supports were offered, whereas there was only agreement for 58% of IHT cases in this regard. In these instances reviewers mentioned delays with putting identified services in place and/or challenges with the IHT offering the appropriate services based on the identified need. For one youth with IHT the reviewer mentioned that IHT services began very quickly but the youth, “would benefit from psychiatry and [the youth] will not be assessed for another three weeks or so.” Another reviewer commented that, “...the implementation of services was poorly executed, and the goals that were astutely laid out based on needs were not addressed” while another mentioned that, “The clinician had the opportunity to add a TT&S and/or TM in the beginning but did not, which may have been a benefit to this family.”

TABLE 11: SUB-DOMAIN 2A EARLY INTERVENTION

SUBDOMAIN 2a: Early Intervention	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
17. As soon as the child and family began experiencing problems, the system clarified the child and family's needs.	6.17	0	1 (4.2)	0	0	5 (20.8)	5 (20.8)	13 (54.2)
18. As soon as the child and family entered the service system, the system responded by offering the appropriate combination of services and supports.	5.71	1 (4.2)	1 (4.2)	3 (12.5)	0	1 (4.2)	6 (25)	12 (50)

Sub-domain 2b: Access to services

Three general areas comprise the *Access to Services* sub-domain: whether services were provided at *convenient times*, in *convenient locations*, and in the *appropriate language*. Reviewers agreed that services were provided to youth and families in convenient locations (96%) and at times (96%) that families indicated worked for them. Reviewers noted that services were provided in locations selected by the family, with comments like, “The team meets with the family either at home or school” and “The providers always meet at convenient locations chosen by the family.” Almost all reviewers mentioned that services were scheduled at convenient times for the family with comments such as: “Mother and youth report that they have determined when the meetings with IHT occur” and “Meetings with the family are at the family’s convenience and follow their schedule.” Another reviewer commented that the IHT provider was, “Very creative and respectful of [the mother’s] time.” In the one instance where a reviewer

reported that services were not scheduled at convenient times, they noted that the IHT team had never included the father in their sessions because, “visits are scheduled on days when he is working.”

All reviewers (100%) agreed moderately or very much that both oral communication and written documentation about services and supports were provided to youth and family in their primary language.

TABLE 12: SUB-DOMAIN 2B ACCESS TO SERVICES

SUBDOMAIN 2b: Access to Services	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Area: Convenient Times								
19. Services are scheduled at convenient times for the child and family.	6.71	0	0	1 (4.2)	0	0	3 (12.5)	20 (83.3)
Area: Convenient Location								
20. Services are provided within or close to the home community.	6.83	0	0	0	0	1 (4.2)	2 (8.3)	21 (87.5)
21. Supports are provided to increase access to service location.*	4.67	0	0	1 (33.3)	0	1 (33.3)	1 (33.3)	0
Area: Appropriate Language								
22. Service providers verbally communicate in the primary language of the child/family.	6.88	0	0	0	0	0	3 (12.5)	21 (87.5)
23. Written documentation regarding services/service planning is in the primary language of child/family.	6.88	0	0	0	0	0	3 (12.5)	21 (87.5)

*Respondents did not need to answer question 21 if they responded “Agree Very Much” to question 20.

Sub-domain 2c: Minimal restrictiveness

All reviewers (100%) indicated that services were provided in an environment that families found comfortable, and that they were provided in the least restrictive and most appropriate environment. Comments reflective of this included:

- “All services are provided within the family home and/or school setting. The caregiver finds it much easier to have services delivered in their home than ‘going someplace’.”

- “Services are provided within the child's day care setting and/or within the family home. The child and family are quite comfortable with the settings and each is the least restrictive and most appropriate environment.”
- “Parent clearly feels comfortable with where services are being provided and [it] appears [to be] the least restrictive environment to hold meetings and provide visitation.”
- “Mother is happy to have the flexibility to stay home and have the children in a comfortable environment.”

TABLE 13: SUB-DOMAIN 2C MINIMAL RESTRICTIVENESS

SUBDOMAIN 2c: Minimal Restrictiveness	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
24. Services are provided in a comfortable environment.	6.88	0	0	0	0	0	3 (12.5)	21 (87.5)
25. Services are provided in the least restrictive and most appropriate environment.	6.92	0	0	0	0	0	2 (8.3)	22 (91.7)

Sub-domain 2d: Integration and coordination

In this sub-domain, about 71% of reviewers agreed moderately or very much that there was on-going two way communication among and between all team members. In general, reviewers noted that clinical documentation and key interviews reflected good communication between service system representatives or providers and family members. Comments reflective of this included:

- “The ICC communicates with all team members, including the Family Partner, Therapeutic Mentor and the school through telephone calls and emails.”
- “The ICC maintains contact with all team members by email, telephone and text messages. She also makes sure that input is received by all provides when they are unable to attend meeting by supplying them with an "Absent Partner Form." ”
- Ongoing communication between all team members occurs on at least a weekly basis depending on issues in [the] house, sometimes more frequently.”
- “All team members and mother agree that communication is ongoing, effective, and cordial. The TM, TT&S, and IHT clinician in particular work seamlessly together.”

Communication was not consistent with all team members, however. Communication and collaboration with school personnel was specifically mentioned as a challenge in at least five of the reviews. A reviewer of an ICC case mentioned, “The ICC never communicated with school prior to accompanying parent to a meeting to prep school and help increase communication.” This lack of communication with school personnel was further detailed by a reviewer of a youth with IHT stating: “The youth has major struggles at school. The youth recently got suspended and constantly gets thrown out of class. The youth talks back to the teacher and struggles

following rules. In my review, there was no evidence that proved that IHT held meetings or directly contacted the school to help problem solve.”

Sixty-three percent (63%) of reviewers agreed moderately or very much that there was a smooth and seamless process for linking the youth and family with additional services when necessary. In two instances, one youth with ICC and one with IHT, connecting youth with psychiatry was mentioned as difficult. In another case, gaining access to a neuropsychiatry appointment was identified as problematic. Several reviewers mentioned there were delays in making referrals for services such as outpatient therapy and therapeutic mentoring that could have been of benefit to the youth. For one IHT case, the inexperience of the clinician and the turn-over of the TT&S worker contributed to difficulties with integration and coordination of care. Here again a difference between ICC and IHT was observed, whereby 75% of reviewers of ICC cases agreed there was a smooth and seamless process for linking the youth and family with additional services versus only 50% of those reviewing IHT cases.

TABLE 14: SUB-DOMAIN 2D INTEGRATION AND COORDINATION

SUBDOMAIN 2d: Integration and Coordination	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
26. There is ongoing two-way communication among and between all team members, including formal service providers, informal helpers (if desired by the family), and family members including the child.	5.63	1 (4.2)	1 (4.2)	2 (8.3)	0	3 (12.5)	8 (33.3)	9 (37.5)
27. There is a smooth and seamless process to link the child and family with additional services if necessary.	5.29	1 (4.2)	2 (8.3)	2 (8.3)	0	4 (16.7)	9 (37.5)	6 (25)

Domain 3: Culturally Competent

The third domain of the SOCPR is intended to measure whether services are attuned to the cultural, racial, and ethnic background and identity of the youth and family. Ratings provided in each sub-domain are meant to evaluate the level of cultural awareness of the service provider, whether evidence shows that efforts are made to orient the family to an agency’s culture, whether sensitivity and responsiveness is shown for the cultural background of families, and whether informal supports are included in services. The sub-domains associated with Culturally Competent Services are: *Awareness, Sensitivity and Responsiveness, Agency Culture, and Informal Supports.*

The *Culturally Competent* domain had a mean score of 5.90 which represents good implementation of this SOC principle. More than half (58%) of the youth reviewed had mean scores in the 6 to 7 range suggesting strong practice in this domain. Another four youth (17%) had mean scores in the 5 range suggesting good implementation of this SOC principle. Five

youth (21%) had mean scores in the 4 range, and one (4%) had a score in the 3 range, reflecting the need for improvement. The greatest area of strength was evident in the *Agency Culture* sub-domain, which assesses how well youth and families are assisted in understanding the culture of the agency providing them with services, the rules and regulations, and what is expected of them. Inclusion of informal or natural supports in the service planning and delivery process stood out as an area for improvement, receiving the lowest mean score (4.92) of all items in this domain.

Sub-domain 3a: Awareness

The *Awareness* sub-domain includes three general areas: Awareness of Child/Family Culture, Awareness of Provider's Culture, and Awareness of Cultural Dynamics.

Awareness of Child/Family Culture: About 63% of reviewers agreed moderately or very much that providers recognized youth within the context of their culture and their community. Sixty-seven percent (67%) agreed that providers know about the family's concepts of health and family, and understood that a family's culture influenced their decision-making process. Positive comments from reviewers in this area included:

- "Team members were aware of the family's beliefs regarding mental health, their involvement with their church, their style of communicating with other family members... and how this played a role in the decision making and planning process."
- "The family believes the team truly understands their culture...the team had good understanding of family's values and beliefs and concept of health."
- "The team has respected and used the cultural knowledge to work with family."
- "ICC and FP are respectful and a good support to the family and understand the family dynamics."
- "IHT provider appears to strongly understand the family's cultures."
- "IHT has an awareness and sensitivity to family's make-up and culture and values that she uses in her interventions with them."

When reviewers noted concerns in this area, they reported that providers appeared to not have given much thought to the impact and/or having discussed it with the family despite being aware of certain cultural issues.

Awareness of Provider's Culture: Seventy-one percent (71%) of reviewers indicated that providers understood their own values and principles and how that might influence how they worked with youth and families. Further, this represented 83% of ICC cases versus 58% of IHT cases reviewed. Comments from reviewers indicated that most providers were able to articulate their own values and culture, how they were similar to or different from the youth and families they served, and what of any impact this had on their interactions. Several reviewers noted however that some providers had not reflected on their own culture or did not think it relevant, and therefore had limited awareness of how their own values and beliefs might impact their work. This was the case slightly more often for the IHT cases reviewed. Conversely, a practice strength identified during one IHT case review was that "within the Assessment Document, there is a section dedicated to "Cultural Considerations" which requires the provider(s) to

complete information re: language, cultural identify, cultural rituals, cultural stress, and to assess whether there are any concerns with the client/family acculturation.”

Awareness of Cultural Dynamics: Sixty-three percent (63%) of reviewers agreed that providers were aware that there may be subtle cultural dynamics present between themselves and the families with whom they worked. Many reviewers mentioned that providers were able to identify how differences in culture and beliefs impacted their work with the youth/family. However, others reported that some providers had not fully explored or considered this issue.

TABLE 15: SUB-DOMAIN 3A AWARENESS

SUBDOMAIN 3a: Awareness	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Area: Awareness of Child/Family Culture								
28. Service providers recognize that the child must be viewed within the context of their own culture group and their neighborhood and community.	5.96	0	0	1 (4.2)	0	8 (33.3)	5 (20.8)	10 (41.7)
29. Service providers know about the family's concepts of health and family.	5.96	0	1 (4.2)	0	0	7 (29.2)	6 (25)	10 (41.7)
30. Service providers recognize that the family's culture, values, beliefs and lifestyle influence the family's decision-making process.	5.96	0	1 (4.2)	1 (4.2)	0	6 (25)	4 (16.7)	12 (50)
Area: Awareness of Providers' Culture								
31. Service providers are aware of their own culture, values, beliefs & lifestyles and how these influence the way they interact with the child and family.	5.83	0	1 (4.2)	2 (8.3)	0	4 (16.7)	7 (29.2)	10 (41.7)
Area: Awareness of Cultural Dynamics								
32. Service providers are aware of the dynamics inherent when working with families whose cultural values, beliefs & lifestyle may be different from or similar to their own.	5.75	0	0	3 (12.5)	1 (4.2)	5 (20.8)	5 (20.8)	10 (41.7)

Sub-domain 3b: Sensitivity and responsiveness

Scores in the *Sensitivity and Responsiveness* sub-domain showed that 75% of reviewers agreed moderately or very much that services were responsive to the values and beliefs of the youth and families, although this was true for 92% of ICC cases versus only 58% of IHT cases reviewed. The data also indicated that providers were able to take their awareness of the cultural beliefs of the families they served and translate these into action steps 63% of the time. Reviewer comments generally highlight service delivery that is responsive to family culture beliefs and values. One reviewer noted “All interventions seem to have been implemented with full awareness of and responsiveness to the youth/caregiver’s culture and values.” However, where providers had either failed to explore the family’s culture or did not fully appreciate its relevance, their service delivery practices were not fully sensitive to these issues.

TABLE 16: SUB-DOMAIN 3B SENSITIVITY AND RESPONSIVENESS

SUBDOMAIN 3b: Sensitivity and Responsiveness	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
33. Service providers translate their awareness of the family’s values, beliefs and lifestyle in action.	5.83	0	0	3 (12.5)	0	6 (25)	4 (16.7)	11 (45.8)
34. Services are responsive to the child and family’s values, beliefs and lifestyle.	5.88	0	0	4 (16.7)	0	2 (8.3)	7 (29.2)	11 (45.8)

Sub-domain 3c: Agency culture

Within the *Agency Culture* sub-domain, 83% of reviewers agreed moderately or very much that providers recognized a family’s participation in service planning and in the decision-making process is influenced by their knowledge/understanding of the expectations of the provider, and that providers assist the child/family in understanding and navigating the agencies they represent. One reviewer commented “youth and caregiver both acknowledged that expectations, policies and procedures were and have been explained to them in an ongoing way.” Another that the caregiver “showed me various pieces of information she received and is very knowledgeable about the agency and its culture.” A practice strength specifically identified in this sub-domain involved how one provider “does a great job of laying out how the Wraparound process works, especially how it is meant to empower parents. This is one of the best ways I have ever seen to educate caretakers as to how the system works. A real practice exemplar.”

Practice challenges identified were among the IHT cases and included the need to navigate and/or connect youth with other needed services, and lack of role clarity among an IHT and TT&S worked which the reviewer felt made it difficult for them accurately represent their agency’s culture.

TABLE 17: SUB-DOMAIN 3C AGENCY CULTURE

SUBDOMAIN 3c: Agency Culture	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
35. Service providers recognize that the family's participation in service planning & in the decision making process is impacted by their knowledge/understanding of the expectations of the agencies/programs/provider	6.54	0	0	0	0	4 (16.7)	3 (12.5)	17 (70.8)
36. Service providers assist the child and family in understanding/navigating the agencies they represent.	6.38	0	0	2 (8.3)	0	2 (8.3)	3 (12.5)	17 (70.8)

Sub-domain 3d: Informal supports

Only 50% of reviewers indicated that service planning and delivery intentionally included informal or “natural” sources of support for the youth and family. Comments from reviewers indicated that in many cases either informal supports had not been identified, or that family members did not want certain informal supports included. In some cases it appeared that providers had not helped the family to identify additional informal supports in the community; in a few instances this was attributed to the readiness/stability of the youth to have others involved.

TABLE 18: SUB-DOMAIN 3D INFORMAL SUPPORTS

SUBDOMAIN 3d: Informal Supports	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
37. Service planning and delivery intentionally includes informal sources of support for the child and family.	4.92	1 (4.2)	1 (4.2)	4 (16.7)	2 (8.3)	4 (16.7)	9 (37.5)	3 (12.5)

Domain 4: Impact

The *Impact* domain includes two sub-domains: *Improvement* and *Appropriateness of Services*, which are meant to determine whether services have had a positive impact on the youth and family and whether these services appropriately met their identified needs. The Impact domain had a mean score of 5.60. Mean scores for 12 youth (50%) fell in the 6-7 range suggesting that the services and supports had enhanced impact. Eight youth (33%) had mean scores in the 5 range suggesting good impact. One youth each had mean scores in the 4, 3, 2 and 1 range, respectively, suggesting the need for improvement in service delivery to improve the situation of these youth and families so their needs could be more appropriately met. It is also important to keep in mind that the youth in the sample were still in active treatment at the time of the review, with seven of the 24 youth enrolled six months or less. Therefore it would be expected that

unresolved issues for many youth remain and that treatment goals may have not yet been realized.

Sub-domain 4a: Improvement

Sixty-seven percent (67%) of reviewers agreed moderately or very much that services and supports provided to both the youth and the family as a whole helped improve their circumstances. Improvements in behavior/functioning of the youth reviewed were mentioned in 14 of the 24 cases. Examples included:

- “The child may have been spared more school expulsions and possibly hospitalizations since he is now much less disruptive and easier to manage.”
- “Child is described as much more verbal and able to follow and respond to treatment interventions.”
- [Youth] has achieved her goal of reducing tantrums by 50% (her mother reports far better than 50%). "She is able to verbally express what is wrong," says mother.

Other areas of improvement noted by reviewers included better family relationships and an increased sense of parental competency and skills in managing their youth’s behavior. One reviewer mentioned that the, “youth's mother parenting skills and follow through is improving as she builds more trust with providers” while another mentioned that, “[The] mother understands what triggers [youth] and has a good grasp of how to handle her behavior.” A couple of reviewers specifically mentioned that communication among family members had improved as a result of the services they had received, with one reviewer writing that, “There is better communication between all family members.” Several reviewers described that services had helped to improve family relationships. In describing the improvement the reviewer commented that, “...father is more involved in a positive way (parents have reunited after separation), more affectionate, more present.”

In those few cases where the reviewers disagreed that the services/supports provided to the family had improved their situation, reviewers mentioned a worsening in the youth’s functioning or behavior. For two youth reviewers mentioned a decline in school attendance or academic performance. In one ICC case the mother reported that her son was worse than when services started and she had not developed any tools to more effectively manage his behavior.

TABLE 19: SUB-DOMAIN 4A IMPROVEMENT

SUBDOMAIN 4a: Improvement		Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
38. The services/supports provided to the child and family has improved their situation.*	CH	5.54	1 (4.2)	1 (4.2)	1 (4.2)	0	5 (20.8)	10 (41.7)	6 (25)
	FAM	5.63	1 (4.2)	1 (4.2)	0	0	6 (25)	10 (41.7)	6 (25)

CH=Child; FAM=Family

Sub-domain 4b: Appropriateness

Nearly 71% of reviewers agreed moderately or very much that the services and supports being provided to the *family* appropriately met their needs, while slightly less (67%) agreed this was the case for the *youth* reviewed. One youth who began services as very isolated and withdrawn had become involved with numerous social activities during. The reviewer mentioned that the services and supports put in place by ICC were instrumental in the gains made by the youth and his family. Another reviewer of a youth with ICC mentioned that, “The family is much more prepared to handle its crises with the new tools learned.” When describing the appropriateness of IHT one family described that, “They understood our problems, gave strategies and encouragement” and went on to say that the services “saved our lives.” For another family the fact that the IHT team offered services in their home was a good match, with the reviewer writing, “Mother was very thankful for services and really thought it worked so well because the team was able to come to the house and model appropriate ways for her children to communicate and for her to work with her children.” For another family the “flexibility of services has added to the appropriateness.” IHT also reportedly had helped a family, “articulate both the problems they were having and what they have done to solve those problems.”

For those families where the reviewer disagreed that the services were appropriate, a lack of progress or worsening in behavior was reported. For one youth in ICC the team reportedly did not have a solid understanding of the youth’s behaviors which had resulted in a lack of progress and indeed a worsening of the youth’s functioning. For another family the IHT team had addressed few of the major presenting issues or concerns with the family facing eviction and the youth at risk of being held back in school due to ongoing truancy issues. One reviewer mentioned that while the family felt “supported” the IHT had not been an effective intervention for a youth with depression. A reviewer described that another with IHT was, “failing out of school and the conflict between the siblings had not been addressed” with the mother reporting that she did not want “therapy anymore.”

TABLE 20: SUB-DOMAIN 4B APPROPRIATENESS

SUBDOMAIN 4B: Appropriateness		Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
39. The services/supports provided to the child and family has appropriately met their needs.	CH	5.54	0	2 (8.3)	2 (8.3)	0	4 (16.7)	9 (37.5)	7 (29.2)
	FAM	5.71	0	1 (4.2)	2 (8.3)	0	4 (16.7)	10 (41.7)	7 (29.2)

CH=Child; FAM=Family

IHT supplemental questions results

In addition to the standard set of questions contained in the SOCPR protocol, nine additional questions were added to the Massachusetts version of the SOCPR. The additional questions were created to assess if the 12 youth in the sample with IHT serving as their “clinical hub” are receiving all medically necessary remedial services including appropriate care coordination.

Therefore, these questions were not completed for the 12 youth in the sample who had ICC serving as their clinical hub.

Question 1 inquired about the need for or receipt of multiple services and the need for coordination of those services. Reviewers indicated that 75% of the youth (n = 9) did not need a care planning team to coordinate services from the same or multiple providers.

Question 2 asked about receiving services from state agencies or special education and the need for coordination of those services. Reviewers indicated that 75% of youth (n = 9) did not need a care planning team to coordinate services from state agencies or special education.

TABLE 21: NEED FOR COORDINATION

	Response	n (%)
Q1. The youth needs or receives multiple services from the same or multiple providers. AND The youth needs are care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof.	No	9 (75)
Q2. The youth needs or receives services from, state agencies, special education, or a combination thereof. AND The youth needs a care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof.	No	9 (75)

Question 3 asked if the level of care coordination, in this case IHT, was appropriate. Sixty-seven percent (n = 8) agreed moderately or very much that the youth was receiving the appropriate level of care coordination.

TABLE 22: APPROPRIATE LEVEL OF CARE COORDINATION

	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Q3. The youth/family is receiving the level of care coordination his/her situation requires.	0	1 (8)	0	0	3 (25)	3 (25)	5 (42)

As seen in question four below, none of the youth reviewed had been previously enrolled in ICC.

TABLE 23: PRIOR ICC ENROLLMENT

	Response	n (%)
Q4. Has the youth previously been enrolled in ICC?	No	12 (100)

Question 5 showed that the option of receiving ICC had been discussed with half of the 12 families by the IHT team. For the six families where the IHT clinician discussed the option of ICC and the family declined; two families were reportedly not interested and declined, three

families felt that IHT was sufficient to meet their care coordination needs, and one family reported they did not have time to meet with an additional provider. When asked why the option of ICC was not discussed with the family, reviewers reported that they felt that the youth/family did not require the level of care coordination that ICC provides. No reason was provided by the reviewer in two cases.

TABLE 24: DISCUSSION OF ICC WITH YOUTH/FAMILY

	Response	n (%)
Q5. Has the IHT team ever discussed the option of ICC with the youth/family?	No	6 (50)

Question 6 asked if the youth needed assistance from their provider in working with the schools. For about sixty-seven (67%) of the youth, reviewers agreed moderately or very much that the youth/family needed assistance in working with the school system.

TABLE 25: NEED FOR COORDINATION WITH SCHOOL

	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Q6. The youth needs providers to coordinate/collaborate with school personnel.	1 (8.3)	1 (8.3)	0	1 (8.3)	1 (8.3)	3 (25)	5 (42)

Question 7 asked reviewers to indicate if the IHT team was in contact with all the service systems involved with the youth and family. About one-third (33%) agreed moderately or very much that the IHT team was connecting with the other service systems.

TABLE 26: CONTACT WITH PROVIDERS AND SERVICE SYSTEMS

	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Q7. The IHT is in regular contact with other providers, state agencies and school personnel involved with the youth and family.	1 (8.3)	3 (25)	1 (8.3)	0	3 (25)	1 (8.3)	3 (25)

For question 8, reviewers were asked to indicate if the multiple service systems involved with the youth participate in care planning. About one-third (33%) of reviewers agreed moderately or

very much that other providers or state agency personnel involved with the youth participate in care planning.

TABLE 27: PARTICIPATION IN PLANNING

	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Q8. Providers, school personnel or other state agencies involved with the youth participate in care planning.	2 (17)	3 (25)	1 (8)	0	2 (17)	3 (25)	1 (8)

Question 9 asked for information about the other hub dependent services that youth were receiving at the time of the review. Four youth (33%) were participating in Therapeutic Mentoring. None of the youth had a family partner nor were any participating in IHBS.

TABLE 28: OTHER HUB DEPENDENT SERVICES

Q9. Indicate the other “hub dependent” services supported by IHT	Response	n ⁶ (%)
Q9i. Therapeutic Mentoring	Yes	4 (33)
Q9ii. Family Support and Training	Yes	0
Q9iii. In-Home Behavioral Services	Yes	0

Discussion

Strengths of the service system

Overall, the findings from this review show that ICC and IHT providers in the Southeast region are generally demonstrating a system of care approach to service planning and delivery, performing best at including the Community-Based SOC value in service planning and provision. Areas of particular strength for providers in this region included:

Assessment

Thorough assessments were conducted across life domains. Southeast region providers were skilled at conducting comprehensive assessments that took into account the full range of life domains. Assessments captured the strengths and needs of the youth and families reviewed with several reviewers commenting that it was clear the provider had a solid understanding of the youth and their family. Many reviewers noted that the assessments were informed by

⁶ Represent unique youth. None of the four youth had more than one of the “hub-dependent” services.

multiple sources (e.g. interviews with youth and parents, school records, CANS, observations of youth and family, etc.) which allowed them to develop a more comprehensive understanding of the youth and his/her needs.

Full participation

Southeast region providers excelled at helping families to be *full and active participants in the service planning and delivery process*. Providers helped engage families in the service planning process, supported them in influencing the planning process (e.g. respecting family voice and choice), and ensured they understood the content of their plans. By helping foster this sense of ownership over the planning process, reviewers found that *families were actively participating in reaching their treatment goals*.

Service accessibility

Services are accessible to children and families and are offered at convenient times, in convenient locations, and in the primary language of the family. Southeast region providers were clearly respectful of the preferences of youth and families with regard to their choice of service location, appointment times, and language. Furthermore, reviewers found that *services were provided in comfortable environments that were the least restrictive and most appropriate*.

Care coordination

There was one person responsible for successfully coordinating care. Almost all the reviewer comments for the ICC cases described the care coordinator as successfully coordinating the planning and service delivery process, mentioning good communication with the family and team members as the hallmark of effective coordination. The majority of IHT cases reviewed were also strong in this area with a few notable exceptions with respect to coordination with schools in particular.

Clarification of need

Southeast region providers quickly assessed and clarified the youth and family's initial concerns. ICC providers in particular then rapidly moved to offer the appropriate combination of services and supports.

Agency culture

Providers in the Southeast recognized that a family's participation in service planning is impacted by their knowledge/understanding of the expectations of the service(s). Providers helped families understand the service(s) and educated them about the roles and responsibilities of various team members, thus setting the stage for families to be more active and engaged members of their own planning teams. *Providers were also skilled at assisting families to understand and navigate the agencies they represent*. This included important activities such as: educating families about their rights and responsibilities as a client of the agency, after-hours access, who to talk to if they have a concern about service delivery, confidentiality issues, etc. By orienting the family to the agency "culture," providers engage families as partners in the process from the beginning and can help to empower families by ensuring they have the information they need to advocate for themselves.

Opportunities for improvement

Although ratings for the majority of youth reviewed fell in the enhanced (n = 15) or good (n = 4) range, findings indicated the greatest opportunities for improvement in the following areas:

Service planning

The service planning process stood out as an area for growth for Southeast region providers. *Specifically, service plans should better incorporate child and family strengths into goals.* Interestingly providers performed well at identifying youth and family strengths, but struggled with how to turn the identified strengths into goals. Training on how to formulate strength-based goals should be explored as a potential professional development opportunity for providers.

Service planning and delivery should be more intentionally inclusive of natural supports and IHT providers in particular should work to include formal providers and natural supports in the service planning process. Engaging school personnel and natural supports in the service delivery and planning process was a particular challenge for providers in the Southeast region. While providers should be working to outreach and engage school personnel and natural supports in the planning process and helping educate them about the value of participating in a collaborative planning process, these same individuals must be willing participants. They also need support from their organizations and the larger system to do so.

Intensity of services and supports

Among IHT cases reviewed, it appeared that while the intensity of IHT services may have been appropriate, the role and/or intensity of additional services were of concern. *For several youth, reviewers commented that because needed services or supports had not yet been put in place, the intensity of services/supports provided to the family did not reflect their needs and strengths.*

Integration and care coordination

A smoother and more seamless process is needed for connecting youth and families with additional services and supports. Reviewers mentioned that in several cases there were delays in making prompt referrals for services such as outpatient therapy and therapeutic mentoring that could have been of benefit to the youth. In other instances, long waits were reported for child psychiatry services.

Early intervention

IHT providers could improve with respect to how quickly they offer the appropriate combination of services and supports. Reviewers reported concerns with how long it took for some providers to assess what the youth and family's needs were and reported delays in providers in making appropriate referrals. Redesigning intake/referral processes and procedures to allow for a more rapid determination of what types of services and supports a family may need could be an area for providers to focus quality improvement activities. An effort to more quickly gather information from multiple informants (e.g. family, teachers, therapists, etc.) and existing reports and plans (e.g. educational plans, DCF service plans, testing results, discharge summaries, etc.) about the most pressing issues and concerns facing the family could also help providers to more quickly and accurately identify pressing areas of need during the early assessment phase.

Cultural competence

IHT clinicians need to develop a greater awareness of how their own culture influences the way they interact with the youth and family. Reviewers noted that some providers had not reflected on their own culture or did not think it relevant, and therefore had limited awareness of how their own values and beliefs might impact their work. Focused supervision on this issue and raising awareness among staff via training and coaching on cultural competence should be considered to help improve service delivery in this area.

Greater responsiveness to the youth and family's values, beliefs, and lifestyle is needed on the part of IHT providers. In a few cases providers had either failed to explore the family's culture or did not fully appreciate its relevance, thus their service delivery practices were not fully sensitive to these issues.

Conclusion

Overall the results of the Southeast SOCPR reviews suggested that providers are delivering care in a way that adheres to important SOC and CBHI values, with overall domain scores suggesting good implementation of SOC principles. Sixty-three percent (15 of 24 cases) fell into the 6 range representing enhanced SOC implementation, and four cases (17%) scored in the 5 range, reflecting good SOC implementation. Southeast region providers are particularly strong when it comes to ensuring that youth and families can make best use of services by ensuring that services are provided at convenient times, locations, and in the primary language of the family. Providers ensured that services were provided in settings that were comfortable for families and were offered in the least restrictive environment. Providers in this region also excelled at conducting thorough assessments that were comprehensive and took into account the full range of life domains. Families were supported by providers to be active participants in the service planning and delivery process. Providers in particular were skilled at helping families understand service requirements and expectations; educating them about the roles and responsibilities of various team members while also assisting families to understand and navigate the agencies they represent.

While overall, practice appeared good in the majority of areas reviewed, opportunity for improvement stood out related to: inclusion and participation of natural supports in the planning process, incorporating strengths into goals, and connecting youth and families with needed services and supports. Other areas for improvement for IHT providers in particular were related to: ensuring the appropriate intensity of services and supports provided to families, including formal providers and natural supports in the planning process, intervening early to put appropriate services and supports in place, and cultural awareness and responsiveness.

This report, along with the information offered at the individual provider-specific debriefings that were convened by staff from MassHealth and EOHHS following the Southeast reviews, should be used to help inform quality improvement efforts and guide discussions with staff about the development of provider-specific strategies for building upon areas of strong performance and how service delivery to youth and families could be improved. The areas identified for growth could serve as important topics for in-service trainings, be given greater attention and focus in individual and group staff supervision, and/or become areas that are regularly reviewed as part

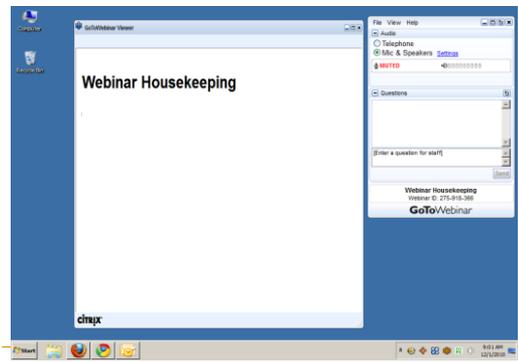
of a provider's quality assurance processes. Recommendations for specific system-level interventions will be made in the final year-end report when trends across regions can be summarized and based upon a larger number of reviews.

System of Care Practice Review (SOCPR) for CBHI

Provider Webinar on Consent & Scheduling Procedures

Kelly English and Amy Horton
Technical Assistance Collaborative
January 28 & 30, 2014

GoToWebinar: Attendee Interface



GoToWebinar Housekeeping: Time for Questions



Your Participation

- Please submit your text questions and comments using the Questions Panel

Note: Today's presentation is being recorded and will be made available to all of the participants.

3

Introduction

- Executive Office of Health & Human Services initiating new case review process to learn about care delivery in the MassHealth CBHI services
- Selected the System of Care Practice Review (SOCPR) protocol, developed by the University of South Florida (USF), to guide this process
- The SOCPR replaces the "Community Service Review (CSR)" conducted by the *Rosie D. Court Monitor*
- What is learned through the SOCPR will help us all to improve the quality of CBHI services

4

What is the SOCPR?

- Method and instrument for assessing whether System of Care (SOC) values and principles are operationalized at the practice level
- The SOCPR is **NOT** an audit but rather a structured way to learn about how services are working for youth and families
- Results will be used to help identify areas where the system is performing well and where resources should be dedicated for system improvements

5

Your Role: Consent & Scheduling

The IHT clinician or care coordinator will be asked to:

- Describe the SOCPR process & obtain informed consent and authorization(s) to release information from the youth/family
- Notify TAC in 1-2 business days to let us know if family/youth consented/did not consent to participate in SOCPR process
- Schedule interviews with a minimum of 4 respondents:
 1. Primary caregiver
 2. Youth if 12 or older (if not available then substitute with a provider familiar with the care planning process for the youth)
 3. Care coordinator or IHT clinician
 4. Family partner or TT&S worker (if not available then substitute with another provider familiar with the care planning process for the youth – therapeutic mentor, teacher, OP therapist, DCF worker, etc.)

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Consent to Participate

Consent Procedures

- IHT clinicians and care coordinators are responsible for obtaining consent from families/youth
- The primary caregiver and youth 18 or older who participate in interviews will receive a **\$25 gift card to Target**
- Print TWO copies of each consent and release to have signed by the family
 - One for the family to keep
 - One to scan/email to TAC and then to keep for agency's own records

Consent Procedures

- TAC randomly selected three youth from your provider site to approach to gain consent
- A minimum of two youth per site is necessary
- We are oversampling by one youth at each site in the likely event that a youth declines to participate

Consent Procedures

- We will assign your provider site 2 'Primary' and 1 'Alternate' youths
- Approach families of the 2 primary youths to obtain consent and schedule the interviews
- Within 1-2 days of approaching family, let TAC know if family consented or declined
- If a 'Primary' youth/family declines, approach 'Alternate' youth/family to obtain consent and schedule the interviews
- If two youths decline to participate, TAC will select the next youth from a list of 15 at the site until the target of two is achieved

Consent Procedures

- The IHT clinician or care coordinator of the **alternate youth** should **wait to contact the family** until asked to by TAC because one or both primary youth declined to participate
 - Clinicians/care coordinators of alternate youth should be well-versed in SOCPR procedures in the likely event that youth 1 or 2 declines

Youth	Day	Required Info
1- Primary	1 st Review Day	Consents, Releases & Schedule
2- Primary	2 nd Review Day	Consents, Releases & Schedule
3- Alternate <i>*Hold pending notification from TAC*</i>	Not assigned	I f youth 1 or 2 declines, approach alternate for: Consents, Releases & Schedule

Obtaining Informed Consent

Three types of consent/assent:

- **1) Caregiver/Parental Consent:**
 - Completed regardless of youth's age
 - Ask caregiver to sign the **Caregiver Consent to Participate** section indicating they give their consent to participate
 - If the youth is ages 12-17, ask the caregiver to also sign the **Parental Consent for Child Ages 12-17** section
 - By signing this, the caregiver allows their child to be interviewed
- **2) Youth (18 or older) Consent:**
 - Completed only if youth is 18 or older
- **3) Youth (ages 12-17) Assent:**
 - Completed only if youth is 12-17 years old

Obtaining Informed Consent

Notify TAC of Status of Consent within 1-2 Business Days:

Age of Youth	Must Have
Under 12	•Caregiver Consent to Participate
12-17	•Caregiver Consent to Participate •Parental Consent for Child Ages 12-17 •Youth Assent
18 or older	•Youth (18 or older) Consent to Participate •Caregiver Consent to Participate (youth must sign a release authorizing the caregiver to be interviewed)

Caregiver Consent

Caregiver Consent to Participate
I acknowledge that the System of Care Practice Review (SOCPR) process has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed that I have the right to not participate and the right to withdraw. If withdrawal, I will not impact the youth's services. I have been assured that the information provided about my child and my family will be kept confidential in all public reports. I have been advised that feedback will be given to my child's service provider to help improve the care that everyone receives.

I am the parent or guardian of _____, who/whom is/are receiving _____ services. I hereby consent to participate in the System of Care Practice Review (SOCPR) process.

Parent/Guardian's Signature _____ Date _____

Parental Consent for Children 12-17
I understand that by signing below, I am giving consent for my child to take part in the SOCPR process, which will include several participating team interviews with trained review team participants.

I understand that by signing below, I am giving consent for my child to take part in the SOCPR process, which will include several participating team interviews with trained review team participants.

Parent/Guardian's Signature _____ Date _____

I certify that I have provided information related to the System of Care Practice Review (SOCPR) to the child's parent or legal guardian, and consider that she/he understands what is involved and freely consents to participation on behalf of his/her child for the study.

Witness/Program or Agency Representative _____ Date _____

Youth (18 or older) Consent

System of Care Practice Review (SOCPR)
YOUTH ASSENT (AGES 12-17 TO PARTICIPATE)

Consent
I acknowledge that the System of Care Practice Review (SOCPR) process has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed that I have the right to not participate and the right to withdraw. If withdrawal, I will not impact my services. I have been assured that the information provided will be kept confidential in all public reports. I have been advised that feedback will be given to my provider to help improve the care that everyone receives.

I hereby consent to participate in the System of Care Practice Review (SOCPR) process.

Youth Signature _____ Date _____

I certify that I have provided information related to the System of Care Practice Review (SOCPR) to the above individual, and consider that she/he understands what is involved and freely consents to participation.

Witness/Program or Agency Representative _____ Date _____

Youth (ages 12-17) Assent

System of Care Practice Review (SOCPR)
YOUTH ASSENT (AGES 12-17 TO PARTICIPATE)

Why am I being asked to take part in the System of Care Practice Review (SOCPR)?
You are being asked to take part in the System of Care Practice Review (SOCPR) because we want to learn more about the types of services you are getting or have gotten from your current service level, how good the services are, and how they best support the children in the home/guardian's care.

What is the purpose of the SOCPR?
We hope to learn the good of your current services and how it is helping you and your family. We also want to learn what you think about our services.

What do I have to do to take part in SOCPR?
A person will come and interview you at a time and place that is convenient for you. The interview will take 45 minutes or so. During the interview, you will be asked about the types of services you are getting and how you feel about them. You will also be asked to fill out a survey about your services. You will also be asked to fill out a survey about your services. You will also be asked to fill out a survey about your services.

Do I have to take part in this process?
No. If you do not want to take part in this process, that's your decision and nothing will happen. If you think that you do not want to participate, you should talk to your parent or other responsible adult and decide together. If you do decide not to take part, you can still get your normal care. You will not lose any of your services to quit.

Who will use the information I give?
Your information will be used to help us learn more about the types of services you are getting and how you feel about them. Your information will be used to help us learn more about the types of services you are getting and how you feel about them. Your information will be used to help us learn more about the types of services you are getting and how you feel about them.

What if I have questions?
You can ask questions at any time during the process. You can also call Amy Horton at the Technical Assistance Center at the phone number 617-266-5657, extension 122.

Subject to Participation
I understand what is being asked of me. I have thought about this and agree to take part in the SOCPR process.

Child/Youth Name _____ Date _____

Witness/Program or Agency Representative _____ Date _____

Tips for obtaining consent

- **Be familiar** with the consent form so you can answer questions
- **Explain the purpose** – mention that info will be used to help other families
- Help them understand **how** they were selected
- Info will **remain confidential**
- Tell them **what is expected** from them
- Interviewers will meet with them at the location and time **most convenient** for them
- Don't forget to mention that each family that participates will receive a **\$25 gift card to Target**

Consent FAQs

- Q: When should I contact TAC to let them know if a family agreed (or not) to participate?**
- A:** Please notify Amy Horton at TAC by leaving a voice mail at 617-266-5657 x122 within 1-2 business days of approaching a youth/family. It is imperative that we know if a family has agreed (or not) ASAP so that we can randomly select another youth to participate if need be. If a family declines, please briefly indicate the reason why the caregiver/youth declined to participate.
- Q: What if one of the youth randomly selected to participate in the SOCPR is scheduled to "close" by the time the interviews will occur. Should I still approach them to participate?**
- A:** Yes. As long as a youth is actively enrolled in services at the time we do the final random selection, we are required to approach them to seek consent. The reasoning behind this is because even if a family closes within the time they are selected and the time the review occurs, chances are the providers and family remember the services well enough to provide a thoughtful review experience.

Consent FAQs

Q: If a youth is in the custody of the Department of Children and Families (DCF), who should sign the consent and release of information forms?

A: The DCF worker for the youth must sign the caregiver consent and release of information forms for youth in their custody.

Q: Are consent forms available in languages other than English?

A: Yes. We have versions in Spanish as well as several other languages. Please contact Amy Horton if you need forms in a language other than English.

Q: How do I return the signed consent forms to TAC?

A: The preferred method is by scanning the forms and emailing them to Amy Horton at ahorton@tacinc.org. You can also fax them to the attention of Amy Horton at 617-266-4343. If you fax them please call Amy Horton at 617-266-5657 x 122 to let her know you have sent them.

Release of Information

Authorization to Release Info Form

- Indicates that youth/family allows specific people to be interviewed and have a record review conducted
- Complete and send TAC one Release for each person who will be interviewed
- Forms should be signed by:
 - Youth, if 18 or older
 - Primary caregiver/parent if youth under 18
- Forms completed for IHT Clinicians or Care Coordinators must also include the provider's agency name
 - This grants SOCPR reviewers permission to view the youth's record at the provider's site

Authorization to Release Info- Page 1

This Authorization to Release Information Form will allow the System of Care Practice Review (SOCP) team to have access to medical and behavioral information, which includes the review of protected health information. The purpose of the SOCP process is to provide feedback services used by Children's Behavioral Health Initiative (CBHI) services delivered through Massachusetts' non-emergency system of care review and services. By participating in this process, we seek them to improve the quality of care they deliver to our children and to other youth with similar needs.

Instructions to Caregiver

1. An Authorization to Release Information Form must be signed and dated for each person who will be interviewed. This release for providers also gives the review team permission to review the record maintained by the provider agency.
2. All signatures must be in ink and must be original. No copies or stamps of signatures are permitted.
3. Only one signature is required on each form.
4. One parent or legal guardian must sign for a child who is under eighteen years of age.

SECTION I

Authorization to release for this case record and interview of the party listed in SECTION II to share the type of information listed in SECTION III about: _____

Name of youth receiving CBHI services _____ Date of birth: _____ (with the SOCP) Team.

SECTION II

Please provide the name of the person and their provider agency (if applicable) that may share treatment and medical information with the SOCP Team.

Street Address _____
 City/State/Zip/Date _____ Telephone Number: _____

SECTION III

The party listed in Section I may share the following types of information with the SOCP Team.

- Psychiatric Information
- All Medical Information & Treatment
- History of Hospitalizations
- Participation and Progress in Treatment
- Medication
- Care and Treatment of the Interviewee
- School Functioning
- How Youth Affected Daily Living Activities and Academic Progress
- Drug and Alcohol Use
- Other (please describe): _____

Name and DOB of youth

Name of person (IHT Clinician, Care Coordinator, TT&S Worker) that family agrees can be interviewed. Please write provider's agency name if applicable.

These are topics the family allows the interviewee to discuss with SOCPR Reviewer

Authorization to Release Info- Page 2

SECTION I: Any medical information that is released as part of the SOCP process will continue to be protected by federal privacy laws.

This permission to release medical information and other types of information ends six months from the date you sign this release form, unless you have canceled permission in writing before then.

I understand that I may cancel this permission at any time by sending a letter to the System of Care Practice Review (SOCP) Team.

I understand that even if I cancel this permission, the case review and interview participant cannot take back any information that I already released to the SOCP Team when I signed my permission to do so.

I also understand that my decision whether to give permission to share medical information and other information with the SOCP Team is voluntary.

SECTION II: _____ (printed name), _____ (signature), by signing this form, I am authorizing the use and/or disclosure of the protected health information identified below.

Signature _____ Date _____
 Address _____
 Phone number: _____

If this form is filled out by someone who has the legal authority to act on behalf of the youth (such as the parent of a minor child, an eligible representative, or legal guardian) give us the following information:

Signature of the person filling out this form: _____
 Printed name: _____
 Authority of person filling out this form to act on behalf of the child/ youth: _____

A copy of this release can be requested from the person who asked you to sign it. You can also request a copy of this signed form at any time by contacting the Technical Assistance Collaborative at the following address:

Youth 18 or over should complete this section

Caregiver or parent of youth should complete this section

Release of Information FAQs

Q: How many releases of information do I need to have signed?
 The parent/caregiver or youth (if 18 or older) must sign a separate release of information form for each person who is scheduled to be interviewed.

For All Youth

- One for the IHT clinician or care coordinator
- One for the family partner or TT&S worker (or other formal provider)

Additional Releases For Youth Under 18

- One for another formal provider (applicable when the youth is under 18 or if the parent does not give consent for the youth to be interviewed)

Additional Releases For Youth 18 or Older

- If the youth is 18 or older, the youth must sign a release for the reviewer to interview his/her caregiver

Release of Information FAQs

Q: Are release of information forms available in languages other than English?

A: Yes. We have versions in Spanish as well as several other languages. Please contact Amy Horton if you need forms in a language other than English.

Q: How do I return the signed release forms to TAC?

A: The preferred method is by scanning the forms and emailing them to Amy Horton at ahorton@tacinc.org. You can also fax them to the attention of Amy Horton at 617-266-4343. If you fax them please call Amy Horton at 617-266-5657 x 122 to let her know you have sent them.

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Scheduling

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Record Review Scheduling

- Record reviews will take place at the provider agency
- Providers are responsible for locating a private space in the office where a youth's records can be reviewed
- Record reviews should occur before any of the interviews
- Record reviews should be scheduled for **2 hours**
- Clinicians and Care Coordinators **do not** need to be present for the record review
 - However, please have someone available to show the reviewer around and help get them situated

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Record Review Scheduling

- Reviewers will need access to the youth's record maintained by your agency, which includes:
 - Comprehensive Assessment
 - CANS
 - Care/Treatment Plan
 - Intake and Referral Information
 - Progress Notes
 - Releases
 - For youth enrolled in ICC: Strengths, Needs, and Culture Discovery (SNCD)
- Some files may be hard copies and some may be electronic
 - If you cannot limit access to the selected youth's files only, please print out copies of the files for the reviewers
- Please have all records available and ready at the time the record review is scheduled to start

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Interview Scheduling

- IHT Clinicians or Care Coordinators are responsible for scheduling interviews
- A minimum of **four (4) interviews** should be scheduled for each youth
- Interviews should be scheduled with:
 - Primary Caregiver/Parent
 - IHT Clinician or Care Coordinator
 - Family Partner or TT&S Worker or other formal provider if no FP or TT&S (Note: If youth is in DCF custody the second formal provider interview should be with the DCF worker)
 - Youth (if 12 or older) or another formal helper (teacher, outpatient therapist, therapeutic mentor, etc.) if youth is under 12 or caregiver does not want youth interviewed

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Interview Scheduling

- All interviews should be scheduled on the day assigned to the youth
- Please keep in mind that the reviewer will need time to get to the next interview, so build in travel time between interviews
- Youth interviews should be scheduled **after** normal school hours

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Scheduling for March 17 & 18

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March Review Schedule

Monday, March 17	Tuesday, March 18	Wednesday, March 19
Reviews (1 per provider)	Reviews (1 per provider)	Reviewer Debriefing
AM: Record Reviews	AM: Record Reviews	Debriefing for reviewers only
Interview w/ Care Coordinator or IHT clinician	Interview w/ Care Coordinator or IHT clinician	
Interview w/ Family Partner, TT&S, or 2 nd formal provider	Interview w/ Family Partner, TT&S, or 2 nd formal provider	
Interview w/ caregiver	Interview w/ caregiver	
Interview w/ youth (if 12 or older) or 3 rd formal provider	Interview w/ youth (if 12 or older) or 3 rd formal provider	

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Sample March Schedule

Monday, March 17	Tuesday, March 18
9:00 – 11:00 AM (2 hours) Record review youth #1 at provider agency	9:00 – 11:00 AM (2 hours) Record review youth #2 at provider agency
11:00 – 12:30 PM (1 hour 30 min) Interview with care coordinator or IHT clinician	11:00 – 12:00 (1 hour) Interview with TT&S or family partner at provider agency
12:30 – 1:00 PM Lunch	12:00 – 12:30 PM Lunch
1:00 – 2:00 PM (1 hour) Interview with TT&S or family partner at provider agency	12:30 – 1:00 (1 hour 30 min) Interview with care coordinator or IHT clinician
2:00 – 3:00 PM (1 hour) Interview with Outpatient Therapist	1:00 – 1:30 Travel to family home
3:00 – 3:30 Travel to family home	1:30 – 3:00 Interview with parent at family home
3:30 – 5:00 PM (1 hour 30 min) Interview with parent at family home	3:00 – 4:00 (1 hour) Interview with youth (age 17) at family home

Please work with the family and formal providers to schedule interviews at times and locations that are convenient for them on their assigned review day.

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Scheduling Template for March SOCPR

Provider: _____ **Review Month:** _____ **For the new only:** _____

Record Review - 2 Hours

Record Review to Youth: _____ Date: _____ State: _____ Zip Code: _____

Record Review to Parent: _____ Date: _____ State: _____ Zip Code: _____

First Provider Interview - 1 Hour 30 Minutes

Interview to Youth: _____ Date: _____ State: _____ Zip Code: _____

Interview to Parent: _____ Date: _____ State: _____ Zip Code: _____

Second Provider Interview - 1 Hour

Interview to Youth: _____ Date: _____ State: _____ Zip Code: _____

Interview to Parent: _____ Date: _____ State: _____ Zip Code: _____

Youth (if 12 or over) or Third Provider Interview - 1 Hour

Interview to Youth: _____ Date: _____ State: _____ Zip Code: _____

Interview to Parent: _____ Date: _____ State: _____ Zip Code: _____

Caregiver Interview - 1 Hour 30 Minutes

Interview to Youth: _____ Date: _____ State: _____ Zip Code: _____

Interview to Parent: _____ Date: _____ State: _____ Zip Code: _____

*Special notes concerning any of the interview questions, pending, change concerns, etc?
Please allow time for the interview to get back and forth, travel between interviews.
Do not schedule youth interviews during school hours.

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Scheduling FAQs

Q: Should I schedule all the interviews at the provider site?

A: No. Only interviews with the provider and the record review need to occur at the provider site. Interviews with the caregiver/youth should occur at their home unless for some reason they would prefer an alternate location. When completing the scheduling form please make sure you note the address where the interview should occur.

Q: Do all of the interviews need to be scheduled during the days assigned to us?

A: Yes. If a family absolutely cannot participate that week due to prior commitments, then they are unable to participate in this round of SOCPR reviews and you should contact TAC immediately so that we can select another youth from your agency.

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Scheduling FAQs

Q: For youth in DCF custody who should I schedule interviews with?

A: You should use your discretion here to determine who is in the best position to respond to the "caregiver" interview questions. In general it should be the person who has been the most involved in the services the youth is participating in and with whom the youth resides. This might be a foster parent, a grandparent, or the birth parent if they are actively involved in the service delivery process with you. DCF workers are not considered caregivers for this purpose of the interview but will need to sign the consent forms and the release of information form. We also suggest that the second formal provider interview be scheduled with the DCF worker for youth in DCF custody.

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Wrapping Up

Receiving Documents

> Process:

1. TAC will send an email to providers that includes the password to the password protected Schedule file
2. TAC will send an email to providers that includes a link to TAC's Sharefile site
3. After clicking on the link, you will be asked to provide your name, title, email, and agency name
4. Then you can download the folder to your computer and open the files

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Returning Documents to TAC

- > Return completed **consents and releases** by scanning and emailing them to Amy Horton at ahorton@tacinc.org or by faxing them to 617-266-4343
- > Return completed **schedules** by saving the excel document and emailing it to Amy Horton at ahorton@tacinc.org
- > **Consents, releases, and schedules must be sent to TAC by Tuesday, February 25, 2014.**

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General FAQs

Q: What if both parents participate in the interview do they both get a gift card?

A: No. Only one card for \$25 will be provided in this case.

Q: Will translators be available if the family does not speak English?

A: Yes. TAC can arrange for a translator please contact Amy Horton at 617-266-5657 x 112 this as soon as possible so we can make the necessary arrangements.

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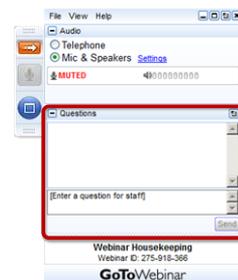
TAC Contacts

For Questions and Concerns about Consent & Scheduling, please contact:

Amy Horton
Human Services Program Assistant
617-266-5657 ext. 122
ahorton@tacinc.org

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Questions??



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Appendix B: Consent, Assent, and Release of Information Forms

System of Care Practice Review (SOCPR)

YOUTH 18 OR OLDER CONSENT TO PARTICIPATE

Purpose of the System of Care Practice Review (SOCPR):

The purpose of the System of Care Practice Review (SOCPR) is to provide feedback on how well Children's Behavioral Health Initiative (CBHI) services delivered through MassHealth use important system of care values and principles. By participating in this process, you will assist them to improve the quality of services they deliver to children/youth with behavioral health challenges. You are being asked to participate because you are receiving or have received CBHI services paid for by MassHealth.

What the SOCPR Process Involves:

A professionally trained reviewer will ask you to participate in a face-to-face interview to ask questions about the types of services you are receiving or have received the quality of the services, and your satisfaction with them. This interview will take between 45 and 60 minutes, and you will receive a \$25 gift card to Target for participating. With your permission, they will also interview some other important people who know you, such as your parent(s), therapists, care managers, or teachers, to ask their opinion of the services you receive. They will also review your record that is kept at the provider agency to learn more about the type and quality of services you receive.

Confidentiality and Privacy:

We take your privacy very seriously. Therefore, no information that tells about your identity will be released or included in public reports without your consent, unless required by law. That said the SOCPR seeks to help improve the services delivered to youth across the state. After your review is completed, our reviewers may suggest ways your provider can improve the services they deliver. This will help ensure that everyone receives the best possible care.

Please contact us if you have any questions or concerns about this policy.

Before our reviewers can conduct interviews with providers or family members you need to acknowledge in writing that you allow them to share information about the services you receive. To do this, an 'Authorization to Release Information' form, must be completed for each person that will be interviewed.

Voluntary Participation and Withdrawal:

Participation in the System of Care Practice Review (SOCPR) is completely voluntary and is your choice. If you do not want to participate, it will not affect the services you are getting now. If you do choose to take part in this process, you can withdraw at any time and it will not affect the services you receive.

Questions

If you do not understand the information presented here about the SOCPR process, or if you have any questions, you may ask the person who gave you this form, or you may contact:

Kelly English, Senior Associate
Technical Assistance Collaborative
617-266-5657 x112
kenglish@tacinc.org

Consent

I acknowledge that the System of Care Practice Review (SOCPR) process has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed that I have the right not to participate and the right to withdraw. If I withdraw, it will not impact my services. I have been assured that the information I provide will be kept confidential in all public reports. I have been advised that feedback may be given to my provider to help improve the care that everyone receives.

I hereby consent to participate in the System of Care Practice Review (SOCPR) process.

Youth Signature

Date

I certify that I have provided information related to the System of Care Practice Review (SOCPR) to the above individual, and consider that she/he understands what is involved and freely consents to participation.

Witness/ Program or Agency Representative

Date

**System of Care Practice Review (SOCPR)
CAREGIVER/PARENTAL CONSENT TO PARTICIPATE**

Purpose of the System of Care Practice Review (SOCPR):

The purpose of the System of Care Practice Review (SOCPR) is to provide feedback on how well Children's Behavioral Health Initiative (CBHI) services funded by MassHealth use important system of care values and principles. By participating in this process, you will assist them to improve the quality of services they deliver to your child and to other children with similar needs. You are being asked to participate because your child is receiving or has received CBHI services paid for by MassHealth.

What the SOCPR Process Involves:

A trained reviewer will ask you to participate in a face-to-face interview to ask questions about the types of services your child is receiving or has received the quality of the services, and your satisfaction with them. This interview will take between 60-90 minutes, and you will receive a \$25 gift card to Target for participating. With your permission, they will also interview some other important adults who work with your child, such as service providers, care managers, or a teacher, to ask their opinion of the services your child receives. If your child is 12 or older they will also want to do a 1 hour interview with him/her to learn about his/her experience. They will also review your child's record that is kept at the provider agency to learn about the type and quality of services your child is receiving.

Confidentiality and Privacy:

Ensuring that the information we learn from your child's record review and interviews is kept private is very important to us. Therefore, no information that tells about you or your child's identity will be released or included in public reports without your consent, unless required by law. That said, the SOCPR seeks to help improve the services delivered to youth across the state. After your child's review is completed, our reviewers may suggest ways your provider can improve the services they deliver. This will help ensure that everyone receives the best possible care.

Please feel comfortable contacting us if you have any questions or concerns about this policy.

Before our reviewers can conduct interviews with anyone about your child's care, you need to acknowledge in writing that you allow them to share information about the services your child receives. To do this, an 'Authorization to Release Information' form, must be completed for person that will be interviewed.

Voluntary Participation and Withdrawal:

Participation in the System of Care Practice Review (SOCPR) is completely voluntary and is your choice. If you do not want to participate, it will not affect the services your child or family is getting now. If you do choose to take part in this process, you can withdraw at any time and it will not affect the services your child or family receives.

Questions

If you do not understand the information presented here about the SOCPR process, or if you have any questions, you may ask the person who gave you this form, or you may contact:

Kelly English, Senior Associate
Technical Assistance Collaborative
617-266-5657 x112
kenglish@tacinc.org

Caregiver Consent to Participate

I acknowledge that the System of Care Practice Review (SOCPR) process has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed that I have the right not to participate and the right to withdraw. If I withdraw, it will not impact my child’s services. I have been assured that the information provided about my child and my family will be kept confidential in all public reports. I have been advised that feedback may be given to my child’s service provider to help improve the care that everyone receives.

I am the parent or guardian of _____, a child who is or was receiving MassHealth CBHI services. I hereby consent to participate in the System of Care Practice Review (SOCPR) process.

Parent/ Guardian’s Signature

Date

Parental Consent for Child Ages 12-17

I understand that by signing below, I am also giving consent for my child to take part in the SOCPR process, which will include my child participating in an interview with trained reviewer for approximately 1 hour.

Parent/ Guardian’s Signature

Date

I certify that I have provided information related to the System of Care Practice Review (SOCPR) to the child’s parent or legal guardian, and consider that she/he understands what is involved and freely consents to participation on behalf of his/herself and/or the child.

Witness/ Program or Agency Representative

Date

**System of Care Practice Review (SOCPR)
YOUTH ASSENT (AGES 12-17) TO PARTICIPATE**

Why am I being asked to take part in the System of Care Practice Review (SOCPR)?

You are being asked to take part in the System of Care Practice Review (SOCPR) because we want to know more about the types of services you are getting or have gotten from (*insert provider name here*), how good the services are, and how you feel about them (whether they were good or helpful, or not).

What is the purpose of the SOCPR?

We hope to learn how good of a job (*insert provider name here*) is doing in helping you and your family. We are also asking other families about the same things.

What do I have to do if I agree to take part?

A person will come and interview you at a time and place that is convenient for you. The interview should take 45 minutes to an hour. During the interview, you will be asked about the kinds of services you and your family receive from (*insert provider name here*) how well those services worked for you, if you liked them, and how happy you were with them. You will also be asked how your care coordinator or clinician has worked with you.

Do I have to take part in this process?

No. If you do not want to take part in this process, that is your decision and nothing bad will happen. If you think that you do not want to take part, you should talk it over with your parent or other important adult and decide together. If you decide to take part, you can still change your mind later. No one will think badly of you if you decide to quit.

Who will see the information I give?

Your information will be added to the information from other people that take part in this process so no one will know who you are or what you said. We may use your information to work with (*insert provider name here*) to make services better for you and other people who get similar care.

What if I have questions?

You can ask questions of the person who gave you this form or of your parent or other important adult about this process. If you think of other questions later, you can contact Kelly English who works at the Technical Assistance Collaborative. Her phone number is 617-266-5657, extension 112.

Assent to Participate

I understand what I am being asked to do. I have thought about this and agree to take part in the SOCPR process.

Child/Youth Name

Date

Witness/Program or Agency Representative

Date

System of Care Practice Review (SOCPR)
AUTHORIZATION TO RELEASE INFORMATION

This Authorization to Release Information Form will allow the System of Care Practice Review (SOCPR) team to have access to records and to conduct interviews, which includes the transmission of protected health information. The purpose of the SOCPR process is to provide feedback on how well Children’s Behavioral Health Initiative (CBHI) services delivered through MassHealth use important system of care values and principles. By participating in this process, I will assist them to improve the quality of services they deliver to my child and to other youth with similar needs.

Instructions for Completing:

1. An Authorization to Release Information Form must be signed and dated for each person who will be interviewed. The release for providers also gives the review team permission to review the record maintained by the provider agency.
2. All signatures must be in ink and must be originals. No copies or stamps of signatures are permitted.
3. Only one signature may appear on a line.
4. One parent or legal guardian must sign for a child, who is under eighteen years of age.

SECTION I

Permission is given for the case record and interview of the party listed in SECTION II to share the type(s) of information listed in SECTION III about:

_____ (____/____/____) with the SOCPR Team.
Name of youth receiving CBHI services Date of Birth

SECTION II

Please print the name of the person and their provider agency (if applicable) that may share treatment and medical information with the SOCPR Team.

Street Address

City/State/Zip Code

Telephone Number

SECTION III

The party listed in Section II may share the following types of information with the SOCPR Team.

- | | |
|--|---|
| <input type="checkbox"/> Psychiatric Information | <input type="checkbox"/> All Medical Information & Treatment |
| <input type="checkbox"/> History of hospitalizations | <input type="checkbox"/> Participation and Progress in Treatment |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Court/Probation/Parole Information |
| <input type="checkbox"/> School Functioning | <input type="checkbox"/> How Needs Affect Daily Living Activities and Academic Progress |
| <input type="checkbox"/> Drug and Alcohol Use | <input type="checkbox"/> Other (please describe): _____ |

SECTION IV

Any medical information that is released as part of the SOCPR process will continue to be protected by federal privacy laws.

This permission to release medical information and other types of information ends six months from the date you sign this release form, unless you have canceled permission in writing before then.

I understand that I may cancel this permission at any time by sending a letter to the System of Care Practice Review (SOCPR) Team.

I understand that even if I cancel this permission, the case review and interview participant cannot take back any information that it already shared with the SOCPR Team when it had my permission to do so.

I also understand that my decision whether to give permission to share medical information and other information with the SOCPR Team is voluntary.

SECTION V

I, _____ (printed name), understand that, by signing this form, I am authorizing the use and/or disclosure of the protected health information identified above.

Signature

Date

Address: _____

Phone number: _____

If this form is filled out by someone who has the legal authority to act on behalf of the youth (such as the parent of a minor child, an eligibility representative, or a legal guardian) give us the following information:

Signature of the person filling out this form: _____

Printed name: _____

Authority of person filling out this form to act on behalf of the child/ youth: _____

A copy of this release can be requested from the person who asked you to sign it. You can also request a copy of this signed form at any time by contacting the Technical Assistance Collaborative at the following address:

Technical Assistance Collaborative
31 Saint James Avenue, Suite 950
Boston, MA 02116
Attn: Kelly English
kenglish@tacinc.org

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION

Systems of Care Practice Review (SOCPR) Supplemental Questions for In-Home Therapy

***Instructions:** Please complete the questions below for youth participating in In-Home Therapy (IHT) ONLY. These questions are not applicable for youth participating in Intensive Care Coordination (ICC). **Only question #5** needs to be directly asked during the caregiver and formal provider interview.*

Question #	Question	Data source	Rating/Response
1	<p>The youth needs or receive multiple services from the same or multiple providers AND</p> <p>The youth needs a care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof.</p>	<p>Document review (all pages)</p> <p>Parent/caregiver interview</p> <p>Formal support interview</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
2	<p>The youth needs or receive services from, state agencies, special education, or a combination thereof. AND</p> <p>The youth needs a care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof.</p>	<p>Document review (all pages)</p> <p>Parent/caregiver interview</p> <p>Formal support interview</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
3	<p>The youth is receiving the level of care coordination his/her situation requires.</p>	<p>Summative Questions Q. 16; p. 84 Q. 26; p. 94 Q. 27 p. 95</p> <p><i>For additional guidance in scoring please refer to the index questions associated with the above questions</i></p>	<p style="text-align: center;"> Disagree -3 -2 -1 0 +1 +2 +3 Agree <input type="checkbox"/> <input type="checkbox"/> Disagree Disagree Disagree Neutral Agree Agree Agree very much moderately slightly slightly moderately very much </p>
4	<p>Has the youth previously been enrolled in ICC?</p>	<p>Document review Q. 8 & 9; p. 5 and p. 11</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If yes, briefly explain below why the youth is no longer enrolled.</i></p>

Question #	Question	Data source	Rating/Response
5	Has the IHT team ever discussed the option of ICC with the youth/family?	This question will need to be explicitly asked during the IHT provider interview as well as the family interview.	<input type="checkbox"/> Yes <i>If yes, briefly explain below the family's reason for declining ICC.</i> <input type="checkbox"/> No <i>If no, briefly explain below why not.</i>
6	The youth needs providers to coordinate/collaborate with school personnel?	Document review p. 4	<p style="text-align: center;"> Disagree -3 -2 -1 0 +1 +2 +3 Agree <input type="checkbox"/> <input type="checkbox"/> Disagree Disagree Disagree Neutral Agree Agree Agree very much moderately slightly </p>
7	The IHT is in regular contact with other providers, state agencies and school personnel involved with the youth and family.	Summative Questions Q. 26; p. 94 Q. 27 p. 95 <i>For additional guidance in scoring please refer to the index questions associated with the above questions</i>	<p style="text-align: center;"> Disagree -3 -2 -1 0 +1 +2 +3 Agree <input type="checkbox"/> <input type="checkbox"/> Disagree Disagree Disagree Neutral Agree Agree Agree very much moderately slightly </p>
8	Providers, school personnel or other state agencies involved with the youth participate in care planning.	Summative Questions Q. 26; p. 94 Q. 27 p. 95 <i>For additional guidance in scoring please refer to the index questions associated with the above questions</i>	<p style="text-align: center;"> Disagree -3 -2 -1 0 +1 +2 +3 Agree <input type="checkbox"/> <input type="checkbox"/> Disagree Disagree Disagree Neutral Agree Agree Agree very much moderately slightly </p>
9	Indicate the other "hub dependent" services supported by the IHT. (check all that apply)	N/A	<input type="checkbox"/> Therapeutic mentoring <input type="checkbox"/> Family support and training <input type="checkbox"/> In-home behavioral services <input type="checkbox"/> None

Appendix D: Summative Question Organization

SOCPR Summative Questions

DOMAIN 1: Child-Centered and Family-Focused

Sub-domain: Individualized

Area: Assessment/Inventory

1. A thorough assessment or inventory was conducted across life domains.
2. The needs of the child and family have been identified and prioritized across a full range of life domains.
3. The strengths of the child and family have been unidentified.

Area: Service Planning

4. There is a primary service plan that is integrated across providers and agencies.
5. The services plan goals reflect needs of the child and family.
6. The service plan goals incorporate the strengths of the child and family.
7. The service planning and delivery informally acknowledges/considers the strengths of the child and family.

Area: Types of Services/Supports

8. The types of services, supports provided to the child and family reflect their needs and strengths.

Area: Intensity of Services/Supports

9. The intensity of the services/supports provided to the child and family reflects their needs and strengths.

Sub-domain: Full Participation

10. The child and family actively participate in the service planning process (initial plan & updates).
11. The child and family influence the service planning process (initial plan & updates).
12. The child and family understand the content of the service plan.
13. The child and family actively participate in services.
14. The formal providers and informal helpers participate in service planning (initial plan & updates).

Sub-domain: Care Coordination

15. There is one person who successfully coordinates the planning and delivery of services and supports.
16. Service plans and services are responsive to the emerging and changing needs of the child and family.

SOCPR Summative Questions

DOMAIN 2: Community-Based

Sub-domain: Early Intervention

17. As soon as the child and family began experiencing problems, the system clarified the child and family's needs.
18. As soon as the child and family entered the service system, the system responded by offering the appropriate combination of services and supports.

Sub-domain: Access to Services

Area: Convenient Times

19. Services are scheduled at convenient times for the child and family.

Area: Convenient Locations

20. Services are provided within or close to the child and family's home community.
21. Supports are provided to the child and family to increase their access to service location(s).
(Rate as "Does not Apply" if Summative rating #20 = +3)

Area: Appropriate Language

22. Service providers verbally communicate in the primary language of the child/family.
23. Written documentation regarding services/service planning is in the primary language of the child/family.

Sub-domain: Minimal Restrictiveness

24. Services are provided in an environment that feels comfortable to the child and family.
25. Services are provided in the least restrictive and most appropriate environment(s).

Sub-domain: Integration and Coordination

26. There is ongoing two-way communication among and between all team members, including formal service providers, informal helpers (if desired by the family), and family members including child.
27. There is a smooth and seamless process to link the child and family with additional services if necessary.

SOCPR Summative Questions

DOMAIN 3: Culturally Competent

Sub-domain: Awareness

Area: Awareness of Child and Family's Culture

28. Service providers recognize that the child and family must be viewed within the context of their own cultural group and their neighborhood and community.
29. Service providers know about the family's concepts of health and family.
30. Service providers recognize that the family's culture (values, beliefs and lifestyle) influences the family's decision-making process.

Area: Awareness of Provider's Culture

31. Service providers are aware of their own culture (values, beliefs and lifestyles) and how it influences the way they interact with the child and family.

Area: Awareness of Cultural Dynamics

32. Service providers are aware of the dynamics inherent when working with families whose culture (values, beliefs and lifestyle) may be different from or similar to their own.

Sub-domain: Sensitivity and Responsiveness

33. Service providers translate their awareness of the family's culture (values, beliefs and lifestyle) into action.
34. Services are responsive to the child and family's culture (values, beliefs and lifestyle).

Sub-domain: Agency Culture

35. Service providers recognize that the family's participation in service planning and in the decision making process is impacted by their knowledge/understanding of the expectations of the agencies/programs/providers.
36. Service providers assist the child and family in understanding/navigating the agencies they represent.

Sub-domain: Informal Supports

37. Service planning and delivery intentionally includes informal sources of support for the child and family.

SOCPR Summative Questions

DOMAIN 4: Impact

Sub-domain: Improvement

38a. The services/supports provided to the **child** have improved his/her situation.

38b. The services/supports provided to the **family** have improved their situation.

Sub-domain: Appropriateness

39a. The services/supports provided to the **child** have appropriately met his/her needs.

38b. The services/supports provided to the **family** have appropriately met their needs.