

System of Care Practice Review Regional Report of Findings: Northeast

February 2014

Completed by:

Francine Arienti, Kelly English
& Amy Horton

Technical Assistance Collaborative

Debra Mowery, Linda Callejas,
Thomas Burrus, & Mario Hernandez
University of South Florida

Completed for:

Massachusetts Executive Office of
Health and Human Services



Table of Contents

Executive Summary	1
SOCPR overview	1
Northeast region review summary	1
Results	2
Identified strengths and opportunities for improvement.....	3
About this report	4
Introduction	5
Overview	5
History of qualitative case reviews in Massachusetts.....	6
Methodology	6
Reviewer training.....	6
Provider selection.....	7
Youth selection.....	7
Consent process	8
Scheduling process	8
SOCPR description	8
SOCPR method.....	9
SOCPR domains.....	10
IHT supplemental questions	10
Organization of the SOCPR.....	11
Quantitative data analysis.....	12
Qualitative data analysis.....	12
Results.....	13
Demographics	13
SOCPR mean domain scores.....	18
SOCPR individual question scores.....	21
Domain 1: Child-Centered and Family-Focused.....	21
Domain 2: Community-Based	29
Domain 3: Culturally Competent	33
Domain 4: Impact.....	36
IHT supplemental questions results.....	38
Discussion	41

Strengths of the service system.....	41
Opportunities for improvement	42
Conclusion	44
Appendix A: Consent and Scheduling Webinar	46
Appendix B: Consent, Assent, and Release of Information Forms	54
Appendix C: IHT Supplemental Questions	62

Tables and Figures

Tables

Table 1: SOCPR domains and sub-domains	1
Table 2: SOCPR domain scores	2
Table 3: CBHI values and SOCPR domains	5
Table 4: Review schedule by state region	6
Table 5: Northeast region SOCPR domain scores.....	19
Table 6: Sub-domain 1a Individualized	25
Table 7: Sub-domain 1b Full participation	27
Table 8: Sub-domain 1c Care coordination	28
Table 9: Sub-domain 2a Early intervention.....	30
Table 10: Sub-domain 2b Access to services.....	31
Table 11: Sub-domain 2c Minimal restrictiveness	32
Table 12: Sub-domain 2d Integration and coordination	33
Table 13: Sub-domain 3a Awareness	34
Table 14: Sub-domain 3b Sensitivity and responsiveness.....	35
Table 15: Sub-domain 3c Agency culture.....	35
Table 16: Sub-domain 3d Informal supports.....	36
Table 17: Sub-domain 4a Improvement	37
Table 18: Sub-domain 4b Appropriateness	37
Table 19: Need for coordination	38
Table 20: Appropriate level of care coordination	38
Table 21: Prior ICC enrollment.....	38
Table 22: Reasons for ICC disenrollment.....	39
Table 23: Discussion of ICC with youth/family.....	39
Table 24: Family reasons for declining ICC.....	39
Table 25: Reasons for not discussing ICC with the family	40
Table 26: Need for coordination with school.....	40
Table 27: Contact with providers and service systems	40
Table 28: Participation in planning	41
Table 29: Other hub dependent services.....	41

Figures

Figure 1: Overall mean scores	3
Figure 2: Age	14
Figure 3: Gender.....	14
Figure 4: Race	15
Figure 5: Language spoken at home.....	15
Figure 6: Length of enrollment at time of review.....	16
Figure 7: Behavioral health services utilized	16
Figure 8: Service systems utilized	17
Figure 9: Behavioral health conditions	18
Figure 10: Overall mean scores	19

Figure 11: Child-centered and family-focused mean scores20
Figure 12: Community-based mean scores20
Figure 13: Culturally competent mean scores21
Figure 14: Impact mean scores.....21

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 October 2013 for providers serving the Northeast 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.

Northeast region review summary

The care of 24 randomly selected youth who received services from ICC or IHT providers in the Northeast region was reviewed using the SOCPR. The majority of youth reviewed were ages 5-9 years (38%), followed by 10-13 and 14-17 years (each at 25%). Seventy-one percent (71%) of the youth were male. In terms of race, Latino/Hispanic and White were equally represented at

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.

38% each, followed by Asian/Pacific Islander (8%) and African American/Black (4%). English was identified as the language spoken at home for 83% of the sample, and Spanish was identified in 13% of families. Typical length of enrollment in IHT or ICC services at the time of review was 4-6 months (in 33% of the families). Forty-two percent of the youth had special education involvement, followed by DCF involvement (17%).

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 Northeast region, SOCPR mean domain scores ranged from 5.50 to 6.32. The overall mean score of the cases examined was 5.91.

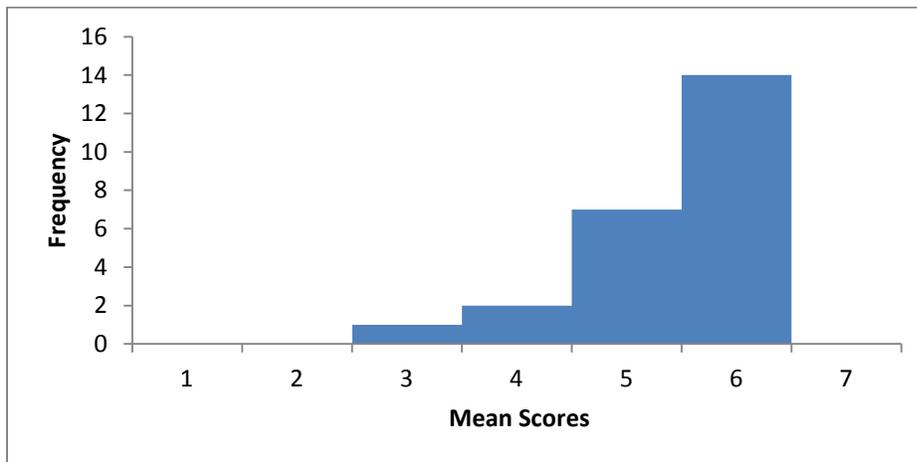
The domain of Community-Based was the highest scoring domain, followed by Child-Centered and Family-Focused, Culturally Competent, and finally, Impact. The scores indicate that in the Northeast region, provider agencies included in the sample performed best at including the Community-Based SOC value 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	3.10	6.68	5.91	0.87	5.56	6.26
Domain 1: Child-Centered Family-Focused	2.25	6.81	5.89	1.16	5.46	6.36
Domain 2: Community-Based	4.60	7.00	6.32	0.66	6.06	6.58
Domain 3: Culturally Competent	2.50	6.70	5.68	0.85	5.34	6.02
Domain 4: Impact	2.25	6.75	5.50	1.22	5.01	5.99

As the histogram in Figure 1 shows, fifty-eight percent (14 of 24 cases) fell into the range from 6 to 7 representing high SOC implementation, and seven cases (29%) scored in the 5 range. One (4%) had a mean in the 3 range and 2 (8%) 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 Northeast region are demonstrating a system of care approach to service planning and delivery. Areas of particular strength for providers in this region included:

- Providers have appropriately identified child and family strengths and their service planning and delivery informally acknowledges and considers these strengths.
- There is active and full participation among children and families in service planning and delivery.
- Providers are responsive to emerging and changing needs of children and families in the planning and delivery of services.
- Services are accessible to children and families and are offered at convenient times, in convenient locations, and in the primary language of the family.
- Services are provided in comfortable environments that are the least restrictive and most appropriate.
- Providers demonstrate awareness that children and families must be viewed within their own cultural context and community.

Although ratings were high overall in the majority of cases, and families generally seem satisfied, findings did indicate opportunities for growth in the following areas:

- The thoroughness of some provider assessments could be improved in terms of both depth (e.g. taking into account important psychosocial information) and breadth (e.g., expanding the range of life domains covered); in some instances this would appear to require greater clinical sophistication among staff conducting assessments.
- Service plans should better incorporate child and family strengths into goals, and both service plans and the planning process should be better integrated across providers and agencies.
- Service planning should be inclusive of both formal and informal providers, with more intentional inclusion of informal supports in both service planning and delivery.

- The types of services and supports a child and family receives should be appropriate based on the individually identified needs of the child/family, and a clear process in place for making linkages to needed services, particularly those outside of an IHT or ICC provider's own agency.
- Awareness among providers of cultural dynamics inherent when working with families whose culture may be similar to or different from their own could be improved.
- Care coordination with others involved in the care of children and families could be improved by greater role clarification among certain types of staff responsible for this critical function.

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 Northeast 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 Northeast region during October 2013. 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 October 2013 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 Northeast region. Twelve of the youth reviewed had ICC serving as their "hub" provider, in other words, the provider with primary responsibility for care coordination, while the other half had IHT serving as the hub.

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	Community-based
Culturally responsive	Culturally competent
Collaborative and integrated	Impact
Continuously improving	

The October 2013 review represented the second time the SOCPR has been used by the state to gather qualitative information about the service planning and delivery process in IHT and the first time it has been used with ICC providers. The first review wave occurred in June 2013 in the Metro/Boston region. Three additional review waves are planned so that adherence to SOC principles by providers in each region of the state will be reviewed over the course of one year.

² The twelve provider sites represented seven unique providers.

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 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 summative question 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.

Additional Massachusetts based reviewers are expected to be trained in January 2014 to ensure an adequate supply of trained reviewers for each review round.

Provider selection

The October SOCPR reviewed the care of 24 youth from 12 provider sites (two youth per site) in the Northeast region. Twelve of these youth had 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 Northeast region were selected to participate. According to the March 2013 Monthly CSA Access Report, the Northeast ICC providers were serving approximately 738 youth, ranging from a high of 227 youth to a low of 35,³ with an average capacity of 123.

Data from the March 2013 Massachusetts Behavioral Health Access (MABHA) report was used to randomly select six IHT providers. According to the report there were 16 IHT providers with 25 sites in the Northeast region serving 1,365 youth, ranging from a maximum capacity of 150 to a low of nine, with an average capacity of 55. By comparison, the six selected provider sites reported serving a total of 332 youth or 24% of the youth participating in IHT in the Northeast region. The capacity of the six selected sites ranged from a high of 94 youth to a low of 23 youth, with an average capacity of 55 youth.

Youth selection

Once the providers were identified, MassHealth requested that the 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.). Each program director returned their completed list to TAC staff who 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 number of two youth from each of the selected organizations was reached for a total of 24 youth.

³ The low number is attributable to a provider that has recently begun service in the Northeast and was still ramping up their capacity.

To reach the goal of 24 interviews for the Northeast review round, a total of 36 families were asked to participate in the SOCPR, with 12 families or 33% declining. Of the families that declined, eight were enrolled in ICC and four were enrolled in IHT. By far the most common reason for not participating, in six of the 12 cases, was that families reported feeling overwhelmed and could not take on an additional task/responsibility. Three families indicated they could not participate for medical reasons (e.g. scheduled surgery, family member being admitted to the hospital). Other reasons for not participating included: concerns about language fluency (though it was made clear interpreters could be made available), a family reporting they were close to graduating and wanted to focus on next phase of their lives, and one family not responding to the provider's repeated requests to meet to discuss the SOCPR consent process.

Consent process

In September 2013, 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 young adult 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 agreed for them to be interviewed) to determine their willingness to be interviewed. Those youth aged 12-17 who agreed to participate signed a written "assent." Copies of the consent, assent, and authorization to release forms are located in Appendix B.

Scheduling process

Providers scheduled interviews 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.). Providers scheduled a minimum of three interviews for each youth with a preference for four. 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.⁴ 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.⁵ 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 Hernandez⁶ 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, informal supports, 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 family consists of the youth involved in the system of care, the primary caregiver (e.g., parent, foster parent, relative), and formal service providers (e.g., care coordinator, therapist, teacher, etc.).

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 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

⁴Hernandez, 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

⁵ Ibid.

⁶ 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.

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 4 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, informal helper); 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 5). 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 5: 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

Each Summative Question rating is accompanied by a narrative in support of that rating. The narrative portion of each Summative Question response provides evidence for a given rating and is used to determine the presence or absence of system of care principles for each sub-domain. Where an overall summative rating relates to a reviewer’s determination of completion of a *thorough assessment*, for instance, qualitative analysis examines the evidence provided to explain the rating. These ratings represent the reviewer’s belief of the extent to which system of care values and principles are actualized.

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. Using these four statistics, an understanding of the range of scores, the average score, as well as an indication of the variability from family to family, could be examined.

Frequency distributions for each individual question were part of the quantitative analysis. The frequency distributions provided both a frequency count and a percentage of individual reviewer responses for each individual question in the SOCPR.

Qualitative data analysis

Qualitative analysis of the narrative portion of Summative questions followed standard coding procedures designed to develop a formal system for organizing the data and documenting links between identified concepts (e.g. codes, themes, etc.) and the experiences of youth, family members, providers and informal supports described in the data.^{7,8} The first step in the process is for research team members to review the data without coding, allowing them to immerse themselves in the data to allow for comprehension of the “big picture,” so to speak, promoting understanding of the scope and context of the site under study. Once data has been reviewed and prepared for coding (i.e. saved as Word documents), the narrative comments are coded.

⁷Bradley, E.H., Curry, L.A., & Devers, K.J. (2007). Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory. *Health Services Research, 42*, 1758-1772.

⁸Crabtree B.F. & Miller W.L. (1999). Using codes and code manuals: A template organizing style of interpretation. In *Doing Qualitative Research, 2nd Edition*. Thousand Oaks, CA: Sage Publications.

Once coding of narrative comments is completed it is reviewed by an additional reviewer to determine consensus with regard to themes identified through initial coding. Where questions arose with regard to identified themes or coding, research team members discussed and reconciled differences to reach consensus. Summative question responses were examined and analyzed for emerging patterns/trends. In order to be considered a trend, at least of half of the review responses had to provide similar information for a given sub-domain area. Trends in each sub-domain were then reviewed together to provide an overall assessment for the larger domain area. The quantitative ratings for each item were also considered in conjunction with the respective narrative to determine a general assessment for each domain. Finally, the results are contrasted against the System of Care core values, resulting in a conclusion to the extent to which the system of care is guiding service delivery. Using these findings, this report section also highlights particular successes and challenges with regard to implementation of System of Care 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 families participated in the Northeast SOCPR review. A summary of the demographic characteristics of these families are presented in the figures below.

FIGURE 2: AGE

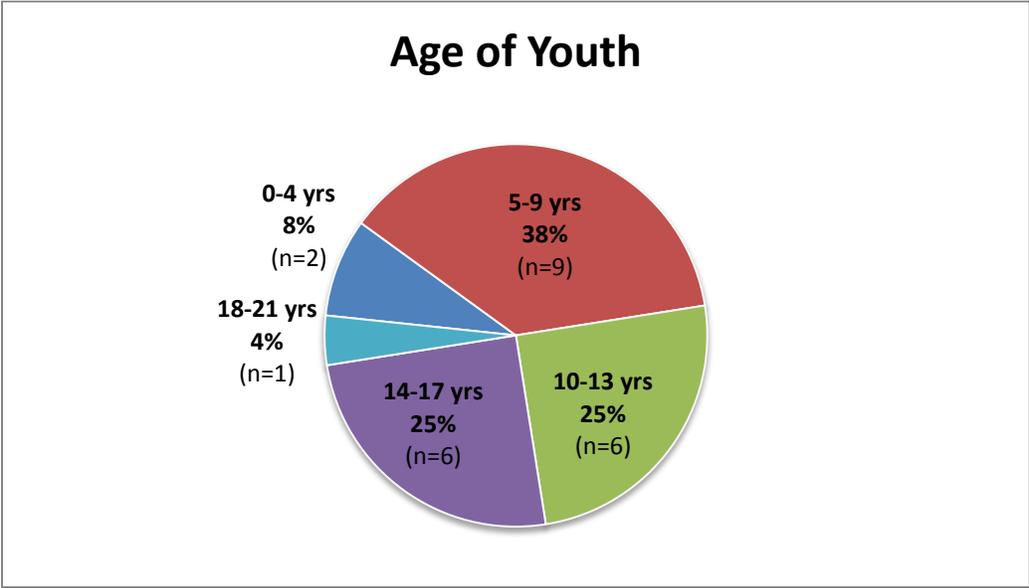


FIGURE 3: GENDER

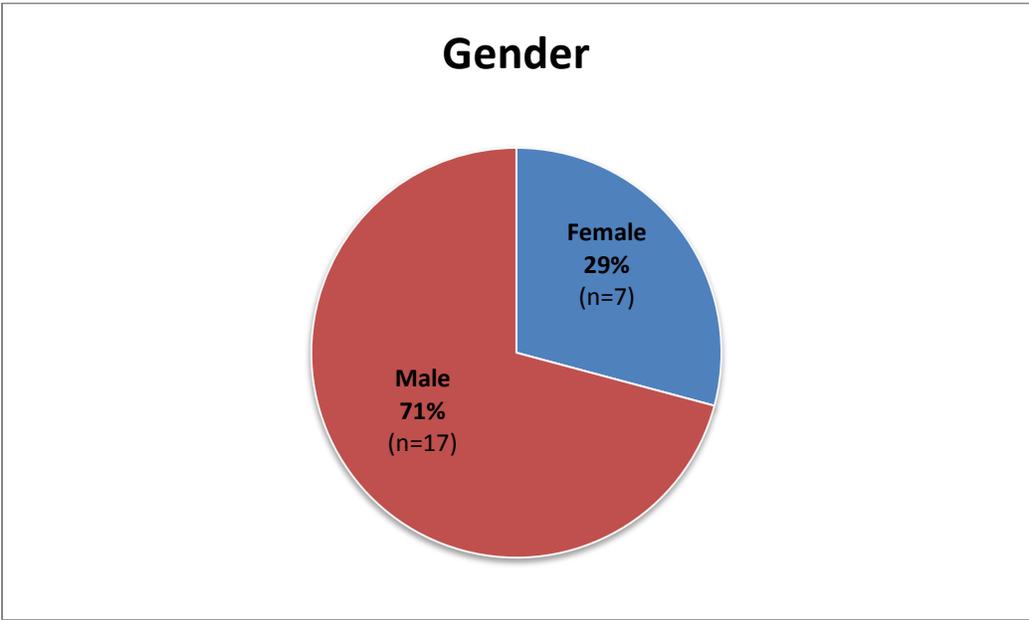


FIGURE 4: RACE

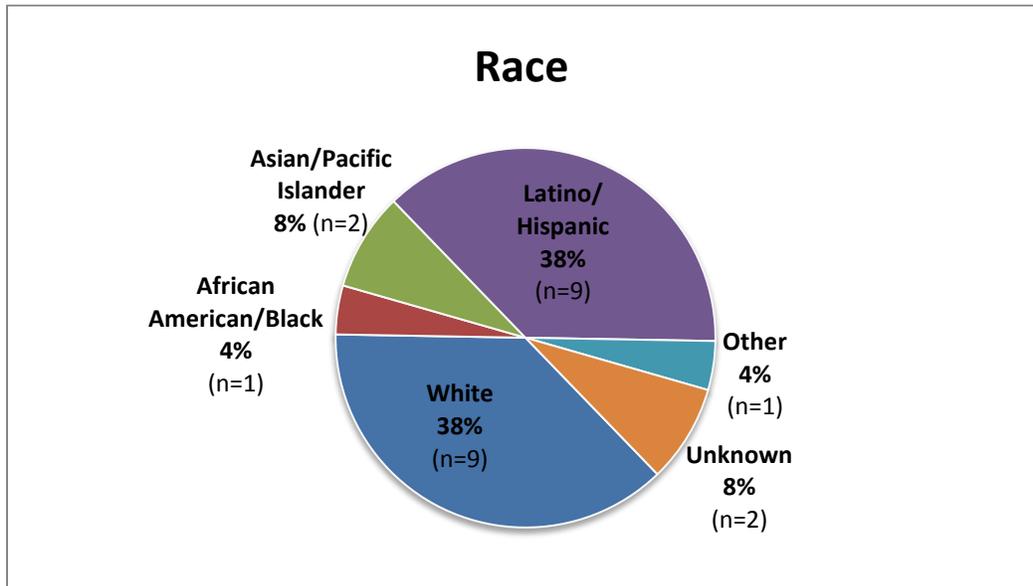
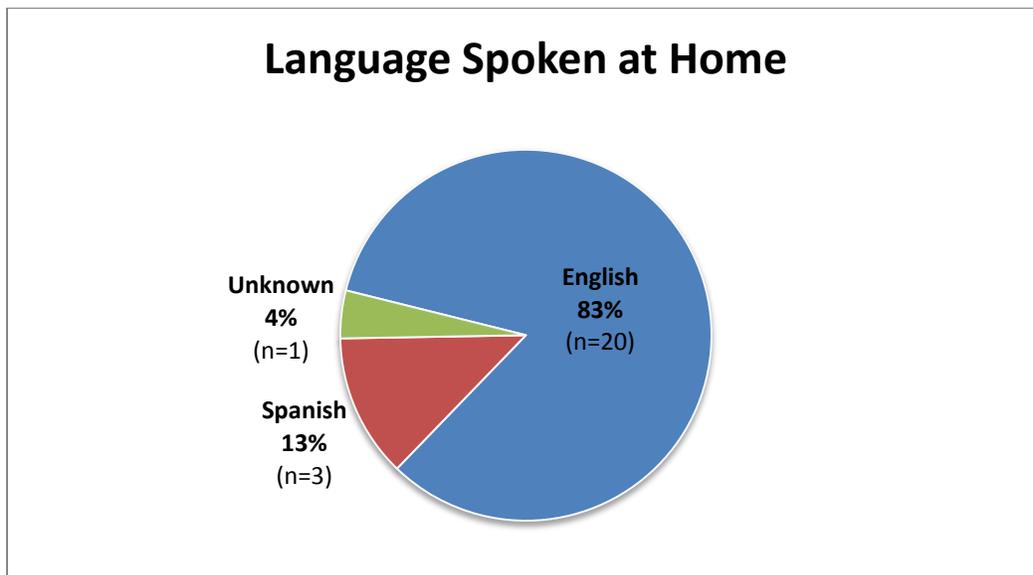
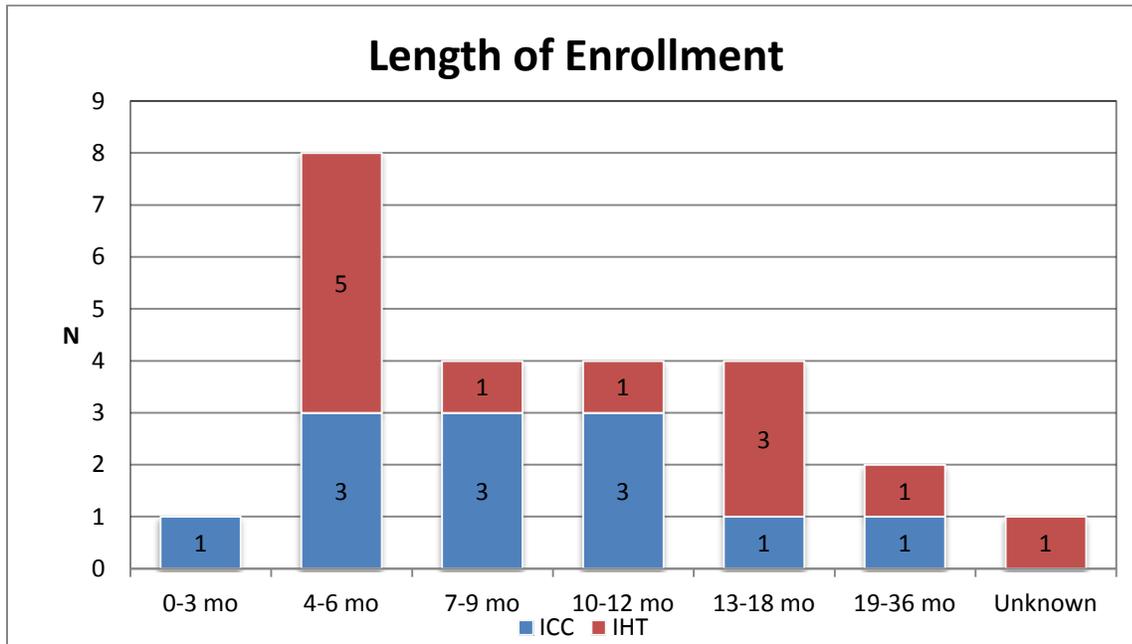


FIGURE 5: LANGUAGE SPOKEN AT HOME



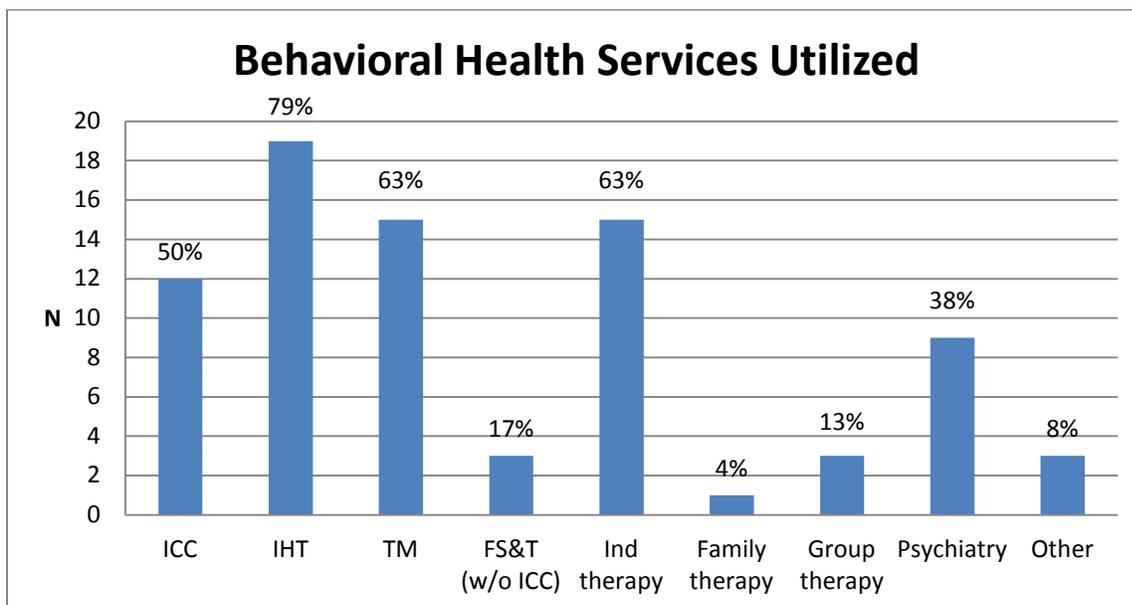
As shown above, the largest group of youth was between the ages of 5-9 years (38%), followed by 10-13 and 14-17 years (each at 25%). Seventy-one percent (71%) of the youth were male. In terms of race, Latino/Hispanic and White were equally represented at 38% each, followed by Asian/Pacific Islander (8%) and African American/Black (4%). English was identified as the language spoken at home for 83% of the sample, and Spanish was identified in 13% of families.

FIGURE 6: LENGTH OF ENROLLMENT AT TIME OF REVIEW



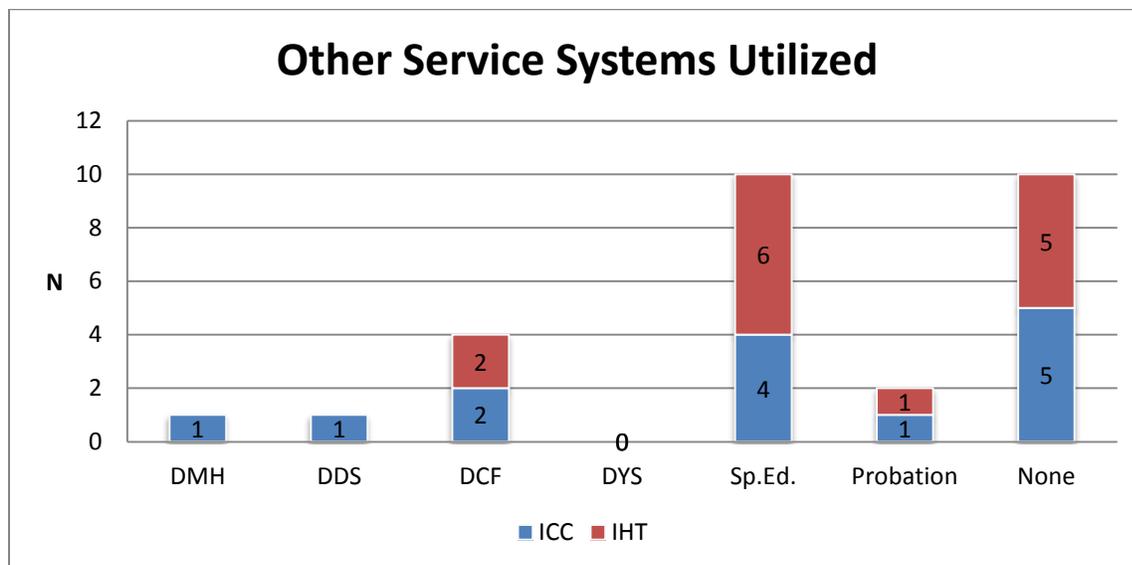
At the time of the review, 33% of the youth (n = 8) had been receiving services between 4-6 months, with over half of these (n = 5) youth enrolled in IHT versus ICC (n = 3). Seventeen percent had been in IHT or ICC for 7-9, 10-12 and 13-18 months each, and 8% had been receiving services for 19-36 months. The vast majority of youth reviewed remained in active treatment at the time of the review, therefore their length of stay at discharge is not yet known.

FIGURE 7: BEHAVIORAL HEALTH SERVICES UTILIZED



The types of behavioral health treatment/interventions currently being utilized by the children and youth reviewed were examined. The most frequently utilized service was IHT (79%),⁹ followed by Therapeutic Mentoring and Individual Therapy (both at 63%). Fifty percent of the sample was receiving ICC, with 29% concurrently receiving IHT. Thirty-eight percent were using Psychiatry services. Outpatient family therapy was the least utilized intervention (4%). Again it is worth noting that the youth reviewed were often utilizing more than one type of service so the percentages in Figure 7 total to more than 100%.

FIGURE 8: SERVICE SYSTEMS UTILIZED

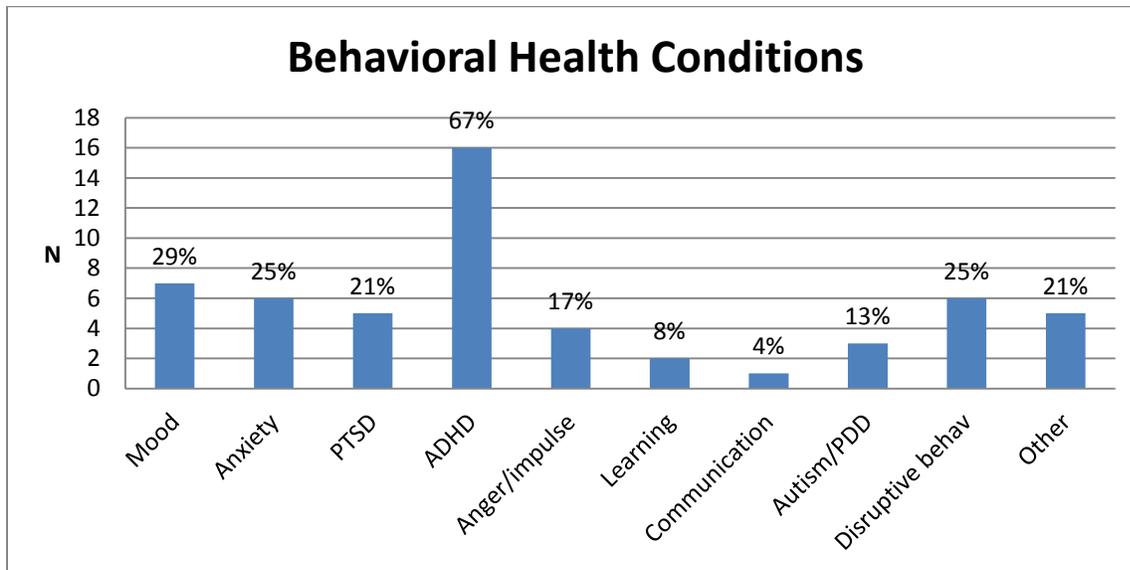


Note: Youth may be involved with more than one service system therefore the total number above is greater than 24.

Six different child-serving systems along with a “None” category were used to capture current service system involvement as part of the services profiles of youth selected as part of the sample. The SOCPR protocols documented that 42% of the youth received special education services, followed by DCF (17%). A smaller number received services from Probation (8% or n = 2) as well as DMH and DDS (4% or n = 1 each). No youth were reported to be receiving services from DYS. The “None” category accounted for 42% of responses. The 18 instances of service system involvement represent 14 youth, half of whom were enrolled in ICC. Four youth, two IHT enrolled youth and two ICC enrolled youth, were involved with two service systems each. Half of the 10 youth who had no service system involvement were enrolled in ICC, though one of these youth had prior involvement with DCF.

⁹ For 12 youth IHT served as their care coordination “hub.” Seven youth were enrolled in both ICC and IHT.¹⁰ It should be noted that in this case once a referral was made for IHT and TM, the provider responded quickly. The reviewer felt that a timelier referral from probation, the court, or another source (i.e. school, primary care, etc.) could have been beneficial for this youth and family.

FIGURE 9: BEHAVIORAL HEALTH CONDITIONS



The most common type of behavioral health condition reported among the youth reviewed was ADHD (67%), followed by Mood (29%), Anxiety (25%), and Disruptive Behavior (25%) disorders. It is important to note that almost two-thirds (62%) of the youth reviewed had more than one reported behavioral health condition thus the percentages in Figure 9 total more than 100%.

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, 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 5 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 Northeast region, SOCPR mean domain scores ranged from 5.50 to 6.32. 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 Northeast 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

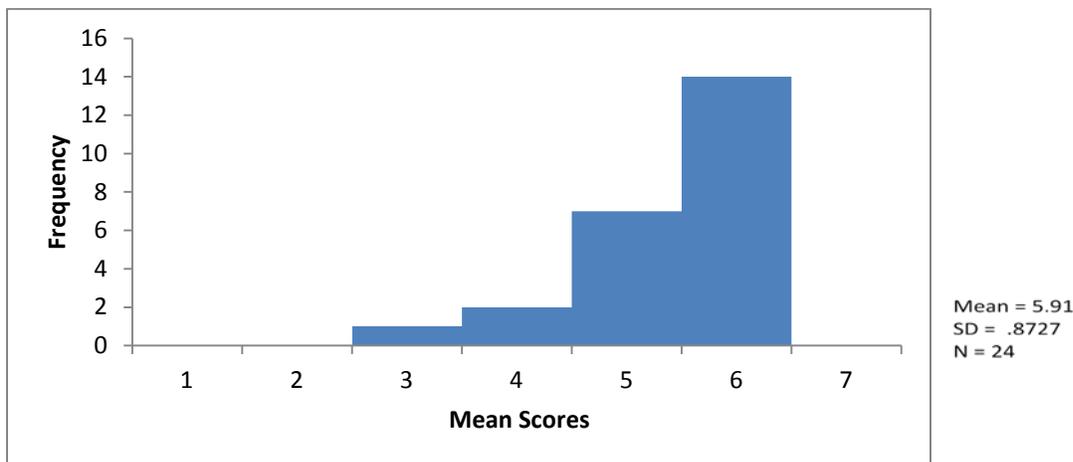
fact that ICC and IHT are services that are delivered primarily in home and community-based settings and are expected to be offered at times that are convenient for youth and families.

TABLE 5: NORTHEAST REGION SOCPR DOMAIN SCORES

	Min	Max	Mean	Standard Deviation	95% CI Lower Limit	95% CI Upper Limit
Overall	3.10	6.68	5.91	0.87	5.56	6.26
Domain 1: Child-Centered Family-Focused	2.25	6.81	5.89	1.16	5.46	6.36
Domain 2: Community-Based	4.60	7.00	6.32	0.66	6.06	6.58
Domain 3: Culturally Competent	2.50	6.70	5.68	0.85	5.34	6.02
Domain 4: Impact	2.25	6.75	5.50	1.22	5.01	5.99

Histograms were drawn to illustrate the range of SOCPR scores for the overall case and the four SOCPR domains. These figures are presented below. The overall mean score of the cases examined was 5.91. Fifty-eight percent (14 of 24 cases) fell into the range from 6 to 7 representing high SOC implementation, and seven cases (29%) scored in the 5 range. One (4%) had a mean in the 3 range and 2 (8%) had means in the 4 range.

FIGURE 10: OVERALL MEAN SCORES



The lowest scoring case with an overall mean of 3.10 appeared to be an outlier, scoring consistently low across all domains with the exception of Community-Based. This ICC case, which received the lowest score on both the Child-Centered and Family-Focused and Culturally Competent domains, is perhaps an example of how a needs assessment that does not fully consider the needs, strengths, and history of both the child and family, combined with infrequent contact or involvement of others involved in the family’s care (i.e. family members, informal supports, other providers) results in ineffective care coordination, service delivery, and outcomes.

Of the remaining two cases with mean scores in the 4 range, one had the lowest score on the Community-Based domain and the other on the Impact domain. For these two cases (both IHT only), problems with the assessment and/or mix of services the child/family was offered combined with care coordination issues appeared to result in ineffective service delivery and outcomes.

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

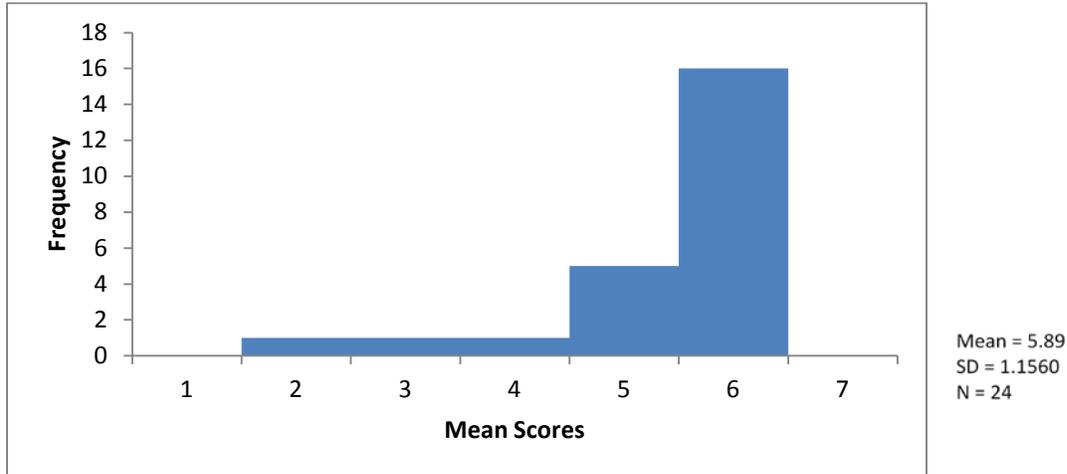


FIGURE 12: COMMUNITY-BASED MEAN SCORES

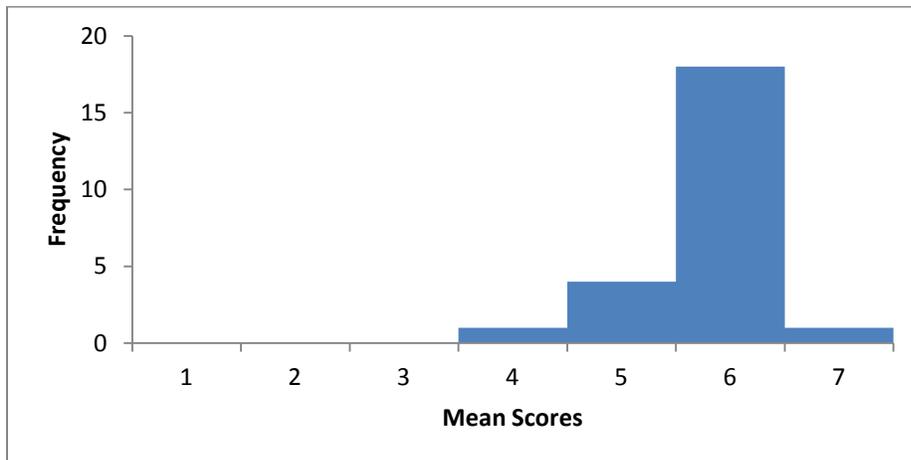


FIGURE 13: CULTURALLY COMPETENT MEAN SCORES

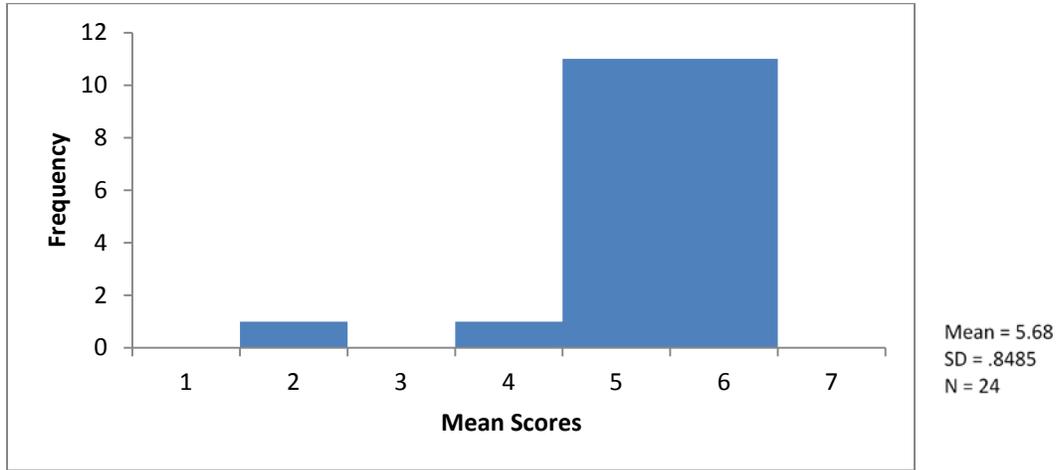
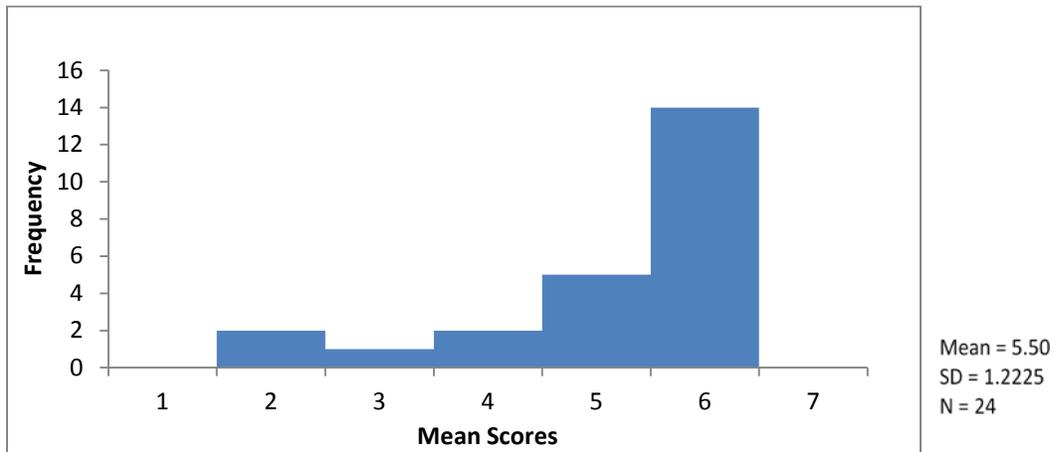


FIGURE 14: IMPACT MEAN SCORES



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 Northeast 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 5.89, which reflects good implementation of this SOC principle. In general, analysis of quantitative and qualitative data provided by SOCPR raters suggests that Northeast providers are delivering services that are child-centered and family-focused. The Full Participation sub-domain showed the greatest strengths, indicating that there is active and full participation among children and families in service planning and delivery. Responsiveness to emerging and changing needs of the child and family was also identified as an area of strength among providers.

Participation of formal and informal providers in service planning is an area for potential improvement, which is true particularly among the IHT only cases reviewed. Ratings also indicated that while providers had appropriately identified child and family strengths and their service planning and delivery informally acknowledged and considered these strengths, formal inclusion of strengths into service plan goals is another area for potential improvement. Qualitative comments from reviewers also suggest thoroughness of the assessment as an area for improvement, as well as several areas that appeared to need improvement among the IHT only cases reviewed including: better service plan integration across providers and agencies; improved care coordination with others involved in the child/family's care; and improved fit between types of services and supports provided and the youth and family's needs.

Sub-domain 1a: Individualized

The *Individualized* sub-domain includes four general areas. The first area focuses on the assessment of the youth and family. About 83% of reviewers agreed moderately or very much that a thorough assessment was conducted across life domains. One reviewer commented that, "the IHT clinician, Therapeutic Training and Support Specialist, and Therapeutic Mentor all described a clear picture of this family with matching information touching on the whole situation of child and family. Their description further matched the mother's description of child and family strengths and needs. She clearly stated that all life domains were addressed in the assessment."

However the written notes of reviewers suggested that in some instances, many but not all life domains were covered by assessments. Where specific missing areas were noted, these included housing, educational, and spiritual. One IHT clinician was quoted as saying that "our form is very basic and doesn't cover all the categories." One reviewer expressed concerns that assessment information did not take into account relevant history about the child and family, noting that "the team is missing an opportunity to really help this mom by not understanding some important aspects of her history." Two reviewers noted that workers who were new to working with the child and family did not seem very familiar with the assessment information that had been gathered previously.

About 75% of reviewers agreed moderately or very much that the needs of the child and family had been identified and prioritized. As one reviewer noted, "the most pressing needs have been addressed and are targeted through the goal statements and services that have been accessed

for the family.” Another reviewer noted that “the prioritization of [the family’s] needs shifted” based on the changing needs of one youth/family enrolled in IHT. A few reviewers did note some discrepancy between priorities that were identified during interviews with providers and families and what was documented. One reviewer noted that “because the assessment was limited in scope...the documented needs of the child were also limited,” and as a result focused only on certain behaviors despite different priority needs being expressed by providers and the family.

Finally 83% of reviewers agreed moderately or very much that the strengths of the youth and family were identified. One reviewer commented that “throughout, this case shows an exceptional consideration of the strengths of all parties.”

The second area of focus within the *Individualized* sub-domain is the service plan. While 75% of reviewers agreed moderately or very much that the service plan was integrated across providers, only 58% or 7 out of 12 agreed for IHT-only cases vs. 92% (11 out of 12) for ICC cases. An analysis of qualitative data points to lack of treatment integration noted for several IHT-only cases, including plans not being shared with other providers, lack of documented contact with or integration of treatment goals from other providers and the school, and lack of documented meetings with providers and family members. One reviewer of an IHT-only case noted “there is a plan in the chart but it does not appear to be integrated across providers. Plan is not shared with others - communication among providers happens via phone.” Another reviewer wrote, “Treatment Plan not integrated at all...mother identified providers about whom IHT was apparently not aware, did not identify other providers when asked by reviewer..” and “Therapeutic Mentor and IHT clinician talk periodically but do not meet together with family for treatment planning purposes.” Another reviewer commented that “treatment integration is a problem in this situation” and went on to cite lack of involvement/integration of several different service providers and the school.

Approximately 75% of reviewers agreed moderately or very much that the service plan goals reflected the needs of the youth and family. As one reviewer commented, “Goals seem to match well the issues and needs identified by the family and the child; all formal providers and mom agreed that goals reflected needs.” A few reviewers indicated that plan goals were better at reflecting the needs of the child than of other family members.

Only 50% of reviewers agreed moderately or very much that service plan goals incorporated the strengths of the youth and family. One reviewer stated “mother answered “no” when asked if the goals reflect her son’s strengths.” Another noted that “the service plan goals do not specifically incorporate the child and family strengths. ‘None reported’ is filled in for the strengths section for each goal.”

Many reviewers commented that while strengths may not be explicitly well-stated in service plan goals, they are acknowledged and/or articulated through the treatment planning and service delivery process. Further, a separate question asked if there was evidence that the provider had “informally” acknowledged and incorporated strengths into the service planning and delivery

process. Eighty-three percent of reviewers agreed moderately or very much that providers did. Comments from reviewers reflective of this included:

- There is tremendous respect for this family by helpers. Notes consistently indicated the strengths of mom and youth.
- Child and family strengths are informally considered throughout the service planning. Mother stated that she could tell from the goals that the team admires her family for being “so hard-working that we can follow through.” The team also noted a strength for both child and whole family as being “very motivated to change.”
- Providers focused on strengths, interest and creativity of all family members. Parents commented on how they felt supported, which encouraged them to utilize their strengths to accomplish their goals. It was evident the family trusted the team.

The final two areas focus on whether the types and the intensity of services and supports provided to the youth and family reflect their needs and strengths. About 79% of reviewers agreed moderately or very much that the types and intensity of services/supports provided did reflect needs and strengths. One reviewer quoted a family member as saying [As a result of ICC] “for the first time, we are getting what we need.” A reviewer of an IHT only case similarly noted that “mother reported she wouldn’t change anything about the services she was receiving.”

Both items showed some differences between IHT only and ICC cases reviewed. Reviewers agreed moderately or very much 58% (7 out of 12) of the time for IHT only vs. 92% (11 out of 12) for ICC that types of services reflected needs and strengths, and 67% vs. 92% that intensity of services was appropriate. Where a family appeared to be receiving the appropriate types of services and supports, the intensity of those services and supports were often noted as “just right” and able to be adjusted based on changing needs. When services and supports were noted as being inappropriate based on family needs and strengths, the intensity was similarly reported as inadequate. In two IHT only cases, reviewers assigned low ratings on these items because the parent had identified additional service needs that were not being met. In one instance, reviewer comments indicate that the IHT clinician failed to coordinate on school-related needs. In another, a mother wanted individual therapy and an IEP for her child and although it appeared the IHT clinician was supportive of these needs system barriers made accessing these services a challenge.

A third IHT only case had a seemingly unique situation which is reflected in the following comments: “The family had IHT for both children in the family, they also have a Family Partner, outpatient therapy, and referrals for two Therapeutic Mentors...having many providers each doing a small piece of the work seems much less useful than having a stronger, family-focused intervention by the IHT team...working on similar goals at the same time and often overlapping activities with the children, seems like more service than the family needs.”

TABLE 6: SUB-DOMAIN 1A INDIVIDUALIZED

SUBDOMAIN: 1a: Individualized	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: Assessment/Inventory								
1. A thorough assessment or inventory was conducted across life domains.	5.71	1 (4.2)	1 (4.2)	1 (4.2)	0	1 (4.2)	14 (58.3)	6 (25)
2. The needs of the child and family have been identified and prioritized across a full range of life domains.	5.75	0	2 (8.3)	0	0	4 (16.7)	12 (50)	6 (25)
3. The strengths of the child and family have been identified.	6.13	0	0	1 (4.2)	0	3 (12.5)	11 (45.8)	9 (37.5)
Area: Service Planning								
4. There is a primary service plan that is integrated across providers and agencies.	5.58	2 (8.3)	1 (4.2)	2 (8.3)	0	1 (4.2)	7 (29.2)	11 (45.8)
5. The service plan goals reflect needs of the child and family.	5.92	0	2 (8.3)	0	0	4 (16.7)	8 (33.3)	10 (41.7)
6. The service plan goals incorporate the strengths of the child and family.	5.21	1 (4.2)	0	4 (16.6)	0	7 (29.2)	7 (29.2)	5 (20.8)
7. The service planning and delivery informally acknowledges/considers the strengths of the child and family.	6.33	0	0	1 (4.2)	0	3 (12.5)	6 (25)	14 (58.3)
Area: Types of Services/Supports								
8. The types of services/supports provided to the child and family reflect their needs and strengths.	5.63	2 (8.3)	0	2 (8.3)	0	1 (4.2)	11 (45.8)	8 (33.3)
Area: Intensity of Services/Supports								
9. The intensity of the services/supports provided to the child and family reflects their needs and strengths.	5.67	1 (4.2)	1 (4.2)	2 (8.3)	0	1 (4.2)	11 (45.8)	8 (33.3)

Sub-domain 1b: Full participation

Reviewers agreed moderately or very much 83% of the time that youth and families actively participate in the service planning process, 96% of the time that they influence this process, and 92% of the time that they understand the content of their plans. One caregiver was quoted as saying “the team makes suggestions and recommendations then I decide, they leave the decisions to me.” Another reviewer noted that “mom and youth were exceptionally articulate about feeling in charge of the work. At one point in our interview, mom said with a smile, “I’m the boss.” One commented “mother reported that initially the youth was not able to sit in the meeting and advocate for herself but the team has taught her how ...now she speaks openly at the meetings about her needs.”

Reviewers agreed (88%) that the child and family were actively participating in services. While some reviewers noted that one of two parents or a sibling may not have been as actively involved, most reviewers commented that at least one caregiver and the youth were very engaged and participating in services.

In terms of participation by formal providers and informal helpers, only 67% of reviewers agreed moderately or very much that they were involved; this represents only 42% (5 of 12 IHT only cases) vs. 92% (11 of 12) for ICC. An analysis of reviewer comments suggests that some providers were more successful than others in including formal providers and/or natural supports in the planning process. For example, one reviewer commented that “case notes indicate frequent communication between and among the family and all providers... the ICC reported that providers attend most meetings, and when they don’t, the ICC updates them promptly.” Another stated that “the case file documentation indicates that all formal providers participate in the planning process; frequent contact/communication is evident.” Conversely, one reviewer noted “only IHT Clinician and Therapeutic Mentor are identified as formal providers in documentation; other formal providers...are not identified in the treatment plan and do not participate in service planning.” A reviewer also reported that for two IHT only cases, contact with other formal providers was made only via telephone. Some reviewers noted where efforts were being made to engage formal providers in the planning process. Comments supporting this observation include:

- Recently, a Therapeutic Mentor has been added and will begin participating in planning with the IHT and mother. IHT plans to involve the child’s school in service planning as well as the child’s PCC, who is prescribing psychotropic medications.
- The charter school that the child attends was not included in the initial planning (over the summer) but has been brought in recently to discussions to coordinate between school and home.

In addition, informal helpers were not always included in the planning process, though at times it was specified that this was the caregiver’s preference (e.g., “per mother’s preference, no informal helpers are involved.”)

TABLE 7: 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)	6.17	0	1 (4.2)	0	0	3 (12.5)	9 (37.5)	11 (45.8)
11. The child and family influence the service planning process (initial plan and updates)	6.33	0	1 (4.2)	0	0	0	11 (45.8)	12 (50.0)
12. The child and family understand the content of the service plan.	6.38	0	1 (4.2)	0	0	1 (4.2)	8 (33.3)	14 (58.3)
13. The child and family actively participate in service.	6.38	0	0	0	0	3 (12.5)	9 (37.5)	12 (50.0)
14. The formal providers and informal helpers participate in service planning (initial plan and updates)	5.29	2 (8.3)	2 (8.3)	1 (4.2)	0	3 (12.5)	9 (37.5)	7 (29.2)

Sub-domain 1c: Care coordination

In the *Care Coordination* sub-domain, 71% of reviewers agreed moderately or very much that one individual appeared to be responsible for coordinating child and family services and was doing so successfully. Reviewers of IHT only cases agreed in only 50% or 6 out of 12 of the cases and reviewers of ICC cases agreed in 92% or 11 out of 12 of the cases. Regardless of whether a case was IHT only or ICC, where a low rating was given it was primarily due to the fact that while someone was charged with the coordination role, they were not fulfilling it with some or all others involved in the child/family’s care. Even when a higher rating was given, some reviewers noted coordination challenges. For example, “while the IHT was doing the coordination she seemed to be struggling since assuming the role from ICC after they closed 6 months ago, there was a lack of coordination with people outside the IHT’s agency” was a comment from one reviewer. Another reported “IHT meets with the family weekly and checks in on how things are going but there is no coordination with other providers, only check-ins.”

Nevertheless, positive reviewer comments regarding IHT only and ICC cases alike demonstrate good coordination efforts:

- Care coordinator has done a superb job of coordinating the planning and delivery of services. Everyone is in the loop, meetings are planned ahead of time, and everyone knows what role everyone on the team is playing.

- The IHT has done an excellent job of coordination, especially in her outreach to the school. After frustration with having no calls back...the IHT and mother together went to school for an impromptu meeting on the spot with the teacher...The IHT also performed the functions of the TT&S worker in the lapse between the first staff (who left the agency) and the new TT&S. When the new worker came on, the IHT brought her up to speed immediately.
- All parties report that the ICC holds everything together. Mom and youth use the same words - "She is always there for us" (youth) "I never have to worry about her returning my call" (mom).
- There is clearly one lead person [IHT] successfully coordinating services and supporting this family.

About 88% 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 area included:

- There was a progression of the service plan where goals/objectives had been added as the needs of the youth/family changed. For instance during the service the youth had been hospitalized and the team prioritized safety as a goal for the youth upon her transition from the hospital.
- Both IHT and family report that they meet the family where they are and if things come up they address accordingly.
- The services have been very responsive to the emerging changing needs of the family. Assessing and changing plans as a more critical need arises such as financial issues, housing, physical health, recovery needs, etc.
- (Grandmother) - "they keep breaking down goals and interventions until they work"

Despite this, there were a few instances where reviewers felt services were not responsive to the changing needs of the youth and family. One reviewer noted that no changes had been made to the initial service plan when it was reviewed "though additional concerns about housing and school had emerged." Another observed that the provider had only, "intermittent contact with family and no contact with other providers" which made it difficult for them to pick up on the changing and emerging needs of the youth and family.

TABLE 8: 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.	5.79	2 (8.3)	1 (4.2)	1 (4.2)	0	3 (12.5)	2 (8.3)	15 (62.5)
16. Service plan and services are responsive to the emerging and changing needs of the	6.04	1 (4.2)	1 (4.2)	1 (4.2)	0	0	8 (33.3)	13 (54.2)

SUBDOMAIN	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 (%)
1c: Care coordination child and family.								

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 public and private providers. The sub-domains in this area 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 = 6.32). Scores in the sub-domains of *Access to Services* and *Minimal Restrictiveness* were the highest scoring areas in the 6 to 7 range. These scores indicated that services are accessible to children 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 Northeast IHT providers. Areas for potential improvement were noted in the *Integration and Coordination* sub-domain, where individual cases exhibited challenges in terms of communication with some other providers and family members and with linkages to certain types of services including services outside of a provider’s own agency.

Sub-domain 2a: Early intervention

In the sub-domain of *Early Intervention*, reviewers agreed moderately or very much 79% of the time that providers quickly assessed and clarified the youth and family’s initial concerns, and once the needs were clarified, initiated appropriate services and supports. In at least 2 instances however, the needs of the child and family were neither appropriately clarified nor responded to with right combination of services. In a few other instances, while clarification of needs happened almost immediately there was a wait ranging from several weeks for Therapeutic Mentoring (TM) services to 1-3 months for IHT services.

In a small number of instances, it was noted that if a referral for services had been made earlier, the youth and family might have benefitted. For example, while one youth quickly accessed IHT and TM services, the reviewer stated “the system as a whole¹⁰ could have been more attentive to this youth’s needs as a CHINS was filed on him over a year ago and he was involved with probation.” The mother of another youth who had immediately received IHT services was noted by the reviewer as having felt that the child’s symptoms “might not have been exacerbated if initial individual therapy had been consistent earlier.”

¹⁰ It should be noted that in this case once a referral was made for IHT and TM, the provider responded quickly. The reviewer felt that a timelier referral from probation, the court, or another source (i.e. school, primary care, etc.) could have been beneficial for this youth and family.

TABLE 9: 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.	5.67	1 (4.2)	2 (8.3)	0	0	2 (8.3)	12 (50.0)	7 (29.2)
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	2 (8.3)	1 (4.2)	0	0	2 (8.3)	10 (41.7)	9 (37.5)

Sub-domain 2b: Access to services

Three general areas comprise the *Access to Services* sub-domain: whether services were provided at *convenient times*, *locations*, and in the *appropriate language*. Reviewers agreed that services were provided to youth and families in convenient locations (100%) and at times (100%) that families indicated worked for them. Reviewers noted that services were by and large provided in the family’s home or nearby community locations, that “the services are flexible around the family’s needs and their schedule”, “meetings are scheduled around the parents’ work and other obligations,” and “consideration was also given to scheduling so school time was not compromised.” A mother was noted as saying the schedule of services “couldn’t be any more convenient.”

Ninety-six percent of reviewers agreed moderately or very much that verbal communication about services and supports were provided to youth and family in their primary language. Reviewers agreed moderately or very much 83% of the time that families were provided written communication in their primary language. By and large, families that did not speak English received services from bilingual providers. Where documentation was not written in the family’s primary language, it was noted that the information is translated for the family verbally.

TABLE 10: 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.	6.83	0	0	0	0	0	4 (16.7)	20 (83.3)
Area: Convenient Location								
20. Services are provided within or close to the home community.	6.92	0	0	0	0	0	2 (8.3)	22 (91.7)
21. Supports are provided to increase access to service location.*	7.00	0	0	0	0	0	0	2 (100)
Area: Appropriate Language								
22. Service providers verbally communicate in the primary language of the child/family.	6.83	0	0	0	0	1 (4.2)	2 (8.3)	21 (87.5)
23. Written documentation regarding services/service planning is in the primary language of child/family.	6.21	2 (8.3)	0	0	0	2 (8.3)	3 (12.5)	17 (70.8)

*NA = 22; 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 96% agreed moderately or very much that they were provided in the least restrictive and most appropriate environment. One reviewer commented that “mother once thought this child might need residential so supporting him in the community has been a big success.” Another noted “in many ways the fact that this complex and difficult youngster remains at home is remarkable. He is clearly in the least restrictive environment, and with mom’s hard work is at the appropriate level of care.”

TABLE 11: 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.	7.00	0	0	0	0	0	0	24 (100)
25. Services are provided in the least restrictive and most appropriate environment.	6.88	0	0	0	0	1 (4.2)	1 (4.2)	22 (91.6)

Sub-domain 2d: Integration and coordination

The *Integration and Coordination* sub-domain data showed that 75% 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 communication between service system representatives or providers and family members. Comments reflective of this included:

- Documents and interviews make it clear that the ICC does an outstanding job of promoting and coordination of communication among all team members.
- The ICC does an exceptional job brokering communication among an extensive group of formal helpers. Mom and youth value highly the work of the ICC in keeping the team connected.
- IHT in constant communication with the family via phone and meetings in the home.
- Excellent communication among all parties, as noted, with extra effort to bring in the latecomers. All formal providers clearly are up to date, as is the mother. Communication is a combination of phone contacts and face-to-face meetings, as appropriate.
- Case file documentation indicates that all formal providers have frequent contact/communication, minimally weekly. Mother reported all the providers involved talk frequently with each other and with her, and they all attend ICP team meetings.

While communication was good in general, it was not consistent with all team members. One reviewer of an ICC case noted communication was happening between the ICC and the mother but not with other formal providers. Slightly more reviewers of IHT only cases (25% or 3) disagreed, citing communication challenges with other providers and between formal providers and some family members. Overall, where provider types were noted in terms of posing a communication challenge, DCF, school, and probation were specifically mentioned.

The data showed that 75% of reviewers also agreed moderately or very much that there was a smooth and seamless process for linking the youth and family with additional services when necessary. Notable exceptions include two instances where no external referrals had been made outside the IHT agency for other services, and two where certain types of services (e.g. respite, trauma-informed care, etc.) had been identified but not accessed.

TABLE 12: 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.	5.67	1 (4.2)	3 (12.5)	0	0	2 (8.3)	7 (29.2)	11 (45.8)
27. There is a smooth and seamless process to link the child and family with additional services if necessary.	5.46	3 (12.5)	0	1 (4.2)	0	2 (8.3)	11 (45.8)	7 (29.2)

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 5.68, which represents good implementation of this SOC principle. The greatest area of strength was evident in the *Awareness* sub-domain, where providers demonstrate awareness that children and families must be viewed within their own cultural context and community. Within the same sub-domain is an area for potential improvement concerning providers’ awareness regarding the subtle impact of their own culture on the delivery of services. Another area for improvement concerns the intentional inclusion of informal supports in both service planning and delivery.

Sub-domain 3a: Awareness

The mean scores for the sub-domain of *Awareness* fell into the 5 to 6 range. About 83% of reviewers agreed moderately or very much that providers recognized youth within the context of their culture and their community, and 88% percent agreed that providers know about the family’s concepts of health and family. Seventy-one percent agreed that providers understood that a family’s culture influenced their decision-making process. An examination of reviewer comments showed that at times this was either not documented or not articulated clearly during interviews. Only 63% of reviewers indicated that providers understood their own values and principles and how that might influence how they worked with youth and families, and 67% agreed that providers were aware that there may be subtle cultural characteristics present between themselves and the families with whom they worked.

Reviewers assessing for *Awareness* noted that providers generally seemed to have a good understanding of culture and community, how cultural issues impacted the family's view of health/mental health, and the impact of culture on the family's choices. These appeared to be strengths of the providers, perhaps due in part to the fact that in many instances the provider seemed to actually share the culture of the child and family. However, often times where the reviewers' culture was different from the family's, providers seemed less aware of the impact of their own respective culture on the delivery of services, and potentially lacked awareness of the dynamics inherent in working with families whose culture differs from the provider's.

TABLE 13: 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	6.04	0	1 (4.2)	0	0	3 (12.5)	12 (50.0)	8 (33.3)
29. Service providers know about the family's concepts of health and family.	5.92	1 (4.2)	0	0	0	2 (8.4)	16 (66.7)	5 (20.8)
30. Service providers recognize that the family's culture, values, beliefs and lifestyle influence the family's decision-making process.	5.88	0	0	2 (8.4)	0	5 (20.8)	9 (37.5)	8 (33.3)
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.	5.58	0	1 (4.2)	1 (4.2)	0	7 (29.2)	11 (45.8)	4 (16.7)
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.	5.29	0	3 (12.5)	1 (4.2)	0	4 (16.7)	14 (58.3)	2 (8.4)

Sub-domain 3b: Sensitivity and responsiveness

Scores in the area of *Sensitivity and Responsiveness* showed that 74% of reviewers agreed moderately or very much that services were responsive to the values and beliefs of the youth and families. 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 70% of the time (83% IHT only, 58% ICC). One reviewer commented that the responses to these questions were too vague to rate, and another also commented about being unsure how to rate this item.

TABLE 14: 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.*	5.65	1 (4.3)	0	0	1 (4.3)	5 (21.7)	12 (52.2)	4 (17.4)
34. Services are responsive to the child and family's values, beliefs and lifestyle.*	5.87	0	1 (4.3)	0	0	5 (21.7)	11 (47.8)	6 (26.1)

*Analysis of questions 33 & 34 is based on 23 responses; reviewer indicated responses were too vague to rate.

Sub-domain 3c: Agency culture

The *Agency Culture* sub-domain data showed that 78% of reviewers agreed moderately or very much that providers recognized that 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. Further, 75% indicated that providers assist the child and family in understanding and navigating the agencies they represent. Reviewer comments suggest it was not always clear whether families understood the agency/providers' expectations or the extent of the services they offered.

TABLE 15: 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	5.79	0	2 (8.7)	0	1 (4.3)	2 (8.7)	10 (43.5)	8 (34.8)
36. Service providers assist the child and family in understanding/navigating the agencies they represent.	5.75	1 (4.2)	1 (4.2)	0	1 (4.2)	3 (12.5)	10 (41.7)	8 (33.3)

*Analysis of question 35 is based on 23 responses; one reviewer indicated the response was too vague to rate.

Sub-domain 3d: Informal supports

Sixty-three percent of reviewers indicated that service planning and delivery did not include informal sources of support for the child and family. This sub-domain represented the lowest mean score for cultural competence. Comments from reviewers of cases receiving lower ratings indicated that either informal supports had not been identified or that family members did not want certain informal supports included and in some cases providers failed to help the family identify alternative sources of informal support in their environment when this was the case.

TABLE 16: 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.	5.00	3 (12.5)	1 (4.2)	1 (4.2)	2 (8.3)	2 (8.3)	11 (45.8)	4 (16.7)

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 if so, whether these services met the child/youth and family’s identified needs.

The Impact domain had the lowest overall mean score of 5.50. It is important to keep in mind that the youth in the sample were still in active treatment at the time of the review. 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

Within the *Impact* domain the *Improvement* sub-domain scored in the mid 5 range. Almost 71% of reviewers agreed moderately or very much that services and supports provided to the family as a whole helped improve their circumstances. However only 54% agreed the youth’s situation had improved as a result of the services and supports he/she received. Most reviewers noted that despite progress there was room for improvement which as mentioned above, is to be expected, especially since some were “just getting started” in services and in making progress toward goals. As one mother who was noted as saying that there was a still a long way to go put it, “if you had seen us a year ago, you wouldn’t know we were the same family.” In a small number of cases, reviewers did not agree that progress had been made; in one instance, the reviewer felt that while the youth had been helped the mother had not; in another, the reviewer saw little documented evidence of progress, while the mother and formal providers noted “a little” or “some”; and in another, the child/family’s housing situation had improved but little else.

Despite this, there were a number of positive reviewer comments indicating improvements. Regarding one youth, a reviewer noted “strong evidence that this has been a wonderful turnaround” and quoted the youth as saying “I am a better person now.” One mom commented that “this has been a wonderful experience; they are great in helping families be successful.” Another said that “the services have helped tremendously” and that she is “now able to be a

better mom.” In most cases, reviewers noted behavioral improvements, doing better in school, improved safety, and increased parenting skills in terms of appropriately managing behavior and better communication with the youth in their family. A few families even reported less stress as a result of the progress that had been made.

TABLE 17: 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	5.46	0	1 (4.2)	1 (4.2)	0	9 (37.5)	10 (41.7)	3 (12.5)
	FAM	5.58	0	2 (8.3)	0	0	5 (20.8)	14 (58.3)	3 (12.5)

CH=Child; FAM=Family

Sub-domain 4b: Appropriateness

Nearly 71% of reviewers agreed moderately or very much that that the services and supports being provided to the *youth* were appropriate for their needs with slightly more agreeing (79%) that this was the case for the *family*. One reviewer noted that the team had “put together an extensive package of services which seem just right for current needs.” The same reviewer commented that “this team, and the way they included the mom as an influential team member is everything CBHI should be.”

In a few instances, it was noted that the parent had behavioral health issues that had not been adequately assessed or addressed that were impacting her parenting despite the child receiving appropriate supports. A few also raised concerns regarding the needs of the youth not being appropriately addressed. In one instance, the reviewer felt the mix of services was in question. In another, while the IHT services were appropriate, there was apparent difficulty accessing other services the parent wanted for the child (IEP and individual therapy). One reviewer noted that an IHT clinician determined he did not have the skills/training needed to appropriately treat a youth with a specific behavioral challenge and planned to refer the youth to another provider with the appropriate training.

TABLE 18: 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	5.58	1 (4.2)	1 (4.2)	1 (4.2)	0	4 (16.7)	11 (45.8)	6 (25)
	FAM	5.38	2 (8.3)	0	2 (8.3)	0	1 (4.2)	17 (70.8)	2 (8.3)

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 youth 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. Two thirds of the reviewers indicated the youth did not need a care planning team to coordinate services from the same or multiple providers (66.6%).

Question 2 asked about receiving services from multiple agencies and the need for coordination of services. Seventy-five percent (75%) of reviewers indicated they did not need assistance.

TABLE 19: 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	8 (66.6)
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 (Table 20) asked if the level of care coordination, in this case IHT, was appropriate. About 67% of the reviewers agreed moderately or very much that it was.

TABLE 20: 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.	1 (8.3)	2 (16.7)	0	0	1 (8.3)	4 (33.3)	4 (33.3)

For question 4 (Table 21), three quarters of reviewers (75%) indicated that the youth had not been enrolled in ICC previously.

TABLE 21: PRIOR ICC ENROLLMENT

	Response	n (%)
Q4. Has the youth previously been enrolled in ICC?	No	9 (75)

Table 22 describes the reasons provided for why ICC ended for the three youth who had been previously enrolled. For those families who had been enrolled, ICC ended because the ICC left the agency and the mom did not want another one (i.e. it was the family’s decision), or ICC level of coordination was no longer needed and the transition was made to IHT and/or TM, although in one instance the reviewer noted that the coordination now being done through IHT was poor quality.

TABLE 22: REASONS FOR ICC DISENROLLMENT

Q4a. If yes, briefly explain why the youth is no longer enrolled.
ICC left agency, mom didn’t want another one.
Achieved goals, was doing well. Does not need ICC level of coordination; IHT is the right level, but very poor quality.
Made transition to IHT and TM.

Question 5 showed that half of reviewers (50%) indicated that the option of receiving ICC had not been discussed with the family by the IHT team.

TABLE 23: 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)

If reviewers said yes, reasons included that it was not needed; family did not want more services; or the youth had been previously enrolled in ICC.

TABLE 24: FAMILY REASONS FOR DECLINING ICC

Q5a. If yes, briefly explain below the family’s reason for declining ICC.
Previously enrolled in ICC.
Not needed. IHT is the right level.
Not needed, all agreed.
IHT facilitates and coordinates at this time. Mom stated no, she did not see a need for it at this time.
Offered initially at time IHT referred but mother refused, wanted fewer people involved with family. Already have IHT and individual therapy for youth and sibling. Recently added Therapeutic Mentoring.
Mother did not want more services. Mother reports that she is slow to trust people.

If reviewers said no, the most frequent reasons included that the IHT clinician believed there was no need; families had minimal services so no need for coordination of services through ICC; it would be too overwhelming for the family; and previously enrolled in ICC.

TABLE 25: REASONS FOR NOT DISCUSSING ICC WITH THE FAMILY

Q5b. If no, briefly explain why not.
Not necessary, doesn't have multiple agencies involved.
IHT did not see a need at this time, appropriate at this time based on what youth needs. Mom feels things are good as they are and does not want anyone else.
No, too overwhelming for the family. First IHT did help to get additional services in place and communicated with all providers.
Didn't see as need. A lot of services put in place at one time.
Care coordination provided by IHT. IHT indicated "No other services needed."
Previously enrolled

Question 6 asked if the youth needed assistance from their formal provider in working with the schools. Reviewers agreed about 67% of the time that the youth/family did need assistance in working with the school system.

TABLE 26: 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)	1 (8.3)	1 (8.3)	0	3 (25)	5 (41.6)

Question 7 asked reviewers to indicate if the IHT team was in contact with all the service systems involved with the youth and family. Fifty percent agreed moderately or very much that the IHT team was connecting with the other service systems.

TABLE 27: 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.	2 (16.7)	1 (8.3)	1 (8.3)	0	2 (16.7)	3 (25)	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%) agreed moderately or very much that the service systems were involved in the planning for youth.

TABLE 28: 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.	5 (41.7)	0	0	0	3 (25)	1 (8.3)	3 (25)

Question 9 asked for information about the other hub dependent services that youth were receiving at the time of the review. Responses indicated that one hub dependent service, Therapeutic Mentoring, was received by about 83% of the families, and Family Support and Training by 25% of families, while In-Home Behavioral Services was not being accessed. Two families were not accessing any of the three hub dependent services.

TABLE 29: OTHER HUB DEPENDENT SERVICES

Q9. Indicate the other “hub dependent” services supported by IHT	Response	n (%)
Q9i. Therapeutic Mentoring	Yes	10 (83.3)
Q9ii. Family Support and Training	Yes	3 (25)
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 Northeast region are demonstrating a system of care approach to service planning and delivery. Areas of particular strength for providers in this region included:

Identification and incorporation of strengths into service delivery

Results of this review suggested that providers appropriately *identified child and family strengths and draw upon these identified strengths in their work with families*. Identification of youth and family strengths and utilizing these strengths in their service planning and delivery processes were the two highest scoring areas within the individualized sub-domain. Northeast region providers clearly understand that drawing upon and developing the unique strengths, talents, and interests of youth and families can promote more active participation and engagement of families and can open up new pathways forward for youth and families who often have only been recognized for what is wrong with them as opposed to areas where they excel.

Participation of youth and families

There is active and full participation among children and families in service planning and delivery. Northeast region providers have embraced the concept of family-driven and youth-guided care and recognize that families need to be engaged as true partners in the planning and delivery of services they receive.

Responsiveness

Providers are responsive to emerging and changing needs of children and families in the planning and delivery of services. While some aspects of service planning and coordination could be improved, whether or not providers were responsive to emergent issues and changing life circumstances of the youth and families they served was not in question. In all but three cases reviewers endorsed that the youth's service plan and providers evolved to meet their changing needs.

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. Northeast 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.*

Cultural awareness

Providers demonstrate awareness that children and families must be viewed within their own cultural context and community. This is an important aspect of ensuring culturally competent care, a key system of care value. Reviewers found evidence that Northeast region providers explored the family's traditions, beliefs, and celebrations as part of their assessment process and were able to view the family's decisions, preferences, and actions through the lens of the family's unique cultural context.

Opportunities for improvement

Although ratings were high overall in the majority of cases and families generally seem satisfied, findings did indicate opportunities for growth in the following areas:

Assessment

The thoroughness of some provider assessments could be improved in terms of both depth (e.g. taking into account important psychosocial information) and breadth (e.g., expanding the range of life domains covered); in some instances this would appear to require greater clinical sophistication among staff conducting assessments. Given that the assessment process serves as the foundation for much of the work that follows, the importance of a thorough assessment that takes into account the perspective of multiple informants cannot be underestimated. As one reviewer pointed out, "because the assessment was limited in scope...the documented needs of the child were also limited." For some providers it seems that the assessment is a static event as opposed to a continuous process that drives changes to the service plan and the work with the youth and family. The results of the IHT supplemental questions also raised concerns about the adequacy of the assessment for youth enrolled in IHT. For approximately 33% or 4 of the 12

youth where IHT was serving as the clinical “hub”, reviewers indicated that the youth was receiving multiple services and needed a care planning team to coordinate services (see question 1 in the IHT supplemental section). These are youth who could likely benefit from a referral to ICC. This suggests that some providers may not have adequately assessed the needs of the youth and family and may need additional guidance determining what services are most appropriate for a youth and family.

Service planning

The service planning process stood out as an area for growth for Northeast region providers. Given the issue described above regarding the quality of the assessment, it is not surprising that service planning, which follows along from the assessment, was an area for improvement. *Specifically, service plans should better incorporate child and family strengths into goals, and both service plans and the planning process should be better integrated across providers and agencies.* Improved integration of the service plan across providers and agencies was a particular need for those youth served by IHT providers. While ICC providers have a clearly defined service planning process in Wraparound, the same is not true in IHT. Greater clarity around expectations for service planning for IHT providers who are serving as the care coordination “hub” appears warranted. Identification and dissemination of best practices on how to develop a cohesive and well-articulated plan across multiple service providers could be an important intervention for IHT providers.

Inclusion of both formal providers and natural supports in the service planning process could be improved, with more intentional inclusion of informal supports in both service planning and delivery. This was another area where IHT providers specifically should focus their improvement efforts. Again, while the Wraparound model utilized in ICC emphasizes the use of a team composed of both formal and natural supports to develop the individualized care plan for the youth, IHT suffers from a lack of clear guidance regarding the service planning process. For example, more than one reviewer reported hearing that because they [IHT providers] are not required to have a planning meeting that involves people other than the youth/family they had not considered convening such a meeting; coordinating with other providers or state agencies only in more informal ways such as through emails or periodic phone calls.

Finally, ensuring that the type of services and supports a child and family receives is based on their individually identified needs and strengths is another opportunity for growth, particularly for IHT providers. Again, the lack of adequate fit between the needs of the youth and family and the services and supports put in place could be viewed as resulting from an assessment that failed to adequately identify or prioritize the needs and strengths of the youth and family. For all providers, developing clear policies and procedures with regard to making referrals for needed services, particularly those outside of an IHT or ICC provider’s own agency is another area to focus improvement efforts.

Awareness of cultural dynamics

Awareness among providers of cultural dynamics inherent when working with families whose culture may be similar to or different from their own could be improved. While providers appeared to understand that cultural issues were an important area to be explored with families,

there was more limited recognition of the need to explore how cultural differences (or similarities) could impact their work with youth and families. This is a concept that can be challenging or even uncomfortable to discuss with families (e.g. exploring what it might be like for a parent to receive services for a much younger individual with no children or from someone from a different race or gender). 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.

Care coordination

Better care coordination with others involved in the care of children and families is needed, which in part requires greater role clarification among certain types of staff responsible for this critical function. A common theme among reviewers at the debriefing was that in several instances there was not a clear understanding as to the role of different members of a child's team or who should be responsible for performing certain tasks. Reviewers of IHT-only cases agreed in only 50% of cases that one individual appeared to be responsible for coordinating services. Further evidence of the need for improved care coordination particularly in those instances where IHT is serving as the "hub" was found in the IHT supplemental section wherein only half of reviewers agreed moderately or very much the IHT clinician was in regular contact with other providers, state agencies, and school personnel. In addition, in only eight of the twelve IHT only cases reviewed did reviewers moderately or strongly agree that the youth was receiving the level of care coordination his/her situation required.

Impact of services

While some evidence exists that the services and supports being provided are appropriately meeting the needs and improving the situation of both the children and the families served, there is room to enhance these outcomes. Of the four SOCP domains, the Impact domain had the lowest overall mean score (M = 5.50). While reviewers endorsed that services had a more profound impact on the family there was less agreement that services had improved the youth's situation. This of course may be an expected result given that approximately 37% of the families reviewed had been participating in services for six months or less.

Conclusion

Overall the results of the Northeast SOCP 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. Northeast 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 in this area also excelled at delivering care that was child-centered and family-focused by actively engaging family's and youth in the service planning and delivery process and being responsive to their emerging and changing needs. While overall, practice appeared strong in the majority of areas reviewed, opportunity for improvement stood out related to the thoroughness and quality of assessments, service planning process particularly for IHT providers, care coordination activities, and awareness of cultural dynamics.

This report, along with the information offered at the individual provider-specific debriefings that were convened by staff from MassHealth and EOHHS following the Northeast 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.

Appendix A:

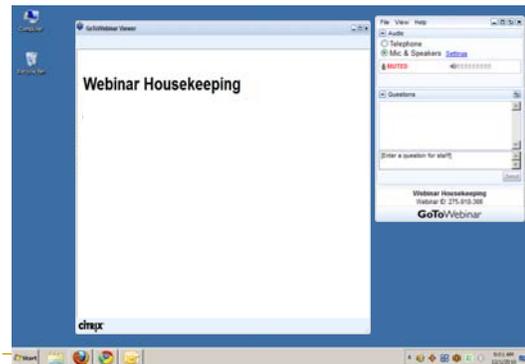
Consent and Scheduling Webinar

System of Care Practice Review (SOCPR) for CBHI

Provider Webinar on Consent & Scheduling Procedures

Kelly English and Amy Horton
Technical Assistance Collaborative
September 4 & 5, 2013

GoToWebinar: Attendee Interface



2

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, authorization(s) to release information from the youth/family
- Notify TAC in 1-2 business days if family/youth does not consent to participate in SOCPR process
- Schedule interviews using the Excel file 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.)

6

Consent to Participate

7

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

8

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

9

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

10

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	Mon., Oct. 21	Consents, Releases & Schedule
2- Primary	Tues., Oct. 22	Consents, Releases & Schedule
3- Alternate *Hold pending notification from TAC*	Not assigned	IF youth 1 or 2 declines, approach alternate for: Consents, Releases & Schedule

11

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 agrees 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

12

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 Consent to Participate •Caregiver Consent to Participate (youth must sign a release authorizing the caregiver to be interviewed)

13

Caregiver Consent

The caregiver signs this indicating that he/she consents to participate and be interviewed

The caregiver signs this indicating that he/she allows youth (age 12-17) to participate and be interviewed

Clinician/care coordinator signs this indicating that SOCPR was explained to and understood by the consenting family

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 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 now receiving **Behavioral Health** CMI 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 giving 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 reviewers 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/her family for the child.

Witness/Program or Agency Representative _____ Date _____

14

Youth (18 or older) Consent

The youth, aged 18 or over, signs this indicating that he/she consents to participate and be interviewed

Clinician/care coordinator signs this indicating that SOCPR was explained to and understood by the consenting youth

System of Care Practice Review (SOCPR)
YOUTH ASSENT (AGED 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 participate and the right to withdraw. If I withdraw, it 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 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 _____

15

Youth (ages 12-17) Assent

The youth, age 12-17, signs this indicating that he/she understands the SOCPR and will be interviewed

Clinician/care coordinator signs this indicating that SOCPR was explained to and understood by the youth

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

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

One way to help us improve the System of Care Practice Review (SOCPR) process is to ask you and your family to take part in the SOCPR process. We would like to know how you feel about the System of Care Practice Review (SOCPR) process and how you feel about the care that you are receiving. We would like to know how you feel about the care that you are receiving and how you feel about the care that you are receiving.

What is the purpose of the SOCPR?

We hope to learn how good the SOCPR process is for helping you and your family. We are also asking other families about the experience.

What will I have to do to take part?

Reviewers will come and interview you at a time and place that is convenient for you. The interview should take 45 minutes or less. During the interview, you will be asked about the individual services you are receiving and how you feel about them. You will also be asked to provide feedback on the care that you are receiving. You will also be asked to provide feedback on the care that you are receiving.

Do I have to take part in the SOCPR?

No. You do not want to take part in this process, that's your decision and nothing bad will happen. If you do not want to take part, you should still receive the same care as other children and their families. If you decide to take part, you can stop at any time. You will not be asked to take part if you decide to stop.

What will I see the information about?

Your information will be used to help improve the SOCPR process. Your information will be used to help improve the SOCPR process. Your information will be used to help improve the SOCPR process.

What if I am uncomfortable?

You can ask questions of the person who gives you the form or your parent or other important adult about this process. If you do not understand anything, you can contact the SOCPR representative at the Behavioral Health Collaborative. The phone number is 617-266-4343, extension 222.

Assent to Participate

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

Child/Youth Name _____ Date _____

Witness/Program or Agency Representative _____ Date _____

16

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.

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.

17

Consent FAQs

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 your TAC representative 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.

18

Release of Information

Authorization to Release Info Form

- Indicates that youth/family allows specific providers 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 (SOCPR) team to have access to records and to conduct interviews, which include an examination of protected health information. The purpose of the SOCPR process is to provide feedback on how well Children Services or Health Related (CR) services are delivered through (S)MHSSE, an 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 youth and their families.

SECTION I: Instructions to Caregivers/Parent

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 release team permission to review the record maintained by the provider agency.
2. All signatures must be in ink and must be legible. No copies or stamps of signatures are permitted.
3. Only one signature is allowed on this form.
4. One parent or legal guardian must sign for a child, unless under agreement with age.

SECTION II: Information to be Released

Permission is granted for the case record and interview of the party listed in SECTION III to share the record of information listed in SECTION II about _____ Institutional/SOCPR Team.

Name of youth receiving CR services _____ Date of Birth _____

SECTION III: Provider Information

Please provide the name of the person(s) that provide agency/department that has shared treatment and medical information to the SOCPR Team.

Street Address _____

City/State/Zip Code _____ Telephone Number _____

SECTION IV: Topics to be Discussed

The party listed in Section I has given the following type of information to the SOCPR Team:

Financial Information All Medical Information & Treatment

History of Hospitalizations Participation and Progress in Treatment

Medications Court/Probation/Parole Information

Career/Work History Law, Health Related Disciplinary Actions and Academic Progress

Drug and Alcohol Use Other (please describe) _____

Annotations:

- Name and DOB of youth (points to Section II)
- Name of person (IHT Clinician, Care Coordinator, TT&S Worker) that family agrees can be interviewed. *Please write provider's agency name if applicable* (points to Section III)
- These are topics the family allows the interviewee to discuss with SOCPR Reviewer (points to Section IV)

Authorization to Release Info- Page 2

SECTION I: Purpose

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 provided permission to extend beyond that.

I understand that even if I cancel this permission at any time by writing 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 already has been 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 II: Signature

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

Signature _____ Date _____

Address _____

Phone Number _____

This form is filed 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 a legal guardian) with the following information:

Signature of the person filing out this form: _____

Printed name: _____

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

A copy of this release can be requested from the person who authorized 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:

Annotations:

- Youth 18 or over should complete this section (points to Section II)
- Caregiver or parent of youth should complete this section (points to Section II)

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 12 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 your TAC representative 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.

Scheduling

25

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

26

Record Review Scheduling

- Reviewers will need access to the youth's record maintained by your agency, which includes:
 - Treatment or care plan
 - Progress notes
 - Assessments
- 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

27

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

28

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

29

October Review Schedule

Monday, October 21 (sample schedule)		Tuesday, October 22 (sample schedule)		Wednesday, October 23	Thursday, October 24 (if needed) (sample schedule)	
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	Reviewer debriefing (reviewers only – providers do not attend)	9:00 – 11:00 AM (2 hours)	Record review for youth #3 (only if necessary)
11:00 – 12:30 PM (1 hour 30 min)	Interview with IHT clinician or care coordinator	11:00 – 12:30 PM (1 hour 30 min)	Interview with IHT clinician or care coordinator		11:00 – 12:30 PM (1 hour)	Interview with TT&S or family partner
12:30 – 1:00	Lunch	12:30 – 1:00	Lunch		12:30 – 1:00	Lunch
1:15 – 2:15 (1 hour)	Interview with TT&S or family partner at provider agency	1:30 – 2:30 (1 hour)	Interview with DCF worker		2:00 – 3:30 PM (1 hour 30 min)	Interview with parent
2:15 – 3:00	Travel to family home	2:30 – 3:00	Travel to provider site			
3:00 – 4:00 (1 hour)	Interview with youth at family home	3:30 – 4:30 (1 hour)	Interview with family partner or TT&S worker		3:30 – 4:30 (1 hour)	Interview with youth
4:00 – 5:30 (1 hour 30 min)	Interview with parent at family home	5:30 – 7:00 (1 hour 30 min)	Interview with parent at family home		5:00 – 6:30 (1 hour 30 min)	Interview with care coord or IHT clinician

33

Scheduling Template

Provider		Weekday Month Day		For TAC Use Only	
Name		Record # Business & Occupations		Provider	
Street Address		City		Zip Code	
Start Time		End Time			
Special Instructions		Phone		Fax	
First Provider Interview - 1 Hour 30 Minutes					
Name		Relationship to Youth		Youth Age	
Street Address		City		Zip Code	
Start Time		End Time			
Second Provider Interview - 1 Hour					
Name		Relationship to Youth		Youth Age	
Street Address		City		Zip Code	
Start Time		End Time			
Youth (if 12 or over) or Third Provider Interview - 1 Hour					
Name		Relationship to Youth		Youth Age	
Street Address		City		Zip Code	
Start Time		End Time			
Special instructions need to be indicated on a separate sheet (if any)?		Yes		No	
Language spoken at home? (if other than English)		English		Other	
Caregiver Interview - 1 Hour 30 Minutes					
Name		Relationship to Youth		Youth Age	
Street Address		City		Zip Code	
Start Time		End Time			
Special instructions need to be indicated on a separate sheet (if any)?		Yes		No	
Language spoken at home? (if other than English)		English		Other	

*Special notes concerning any of the locations (addresses, parking, subway crossings, etc.)

Please allow time for the providers to get lunch and for travel between interviews.
Do not schedule youth interviews during school hours.

31

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.

32

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.

33

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

35

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, October 1, 2013.**

36

General FAQs

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

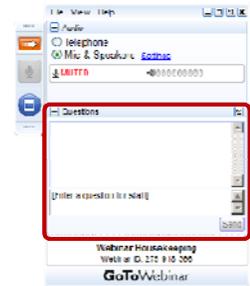
A: No. Only one card for \$25 will be provided in this case.

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.

37

Questions??



38

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

**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

Appendix C:

IHT Supplemental Questions

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 slightly moderately very much </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 slightly moderately very much </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 slightly moderately very much </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