

FY 16 YEAR-END SUMMARY REPORT

MASSACHUSETTS PRACTICE REVIEW (MPR)

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Executive Summary

The Massachusetts Practice Review (MPR) was implemented as part of the Commonwealth's ongoing effort to evaluate the quality of care delivered to youth under 21 receiving MassHealth Children's Behavioral Health Initiative (CBHI) services. The MPR evaluates the quality of CBHI services at the practice level, and follows earlier implementation of the System of Care Practice Review (SOCPR) by the Commonwealth and the Community Service Review (CSR) by the *Rosie D.* Court Monitor for the same purpose. After developing and pilot testing the MPR protocol in Fiscal Year (FY) 15, the Commonwealth began implementing MPR case reviews in FY16. This report summarizes MPR reviews conducted between October 2015 and June 2016 with 120 youth/families enrolled in either In-Home Therapy (IHT) or Intensive Care Coordination (ICC) services.

The MPR is a qualitative case review tool that is used to guide evaluation of the clinical record and interviews with multiple stakeholders, including the IHT or ICC service provider, the caregiver, the child/youth (if over 12), and other formal providers working with the child/youth and family. MPR reviews focus on IHT and ICC services because of the critical role that providers of these services play in the CBHI service system, serving as "clinical hubs" responsible to provide care coordination for youth with the most serious behavioral health challenges.

Trained reviewers use the MPR protocol to elicit information on 12 Areas of service delivery practice within three larger Domains consistent with CBHI values and principles to determine the extent to which services are: 1) Family-Driven and Youth-Guided; 2) Community-Based; and 3) Culturally Competent. Scoring of the 12 MPR practice Areas is done using a 5-point rating scale as shown in [Table 1](#) below.

Table 1: MPR Practice Rating Scale (Domains 1-3)

Adverse Practice	Poor Practice	Fair Practice	Good Practice	Exemplary/ Best Practice
1	2	3	4	5

As shown in [Table 2](#), MPR Practice Domain mean scores ranged from 3.1 to 3.7 with an overall mean score of 3.2.

Table 2: MPR Practice Domain Overall & Mean Scores

Domain	Min	Max	Mean	Standard Deviation
Practice Overall	1.1	4.7	3.2	.65
-ICC	2.0	4.7	3.4	.60
-IHT	1.1	4.6	3.1	.67
Domain1: Family Driven & Youth Guided	1.0	4.8	3.2	.74
-ICC	1.8	4.8	3.3	.70
-IHT	1.0	4.6	3.0	.75
Domain 2: Community-Based	1.5	5.0	3.7	.63
-ICC	2.0	5.0	3.7	.57
-IHT	1.5	5.0	3.7	.70
Domain 3: Culturally Competent	1.0	4.5	3.1	.77
-ICC	1.5	4.5	3.2	.74
-IHT	1.0	4.5	2.9	.78

Community-Based was the highest scoring Practice Domain with a mean score of 3.7. The Family Driven and Youth Guided Domain had the next highest Practice Domain mean score of 3.2. Culturally Competent had the lowest mean score of all Practice Domains (3.1).

The MPR protocol also requires reviewers to assess 2 Areas that examine youth and family progress since their enrollment in IHT or ICC services. Scoring of the 2 MPR progress Areas (Domain 4) is done using a 5-point rating scale as shown in [Table 3](#).

Table 3: MPR Progress Rating Scale (Domain 4)

Worsening or Declining Condition	Little to No Progress	Fair Progress	Good Progress	Exceptional Progress
1	2	3	4	5

[Table 4](#) shows that overall mean scores for the Youth and Family Progress Domain which ranged from 1.5 to 4.5, with an overall mean score of 3.1.

Table 4: Youth & Family Progress Domain Mean Scores

Domain	Min	Max	Mean	Standard Deviation
Domain 4: Youth/Family Progress	1.5	4.5	3.1	.76
-ICC	1.5	4.0	3.1	.72
-IHT	1.5	4.5	3.2	.81

Many of the findings in FY16 are consistent with previous years' quality reviews. Areas of relatively strong practice continue to hold true while relative challenges seen in the past persist. Areas identified as overall strengths of the service system include:

- **Youth and Family Engagement** - Providers both value and have the skills to build a relational foundation with youth and caregivers.
- **Service Accessibility** - Providers structure the work based upon the family's needs, delivering services at time and in locations that best accommodate the family's needs and preferences.
- **Family/Caregiver Progress** - Many caregivers' own ability to cope with and manage their youth's behavior improved as did their family's overall quality of life.

The need for practice improvement across both IHT and ICC services was indicated in two Areas:

- **Assessment** - Ratings, reviewer comments, and debriefing discussions all consistently identified concerns regarding the quality of the assessments, particularly in the areas of clinical formulation, trauma history, family/youth strengths, and collaboration with other providers.
- **Transition** - Many families experienced a fractured transition process through staff changes, movement from child to adult services, in/out of acute levels of care, and, most notably, termination from services.

The need for practice improvement among IHT providers specifically was indicated in three highly interrelated Areas within the Family-Driven and Youth Guided Domain and in one Area within the Culturally Competent Domain:

- **Team Formation, Team Participation, and Care Coordination** - Insufficient contact with both formal providers and natural supports was pervasive. In particular, additional outreach and inclusion was indicated as being needed yet absent with regard to schools, the Department of Children and Families (DCF), and prescribers of psychopharmacology.
- **Cultural Sensitivity and Responsiveness** - Providers often dismissed the importance of culture, failed to recognize its bearing on their work, or viewed culture with a very narrow lens, equating the notion of culture with race alone.

The Commonwealth has undertaken several initiatives aimed at improving the quality of CBHI services, based in part on findings from previous quality reviews. These include targeted training and coaching activities for IHT and ICC providers on topics that are well-aligned with the areas identified as most needing improvement. These initiatives, which are briefly highlighted below, should continue to be developed and expanded to support practice improvement.

- **Wraparound Coaching** - Training and coaching continues to be provided to the CSAs to support fidelity to the Wraparound model for ICC.
- **IHT Practice Profile** - While in the early stages of implementation, activities to support the initial training and ongoing learning associated with the Practice Profile will support greater adherence to the nine core components of IHT practice identified in the tool, several of which (Practicing Cultural Relevance, Assessment and Clinical Understanding, Care Coordination and Collaboration, and Preparing to Exit) directly relate to the areas identified in this report as needing practice improvement.
- **Trauma Training** - Attachment, Regulation and Competency (ARC) training, and the accompanying consultation and support that is currently being offered to IHT and ICC providers across the state, provides a guiding framework for thoughtful clinical intervention with regard to complex trauma for youth and their caregiver systems and should serve to strengthen practice in the area of Assessment.
- **Cultural Competency** - CBHI continues to support initiatives to bolster cultural competency as it relates to workforce development and also to enhance clinical practice, including trainings delivered by Dr. Ken Hardy to three regional IHT cohorts this past year. Dr. Hardy will offer an additional training for IHT providers in the central region this fall.
- **Supervision Supports** - Upcoming initiatives focused on strengthening supervision practice to improve overall care as well as staff retention include a *Reflective Supervision Learning Community*, which will serve to broaden and enhance reflective practice within six IHT programs, and *Yale Strengthening Supervision*, which will focus on agency standards, policies, and procedures related to supervision at four provider agencies.

This report also includes recommendations for the Commonwealth to consider that would support practice improvements in the Areas of Assessment and Transition for ICC. These include the development of best practice guides highlighting exemplary practices captured by MPR qualitative data in these Areas, specifically incorporating these Areas into existing coaching activities with the CSAs, and potentially modifying components of the IHT Practice Profile to support the CSAs in these Areas.

Background

In Fiscal Year (FY) 2014, the Commonwealth began implementing the System of Care Practice Review (SOCPR) as part of its ongoing effort to evaluate the quality of care delivered to youth under 21 receiving MassHealth Children's Behavioral Health Initiative (CBHI) services. The SOCPR used 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. Five regionally-based reviews were conducted with In-Home Therapy (IHT) and Intensive Care Coordination (ICC) providers using the SOCPR protocol, the findings of which were disseminated through a series of reports. ICC and IHT providers were selected for these reviews because of their important role in the system, serving as "clinical hubs" responsible for delivering care coordination for youth with the most serious behavioral health challenges.

The final FY 14 SOCPR report included a recommendation to create a Massachusetts-specific version of the SOCPR protocol. Specifically, changes were suggested that would align the interview protocol more with the best practice Wraparound process implemented by MassHealth for its CBHI services. Revisions to the protocol were made between June and August 2014, and pilot tests of the new protocol, the Massachusetts Practice Review (MPR), occurred in October 2014 and June 2015 and were summarized in an October 2015 report.

In Fiscal Year 2016, the Technical Assistance Collaborative (TAC), a Boston-based nonprofit contracted by the Commonwealth to manage the quality case review process, conducted three total MPR review rounds in October 2015, and in March-April and May-June 2016. The care of 120 youth/families in total was reviewed using the MPR in FY16, including 61 youth/families receiving ICC services and 59 receiving IHT. [Table 5](#) provides a summary of the number of youth reviewed by round. All 32 CSAs delivering ICC services and 21 of the approximately 150 IHT provider sites were sampled in FY16. Of those sampled, 31 CSAs and 20 IHT providers had completed MPR reviews. *(See the Methodology section of this report for more detail regarding review sampling and completion.)*

Table 5: Summary of Completed MPR Reviews by Round

Review Round	IHT		ICC	
	# Providers	# Youth	# Providers	# Youth
October 2015	13	38	-	-
March-April 2016	7	18	10	19
May-June 2016	-	3	21	42
Total	20	59	31	61

MPR Overview

Protocol Description

The MPR is a qualitative case review tool that is used to guide evaluation of the clinical record and interviews with multiple stakeholders, including the In-Home Therapy (IHT) or Intensive Care Coordination (ICC) service provider, the caregiver, the child/youth (if over 12), and other formal providers working with the child/youth and family. Trained reviewers use the MPR protocol to elicit specific information on 12 Areas of service delivery practice and 2 Areas that examine youth and family progress since their enrollment in IHT or ICC services. By triangulating responses from the record review and other informants, MPR reviewers obtain a comprehensive picture of services delivered at the practice level, and then are asked to rate each of the 14

Areas by assigning a numerical score that reflects the extent to which practice is meeting established standards and best practice for the service. Qualitative information, such as quotes or specific examples, is also recorded by reviewers to support the numerical ratings, and because of its explanatory and illustrative value. Qualitative observations and quantitative ratings play a complimentary role in understanding the current state of practice in the system.

Practice Domains/Areas

Consistent with CBHI values and principles, the MPR assesses service delivery practice Areas within three larger Domains to determine the extent to which services are: 1) Family-Driven and Youth-Guided; 2) Community-Based; and 3) Culturally Competent.

Table 6 summarizes the 12 specific Areas that are scored across the 3 MPR Practice Domains, along with the prompts or considerations that are included in the protocol for each Area to guide reviewers in scoring.

Table 6: MPR Practice Domains/Areas & Reviewer Scoring Prompts

Practice Domain/Area
Domain 1: Family-Driven & Youth-Guided
<p>Area 1: Assessment</p> <ul style="list-style-type: none"> • Relevant data/information about the youth and family was diligently gathered through both initial and ongoing processes. • The needs of the youth and family have been appropriately identified and prioritized across a full range of life domains. • Actionable strengths of the youth and family have been identified and documented. • The provider has explored natural supports with the family. • The written assessment provides a clear understanding of the youth and family. <p>Area 2: Service Planning</p> <ul style="list-style-type: none"> • The provider actively engages and includes the youth and family in the service planning process. • The service plan goals logically follow from the needs and strengths identified in the comprehensive assessment. • Service plans and services are responsive to the emerging and changing needs of the youth and family. • An effective risk management/safety plan is in place for the youth/family. <p>Area 3: Service Delivery</p> <ul style="list-style-type: none"> • The interventions provided to the youth and family match their needs and strengths. • The provider incorporates the youth's and family's actionable strengths into the service delivery process. • The intensity of the services/supports provided to the youth and family match their needs. • Service providers assist the youth and family in understanding the provider agency and the service(s) in which they are participating. <p>Area 4: Youth & Family Engagement</p> <ul style="list-style-type: none"> • The provider actively engages the youth and family in the ongoing service delivery process. <p>Area 5: Team Formation</p> <ul style="list-style-type: none"> • The provider actively engages and includes formal providers in the service planning and delivery process (initial plan and updates). • The provider actively engages and includes natural supports in the service planning and delivery process (initial plan and updates). <p>Area 6: Team Participation</p> <ul style="list-style-type: none"> • Providers, school personnel or other agencies involved with the youth participate in service planning. <p>Area 7: Care Coordination</p> <ul style="list-style-type: none"> • The provider (i.e. IHT clinician, ICC) successfully coordinates service planning and the delivery of services and supports. • The youth is receiving the amount and quality of care coordination his/her situation requires. • The provider facilitates ongoing, effective communication among all team members, including formal service providers, natural supports (if desired by the family), and family members including the youth. <p>Area 8: Transition</p> <ul style="list-style-type: none"> • Care transitions and life transitions (e.g. from youth to adult system, from one provider to another, from one service to another, from hospital to home, etc.) are anticipated, planned for, and well coordinated.

Practice Domain/Area

Domain 2: Community-Based

Area 9: Responsiveness

- The provider responded to the referral (for its own service) in a timely and appropriate way.
- The provider made appropriate service referrals (for other services/supports) in a timely manner and engaged in follow-up efforts as necessary to ensure linkage with the identified services and supports.

Area 10: Service Accessibility

- Services are scheduled at convenient times for the youth and family.
- Services are provided in the location of the youth and family's preference.
- Service providers verbally communicate in the preferred language of the youth/family.
- Written documentation regarding services/planning is provided in the preferred language of the youth/family.

Domain 3: Culturally Competent

Area 11: Cultural Awareness

- The service provider has explored and can describe the family's beliefs, culture, traditions, and identity.
- Cultural differences and similarities between the provider and the youth/ family have been acknowledged and discussed, as they relate to the plan for working together.

Area 12: Cultural Sensitivity & Responsiveness

- The provider has acted on/incorporated knowledge of the family's culture into the work.
- The provider has explored any youth or family history of migration, moves, or dislocation. If the youth or family has experienced stressful migration, moves, or dislocation, then those events inform the assessment of family's strengths and needs and the treatment/care plan.
- The provider has explored any youth or family history of discrimination and victimization. If the youth or family has experienced discrimination or victimization, then the provider ensures that the treatment process is sensitive/responsive to the family's experience.
- The provider has explored cultural differences within the family (e.g. intergenerational issues or due to couples having different backgrounds) and has incorporated this information into the understanding of the youth and family's strengths and needs and the care/treatment plan.
- The provider helps the entire team understand and respect this family's culture.

Practice Indicator Rating Scale

Scoring of the 12 MPR practice Areas within Domains 1-3 is done using a 5-point rating scale tied to practice indicators as shown in [Table 7](#).

Table 7: MPR Practice Rating Scale & Indicators (Domains 1-3)

Adverse Practice	Poor Practice	Fair Practice	Good Practice	Exemplary/ Best Practice
1	2	3	4	5
Practice is either absent or wrong, and possibly harmful - or - practices used may be inappropriate, contraindicated, or performed inappropriately or harmfully	Does not meet minimal established standards of practice	Does not consistently meet established standards and best practices	Consistently meets established standards and best practices	Consistently exceeds established standards and best practices

Progress Domain/Areas

Reviewers are also asked to rate 2 Areas concerning child/youth and family progress to determine the extent to which improvements have been realized in relation to specific skill development, functioning, well-being, and quality of life. [Table 8](#) summarizes the 2 Areas that are scored within the Progress Domain, along with the accompanying reviewer prompts or considerations for scoring contained in the MPR protocol.

Table 8: MPR Progress Domain/Areas & Reviewer Scoring Prompts

Progress Domain	
Domain 4: Youth/Family Progress	
Area 13: Youth Progress	
<ul style="list-style-type: none"> • Since the youth's enrollment in the service being reviewed, he/she has developed improved coping or self-management skills. • Since the youth's enrollment in the service being reviewed, he/she has made progress in their social and/or emotional functioning at school. • Since the youth's enrollment in the service being reviewed, he/she has made progress in their social and/or emotional functioning in the community. • Since the youth's enrollment in the service being reviewed, he/she has made progress in their social and/or emotional functioning at home. • Since the youth's enrollment in the service being reviewed, there has been improvement in the youth's overall well-being and quality of life. 	
Area 14: Family Progress	
<ul style="list-style-type: none"> • Since the family's enrollment in the service being reviewed, the parent/caregiver has made progress in their ability to cope with/manage their youth's behavior. • Since the family's enrollment in the service being reviewed, there has been improvement in the family's overall well-being and quality of life. 	

Progress Indicator Rating Scale

Scoring of the 2 MPR progress Areas (Domain 4) is done using a 5-point rating scale tied to progress indicators as shown in [Table 9](#).

Table 9: MPR Progress Rating Scale & Indicators (Domain 4)

Worsening or Declining Condition	Little to No Progress	Fair Progress	Good Progress	Exceptional Progress
1	2	3	4	5

Reviewer Summative Responses

MPR reviewers also provide qualitative information for each youth/family reviewed to support the numerical scores assigned by the reviewer. This information also forms the basis of reviewer case presentations given during the debriefings (see Methodology section of this report for more detail). As shown in [Table 10](#), some categories require that reviewers summarize information obtained through record reviews and key informant interviews, and others illustrate examples or quotes obtained during interviews and/or reviewer judgment.

Table 10: MPR Reviewer Summative Response Guidelines

Summative Response Categories		
Background	Identifying Information	Age, sex, living place and arrangement, primary language, and any other key characteristics of child and family
	Reason for referral	Briefly, why the family was referred for IHT services, when and by whom
	Services provided	Length of IHT service to date, co-occurrence of any other MassHealth services or clinically relevant services, including educational services and state agency involvement, and any notable issues in terms of change of staff, interruption due to MassHealth eligibility issues, etc.
	Focus of the IHT intervention	Primary goals, including priorities reflected in CANS ratings, and interventions, including IHT Hub's use of other services to attain goals; note also if focus changed significantly during the IHT intervention
Impact	Nature and amount of progress as seen by youth and family	Progress toward primary goals or other goals; lack of expected progress or setbacks. For example, specifics about behavior change in child or family; evidence of changes in child symptoms, changes in child functioning, changes in family competence and empowerment; changes in quality of life noted by family; do not focus only on net change but also on the course including setbacks and jumps forward.

Summative Response Categories		
	Nature and amount of progress as seen by clinician	See prior question. Additionally, were the changes reflected in the clinician's CANS?
	Reviewer judgment regarding nature and amount of progress	See prior question; may differ from judgment of family and primary clinician, and may incorporate views of other participants
Quality-Family and Clinician Perceptions	Strengths about the IHT service that were observed by youth and/or family	This includes youth / family identification of service elements from any MPR practice domain that were notably helpful; this could include assessment, planning, development and use of a team, attention to transitions, and cultural competence, as well as direct treatment interventions by IHT staff
	Dissatisfaction reported by youth or family	For example, statements about lack of engagement with or by the service or clinician; lack of clarity regarding the plan or roles of team members; feeling that interventions used by the clinician are not helpful and/or possibly making the situation worse; clinician not available or following through on plans; weakness in developing or working with a team of services and supports; poorly managed transitions; or other shortcomings in IHT practice
	Strengths about the IHT service that were observed and/or specifically stated by primary clinician	Any elements of the IHT process that went very well (from any of the first 3 MPR domains), and factors that contributed to this
	Challenges about the service or circumstances that were observed and/or specifically stated by primary clinician	Examples might include lack of success engaging the family or other team members; inability to arrive at helpful diagnostic formulation; inability to access services or resources; language or cultural barriers; or any other barriers or shortcomings. Distinguish factors that the clinician felt were beyond the control of IHT from areas where the clinician felt in retrospect that IHT practice could have been better.
Quality-Reviewer Judgment	Reviewer judgment: Areas where practice was substandard	Areas where practice was not consistent with service specification or general expectations of competent practice, whether this was the result of clinician actions, TT&S actions, or provider agency factors; do not include here issues that were entirely outside of the IHT provider's control
	Reviewer judgment: Areas where practice was acceptable but could have been significantly strengthened	For example, Areas in which a more experienced clinician, or a clinician or TT&S with a different skill set might have had more success; where more training could have significantly improved practice; where skilled supervision or access to better diagnostic services could have facilitated a more effective service, etc. Don't comment on unexceptional areas unless you see a notable opportunity for improvement
	Reviewer judgment: Areas where practice was of noteworthy or exceptional quality	This could be the result of excellent work by the clinician, the TT&S, or high quality support by the agency. It could also be the result of external factors, such as an excellent IHBS team or other service or support

Demographic & IHT Supplemental Questions

In addition to collecting information to rate the 14 MPR Areas, reviewers also collect basic demographic information for the youth/family being reviewed, along with other basic service-related information. Eight IHT Supplemental questions were also carried over from the SOCPR protocol to assess whether youth with IHT serving as their clinical hub are receiving the quality and level of care coordination they require.

Reviewer Recruitment & Training

A recruitment process for MPR reviewers was developed whereby individuals with the appropriate experience, expertise, and skills were selected to fulfill this critical role in the quality service review process. The result is the formation of a core team of qualified reviewers with strong clinical understanding, and appreciation for System of Care (SOC) principles and the design of MassHealth's CBHI service system, as well as sound interviewing skills.

For the October 2015 review round, TAC engaged 26 reviewers who brought experience as CBHI program directors, state agency leadership, and managed care administrators. In preparation for subsequent FY 16 review rounds, TAC and CBHI agreed to shift to a smaller cadre of reviewers with the intent of streamlining the process and enhancing reviewer familiarity with the MPR protocol. Interested individuals were encouraged to submit an application outlining their experience with: CBHI and MassHealth, as well as other children's systems; SOC and/or Wraparound principles; CSR/SOCPR/MPR review processes; and qualitative interviewing. TAC and CBHI collaborated on the development of the application, and on the interview and hiring process. The reviewer team for the second and third FY16 review rounds was comprised of four individuals with experience in program evaluation, Wraparound, and the array of CBHI services. One of the reviewers also had Spanish and Portuguese language capacity.

All new reviewers participated in 1.5 days of in-person training consisting of didactic presentation, role playing, and experiential scoring. The training explores in depth the fourteen Areas of the MPR protocol, as well as the Practice and Youth/Family Progress rating scales. In addition, new reviewers shadowed experienced reviewers prior to conducting any MPR reviews alone.

Methodology

Provider Sampling

The Commonwealth is committed to conducting at least 120 MPR reviews of CBHI services annually. TAC and MassHealth develop annual sampling strategies which determine: what CBHI service(s) will be reviewed, how many providers must participate, and if any specialized sampling methods, such as stratifying by location or enrollment data, should be employed. The current MPR sampling strategy plans for 127 reviews, with approximately equal sampling of IHT and ICC cases, to ensure 120 in total are completed to account for families who may be unable or unwilling to participate.

The FY16 MPR sampling strategy ensured the state could evaluate ICC practice delivered at all 32 CSAs by assigning each CSA two reviews (n=64 ICC reviews total). Ultimately, 61 ICC reviews were completed¹ at 31 CSAs.

Given a sampling plan that called for the completion of 63 IHT reviews, a process was developed to select providers from the approximately 150 IHT sites statewide. Using data from the Massachusetts Behavioral Health Access (MABHA) report, all of the state's IHT providers were sorted by their total capacity and location prior to being sampled using the True Random Number Generator at www.random.org. Stratifying providers in this way ensures that high volume providers have more reviews completed than low volume providers and that reviews aren't concentrated in one area of the state.

Twenty-one IHT provider sites were sampled between the October 2015 and March-April 2016 review rounds. Of those, 59 reviews² were completed across 20 provider sites.³

¹ Three ICC reviews across 2 CSAs were incomplete.

² One IHT review was incomplete.

³ One IHT provider was removed from the review process for having just 1 youth enrolled in IHT at the time of the sample.

Youth Selection

Once providers were sampled, youth who were enrolled with those providers were randomly selected to participate. Also, so as to more clearly understand how IHT functioned as a “hub” of care coordination, only those youth enrolled in IHT without concurrent enrollment in ICC were eligible for the random selection from IHT providers.

As shown in **Table 11**, 182 families were approached for consent to participate; of these, 120 consented and had completed reviews, 3 reviews had incomplete family interviews, 1 review was canceled for having less than the required minimum number of interviewees⁴, and 58 families (31.9%) declined to participate. Just over half of those declining (55% or n=32) cited the reason as anxiety about having “strangers” in their home and feeling overwhelmed by the prospect of another task/responsibility added to their busy lives. Another 12% (n=7) declined due to family medical reasons, such as surgery, illness, or childbirth. Another 12% (n=7) were unable to be contacted or did not respond to multiple attempts to obtain consent.

Table 11: Families Approached, Decline Rate & Completed Reviews

FY16 Reviews	ICC	IHT	Total
Reviews Planned	64	63	127
Families Approached	96	86	182
Families Declining	32	26	58
Incomplete Reviews			
<i>Incomplete family interviews</i>	3	0	3
<i>Less than required # of interviewees</i>	0	1	1
Reviews Completed	61	59	120

Consent Process

Two informational webinars were held per review round to ensure providers understood the MPR process, their responsibilities pertaining to obtaining informed consent, and MPR scheduling procedures. Following the webinar, providers were emailed the final random sample of youth who were to be approached for consent, along with detailed instructions and guidance on obtaining informed consent, scheduling interviews, and preparing for the review day. 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 MPR. Parents and youth over 18 were informed that their participation in the MPR process was voluntary and would not impact their service delivery if they chose not to participate. They were also informed that they would receive a gift card to Target upon completion of their interview. If the youth or parent agreed, they were asked to sign a consent form and the necessary release of information forms. Providers also explained the MPR process to those youth between the ages of 12-17 whose parents had agreed for them to be interviewed and obtained their written assent to participate.

Worth noting is that the “decline” rate among families approached to participate in the quality review process has trended downward over the last three years. In FY14, 41.4% of families who were approached declined, and in FY16, this dropped to 31.9%. This may be attributed to specific steps that were taken to curb the decline rate between FY15 and FY16. All families now receive a letter from the Director of CBHI outlining the importance of their perspective to the CBHI system, and how their feedback will help to improve services for other youth and families. At the same time, families receive a brochure, written in family-friendly language,

⁴ Each review must contain three interviews inclusive of the caregiver, primary clinician, and one additional interviewee.

that explains the MPR and includes answers to frequently asked questions. Additionally, providers who are responsible for working with families to obtain consent are given more descriptive tools and tips on obtaining consent.

Scheduling/Conducting Reviews

Each youth in the final sample was assigned a specific review day based upon reviewer availability. Once providers obtained written informed consent, they began to work with families and other stakeholders to schedule interviews. 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) up to 3 additional formal providers 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 more. A review of the youth's record at the provider agency preceded the interviews. It is important to note that for an MPR review to be considered valid, a minimum of four data points (the record review and three interviews) is required.

Debriefings

Following each review month (October, March, April, May and June), reviewers joined MassHealth, TAC, MCE representatives, the *Rosie D.* Court Monitor, and other system partners to debrief on MPR review findings during that month. The first portion of these debriefing days was comprised of reviewer presentations on each youth/family reviewed. These presentations included relevant historical, demographic, diagnostic, and service history, as well as in-depth discussion regarding practice strengths/challenges, and client satisfaction with services and progress. Since reviews were scored by reviewers in advance, debriefings enabled the group to discuss scores for accuracy, thus improving data reliability. Monthly debriefings concluded with a brainstorming session where themes, including strengths and areas for improvement, were noted and discussed.

Data Analysis & Reporting

At the conclusion of each review round, all MPR data, inclusive of demographic information, Area ratings, IHT supplemental questions, and summative responses were extracted from a HIPAA-compliant Survey Monkey and analyzed. Case means and standard deviations were computed for practice Domains 1, 2, 3 and practice overall, as well as for the progress Domain (Domain 4). Means and frequencies of ratings for all 14 MPR Areas were also computed, along with frequencies for the IHT Supplemental responses and all demographic data. Brief summary reports containing findings from these quantitative analyses were developed and disseminated following each review round. Similar analyses were conducted and summarized for this Year-End Summary report for all 120 reviews, as was analyses of all qualitative data collected through reviewer summative responses to provide a more rich discussion of practice strengths and opportunities for practice improvement.

Results

Demographics

Demographic characteristics of the children/youth reviewed in FY 16 are summarized in [Table 12](#). More than half of the youth reviewed (58% or n=70) were male. Forty-two percent (n=50) were White, 24% (n=29) Latino/Hispanic, and 16% (n=19) reported Biracial or Mixed race/ethnicity. Youth ages 5-9 (n=45) and 10-13 (n=39) each represented approximately one-third of those reviewed. Nearly three-quarters (70% or n=84) had

more than one behavioral health condition, pointing to the complexity of needs among the youth reviewed. Just over half of youth (53% or n=63) were receiving individual counseling, and 49% (n=59) utilized psychopharmacology services. Further, two-thirds (66% or n=79) were involved with special education, highlighting the need for coordination with this system for many of the youth reviewed.

Table 12: Select Demographic Characteristics

		(n)	%			(n)	%
Status of Case at Time of Review	Open	(102)	85%	Gender	Male	(70)	58%
	Closed	(18)	15%		Female	(50)	42%
Age of Youth	0-4 years	(5)	4%	Race/Ethnicity	White	(50)	42%
	5-9 years	(45)	38%		Latino/Hispanic	(29)	24%
	10-13 years	(39)	33%		Biracial/Mixed	(19)	16%
	14-17 years	(25)	21%		Black	(12)	10%
	18-21 years	(6)	5%		Other	(8)	7%
>1 Behavioral Health Condition	Yes	(84)	70%		Asian	(1)	1%
	No	(36)	30%		Native American	(1)	1%
Behavioral Health Conditions	ADD/ADHD	(54)	45%	Interventions (Current)	In-Home Therapy (IHT)	(75)	63%
	Mood Disorder	(44)	37%		Individual Counseling	(63)	53%
	Anxiety Disorder	(38)	32%		Psychopharmacology	(59)	49%
	PTSD	(28)	23%		Intensive Care Coordination (ICC)	(55)	46%
	Anger/Impulse Control	(23)	19%		Therapeutic Mentoring	(56)	47%
	Autism/Autism Spectrum Disorder	(17)	14%		FS&T (Family Partner)	(51)	43%
	Disruptive Behavior Disorder	(15)	13%		Therapeutic Training & Support	(47)	39%
	Adjustment Disorder	(13)	11%		Recreation activities	(17)	14%
	Learning Disorder	(10)	8%		In- Home Behavioral Services (IHBS)	(16)	13%
	Communication Disorder	(7)	6%		Mobile Crisis Intervention	(7)	6%
	Other	(6)	5%		Inpatient/CBAT	(5)	4%
	Intellectual Disability	(6)	5%		Group counseling	(4)	3%
	Substance Use/Dependence	(1)	1%		Family counseling	(3)	2.5%
					Substance Use Treatment	(1)	1%
					Day tx/Partial Hosp.	(1)	1%
Service System Use (Current)	Special Education	(79)	66%	DCF Involved (Past Year)*	No	(99)	83%
	DCF	(32)	27%		Yes	(21)	18%
	DMH	(7)	6%	*Excludes those with current DCF involvement			
	Child Requiring Assistance (CRA)	(6)	5%				
	DDS	(3)	3%				
	Probation	(3)	3%				

Practice Domains

Overall & Domain Mean Scores

As mentioned previously, MPR scores range from 1 to 5, with 1 representing Adverse practice, 2 being Poor practice, 3 being Fair practice, 4 being Good practice, and 5 representing Exemplary/Best practice. The level of practice for a Domain or Area can be summarized by giving the mean rating score, or by giving the percentage of cases scoring at or above a certain level (such as Fair and above, or Good and above). In the following discussion of Domains and Areas we do both: we cite mean scores, and we also cite the percentage of cases

falling at the level of Fair or above (while acknowledging that other dividing points could be chosen). We use 70% Fair or above to discriminate stronger from weaker Domains and Areas of practice (while acknowledging that this divide, also, is a matter of judgment).

As shown in **Table 13**, MPR Practice Domain mean scores ranged from 3.1 to 3.7 with an overall mean score of 3.2.

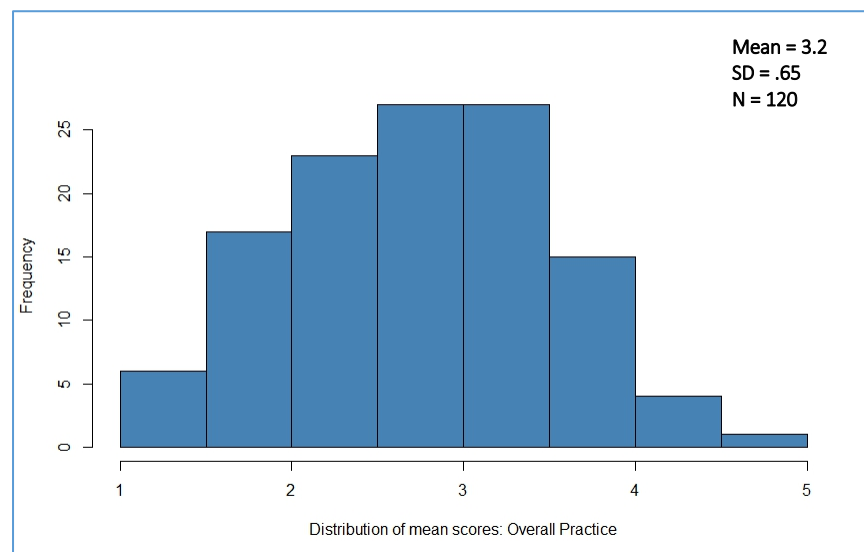
Table 13: MPR Practice Domain Overall & Mean Scores

Domain	Min	Max	Mean	Standard Deviation
Practice Overall	1.1	4.7	3.2	.65
-ICC	2.0	4.7	3.4	.60
-IHT	1.1	4.6	3.1	.67
Domain1: Family Driven & Youth Guided	1.0	4.8	3.2	.74
-ICC	1.8	4.8	3.3	.70
-IHT	1.0	4.6	3.0	.75
Domain 2: Community-Based	1.5	5.0	3.7	.63
-ICC	2.0	5.0	3.7	.57
-IHT	1.5	5.0	3.7	.70
Domain 3: Culturally Competent	1.0	4.5	3.1	.77
-ICC	1.5	4.5	3.2	.74
-IHT	1.0	4.5	2.9	.78

Community-Based was the highest scoring Practice Domain with a mean score of 3.7. The Family Driven and Youth Guided Domain had the next highest Practice Domain mean score of 3.2. Culturally Competent had the lowest mean score of all Practice Domains (3.1).

Figure 1 illustrates the distribution of overall MPR Practice Domain mean scores for the youth/families reviewed.

Figure 1: Overall Practice Domain Mean Scores



Looking at practice overall (120 youth across 12 Areas, or 1,440 instances of practice), 4% of practice fell into the Adverse range, 18% into the Poor range, 35% into the Fair range, 37% into the Good range, and 6% into the Exemplary range. Of all practice instances, 78% fell into the Fair range and above, while 42% was either Good or Exemplary.

Practice Area Mean Scores & Frequencies

The following sections summarize the results across each MPR Practice Domain and the Areas within them.

Domain 1: Family Driven & Youth Guided

As noted previously, the Family Driven and Youth Guided Domain had the second highest Practice Domain mean score (3.2).

Figure 2 illustrates the distribution of mean scores for Family Driven and Youth guided Domain for the youth/families reviewed.

Figure 2: Family Driven & Youth Guided Mean Scores

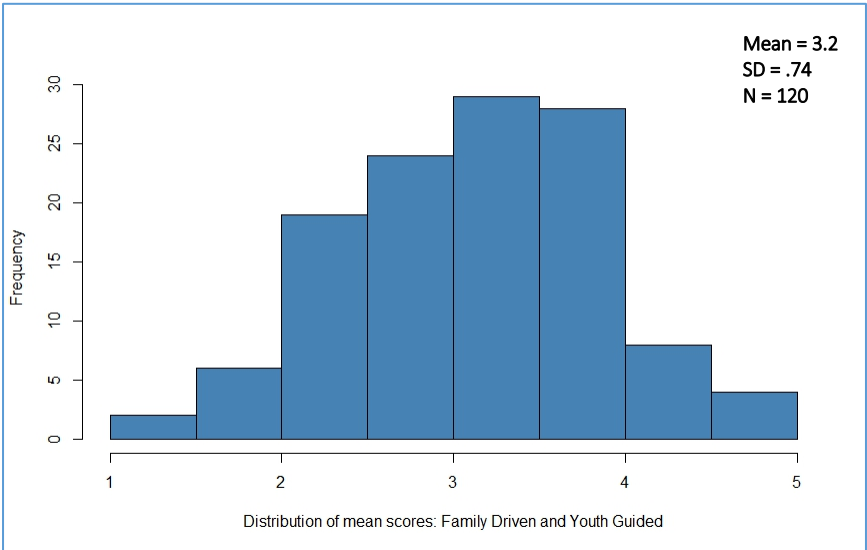


Table 14 summarizes the mean scores and frequencies for each of the 8 Areas in this Practice Domain. Youth and Family Engagement was the second highest rated practice area overall, with IHT practice rated slightly better than ICC (a relatively uncommon phenomenon) in this area (3.8 vs. 3.6). IHT practice was rated lower, in the areas of Assessment, Team Formation, Team Participation, Care Coordination and Transition. Transition (2.9) was the lowest rated practice area overall, for both ICC and IHT. Assessment and Team Formation (3.0) were the second lowest rated practice areas.

Looking at practice overall (120 youth across 8 Areas, or 960 instances of practice), 4% of practice fell into the Adverse range, 20% into the Poor range, 36% into the Fair range, 33% into the Good range, and 6% into the Exemplary range. Practice was Fair or better in 76% of instances across the domain. In ICC, 81% of practice instances were Fair or better, while the proportion in IHT was 70%. This discrepancy between practice in ICC and IHT has been a common finding in case reviews of the two services.

Table 14: Family Driven & Youth Guided Mean Scores & Frequencies

Area	Mean	Frequencies (n) %*					
		Adverse Practice 1	Poor Practice 2	Fair Practice 3	Good Practice 4	Exemplary/ Best Practice 5	Percent Fair or above *
Assessment	3.0	(4) 3%	(34) 28%	(42) 35%	(37) 31%	(3) 3%	68%
-ICC	3.1	(1) 2%	(19) 31%	(18) 30%	(21) 34%	(2) 3%	67%
-IHT	3.0	(3) 5%	(15) 25%	(24) 41%	(16) 27%	(1) 2%	69%
Service Planning	3.1	(5) 4%	(25) 21%	(46) 38%	(37) 31%	(7) 6%	75%
-ICC	3.3	(1) 2%	(10) 16%	(27) 44%	(19) 31 %	(4) 7%	82%
-IHT	3.0	(4) 7%	(15) 25%	(19) 32%	(18) 31%	(3) 5%	68%
Service Delivery	3.5	(2) 2%	(14) 12%	(43) 36%	(50) 42%	(11) 9%	87%
-ICC	3.5	-	(8) 13%	(20) 33%	(27) 44%	(6) 10%	87%
-IHT	3.4	(2) 3%	(6) 10%	(23) 39%	(23) 39%	(5) 8%	86%
Youth & Family Engagement	3.7	(1) 1%	(10) 8%	(33) 28%	(55) 46%	(21) 18%	91%
-ICC	3.6	-	(9) 15%	(18) 30%	(23) 38%	(11) 18%	85%
-IHT	3.8	(1) 2%	(1) 2%	(15) 25%	(32) 54%	(10) 17%	97%
Team Formation	3.0	(9) 8%	(24) 20%	(55) 46%	(28) 23%	(4) 3%	73%
-ICC	3.2	(2) 3%	(6) 10%	(34) 56%	(15) 25%	(4) 7%	87%
-IHT	2.7	(7) 12%	(18) 31%	(21) 36%	(13) 22%	-	58%
Team Participation	3.1	(7) 6%	(24) 20%	(47) 39%	(38) 32%	(4) 3%	74%
-ICC	3.4	(1) 2%	(7) 11%	(21) 34%	(28) 46%	(4) 7%	87%
-IHT	2.7	(6) 10%	(17) 29%	(26) 44%	(10) 17%	-	61%
Care Coordination	3.2	(4) 3%	(30) 25%	(35) 29%	(44) 37%	(7) 6%	72%
-ICC	3.5	-	(11) 18%	(16) 26%	(27) 44%	(7) 11%	82%
-IHT	2.8	(4) 7%	(19) 32%	(19) 32%	(17) 29%	-	61%
Transition	2.9	(10) 8%	(32) 27%	(44) 37%	(29) 24%	(5) 4%	65%
-ICC	3.0	(4) 7%	(15) 25%	(24) 39%	(14) 23%	(4) 7%	69%
-IHT	2.8	(6) 10%	(17) 29%	(20) 34%	(15) 25%	(1) 2%	61%

* Accurately rounded percentages; areas with 70% Fair or above are in **bold**.

Domain 2: Community-Based

As previously noted, Community-Based was the highest rated Practice Domain (3.7). **Figure 3** shows the distribution of ratings for this domain.

Figure 3: Community-Based Mean Scores

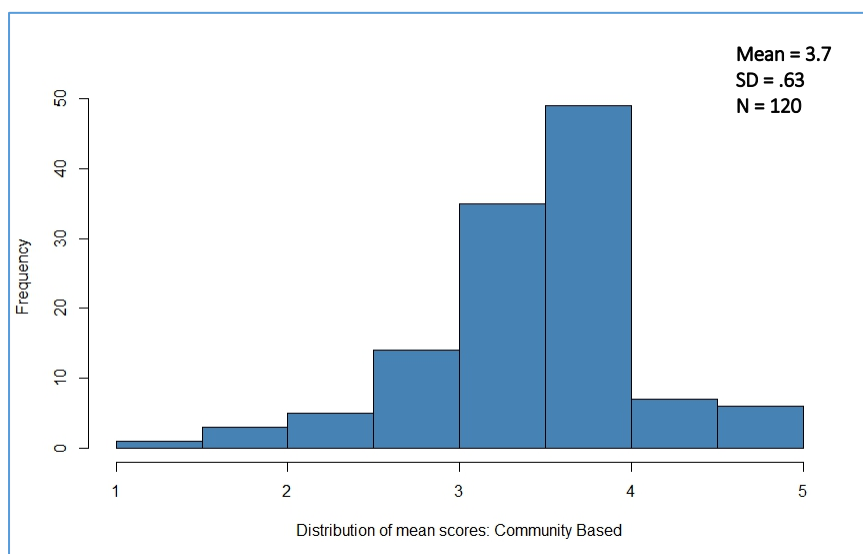


Table 15 summarizes the mean scores and frequencies for the two Areas in the Community-Based practice domain, which includes the highest rated Practice Area overall, Service Accessibility (3.9).

Across Domain 2, youth experienced practice that was Fair or better in 91% of instances. For youth in ICC, practice was Fair or better 93% of the time, while the proportion for youth in IHT was 89%. Again, ICC practice was a bit stronger, on average, than IHT practice.

Table 15: Community-Based Area Mean Scores & Frequencies

Domain/Area	Mean	Frequencies (n) %*					
		Adverse Practice 1	Poor Practice 2	Fair Practice 3	Good Practice 4	Exemplary/ Best Practice 5	Percent Fair or above **
Responsiveness	3.5	(2) 2%	(14) 12%	(38) 32%	(56) 47%	(10) 8%	87%
-ICC	3.5	(1) 2%	(6) 10%	(23) 38%	(26) 43%	(5) 8%	89%
-IHT	3.5	(1) 2%	(8) 14%	(15) 25%	(30) 51%	(5) 8%	85%
Service Accessibility	3.9	(1) 1%	(4) 3%	(16) 13%	(86) 72%	(13) 11%	96%
-ICC	3.9	-	(1) 2%	(9) 15%	(45) 74%	(6) 10%	98%
-IHT	3.8	(1) 2%	(3) 5%	(7) 12%	(41) 69%	(7) 12%	93%

*Due to rounding of percentages, some Area totals may not equal 100%.

** Accurately rounded percentages; areas with 70% Fair or above are in **bold**.

Domain 3: Culturally Competent

Culturally Competent was the lowest rated practice Domain overall (3.1). **Figure 4** shows the distribution of mean scores for this domain.

Figure 4: Culturally Competent Mean Scores

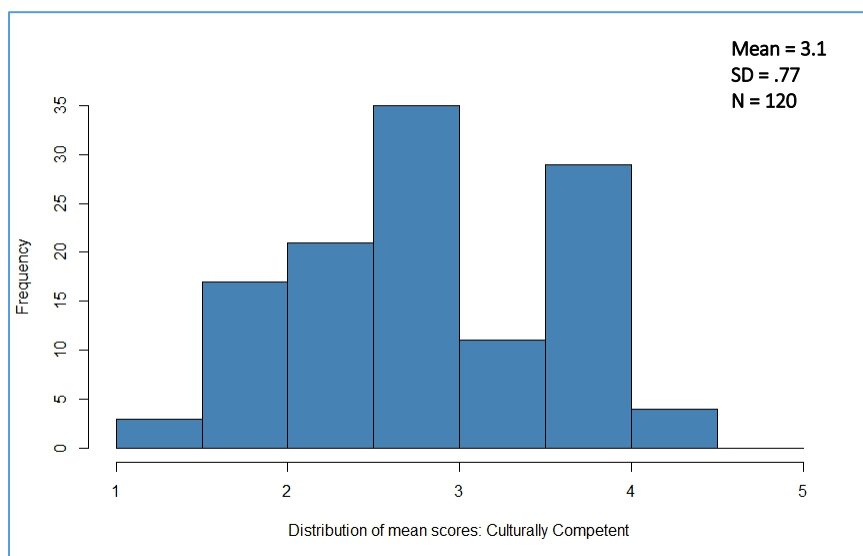


Table 16 summarizes mean score and frequencies for the Areas within this practice Domain, which contained the third lowest scoring Area, Cultural Sensitivity & Responsiveness (3.0).

Across ICC and IHT, practice for Domain 3 was Fair or better in 75% of instances. Youth in ICC experienced Fair practice or better 82% of the time, while the proportion for youth in IHT was 68%. While Domain 3 clearly represents an opportunity for improvement in both ICC and IHT, the discrepancy between services is quite pronounced in this domain.

Table 16: Culturally Competent Area Mean Scores & Frequencies

Domain/Area	Mean	Frequencies (n) %*					
		Adverse Practice 1	Poor Practice 2	Fair Practice 3	Good Practice 4	Exemplary/ Best Practice 5	Percent Fair or above **
Cultural Awareness	3.2	(2) 2%	(20) 17%	(55) 46%	(42) 35%	(1) 1%	82%
-ICC	3.3	-	(5) 8%	(31) 51%	(24) 39%	(1) 2%	92%
-IHT	3.0	(2) 3%	(15) 25%	(24) 41%	(18) 31%	-	71%
Cultural Sensitivity & Responsiveness	3.0	(5) 4%	(33) 28%	(46) 38%	(33) 28%	(3) 3%	68%
-ICC	3.0	(3) 5%	(14) 23%	(23) 38%	(19) 31%	(2) 3%	72%
-IHT	2.9	(2) 3%	(19) 32%	(23) 39%	(14) 24%	(1) 2%	64%

*Due to rounding of percentages, some Area totals may not equal 100%.

** Accurately rounded percentages; areas with 70% Fair or above are in **bold**.

Youth & Family Progress Domain

Domain Mean Scores

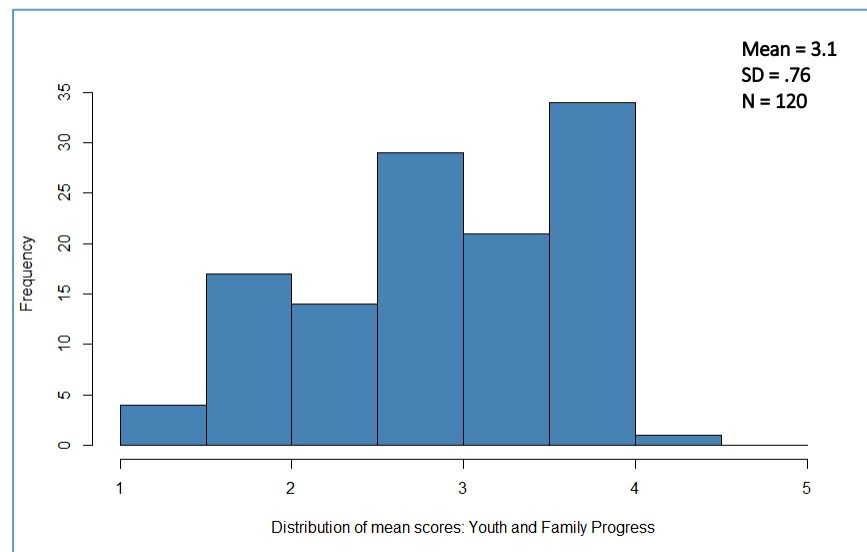
Table 17 shows that overall mean scores for the Youth and Family Progress Domain ranged from 1.5 to 4.5, with an overall mean score of 3.1.

Table 17: Youth & Family Progress Domain Mean Scores

Domain	Min	Max	Mean	Standard Deviation
Domain 4: Youth/Family Progress	1.5	4.5	3.1	.76
-ICC	1.5	4.0	3.1	.72
-IHT	1.5	4.5	3.2	.81

Figure 5 illustrates the distribution of mean scores in the Progress Domain.

Figure 5: Youth & Family Progress Mean Scores



Progress Area Mean Scores & Frequencies

Table 18 summarizes the mean scores and frequencies for the youth and family progress Areas in this Domain. Overall, youth progress was rated less favorably than family progress. For youth in ICC, 75% had Fair progress or better, while the proportion for youth in IHT was 76%. For families in ICC, 80% had Fair progress or better, while the proportion for families in IHT was 78%. Of the 120 youth reviewed, four youth had worsening status in IHT, and three youth had worsening status in ICC.

While practice in ICC is usually somewhat superior, on average, to practice in IHT, youth and family progress does not differ greatly across the two services.

Table 18: Youth & Family Progress Area Mean Scores & Frequencies

Domain/Area	Mean	Frequencies (n) %*					
		Worsening or Declining Condition 1	Little to No Progress 2	Fair Progress 3	Good Progress 4	Exceptional Progress 5	Percent Fair or above **
Youth Progress	3.1	(7) 6%	(22) 18%	(49) 41%	(42) 35%	-	76%
-ICC	3.0	(3) 5%	(12) 20%	(28) 46%	(18) 30%	-	75%
-IHT	3.1	(4) 7%	(10) 17%	(21) 36%	(24) 41%	-	76%
Family Progress	3.2	-	(25) 21%	(45) 38%	(49) 41%	(1) 1%	79%
-ICC	3.2	-	(12) 20%	(25) 41%	(24) 39%	-	80%
-IHT	3.2	-	(13) 22%	(20) 34%	(25) 42%	(1) 2%	78%

*Due to rounding of percentages, some Area totals may not equal 100%.

** Accurately rounded percentages; areas with 70% Fair or above are in **bold**.

IHT Supplemental Question Results

Table 19 on the next page summarizes responses to the eight supplemental questions added to the MPR protocol to ascertain whether care coordination delivered as part of the IHT service was adequate to the needs and circumstances of the youth/families reviewed. As reported in questions 1 and 2, most families, 64% and 69% respectively, did not need a CSA Wraparound care planning team as a result of involvement with providers, state agency, special education, or a combination thereof. However, reviewers either disagreed (n=18) or disagreed very much (n=9) nearly half the time (46%) that youth were receiving the amount and quality of care coordination required. Results also demonstrated that 88% (n=52) of youth and families needed coordination with school personnel, yet regular contact with the school occurred for only 40% (n=21) of these youth/families. For the 71% (n=42) of youth reviewed who required coordination with other service providers, reviewers agreed only 41% of the time that regular contact occurred. Most of the youth reviewed did not require care coordination with state agency staff (68% or n=40). Reviewers reported that regular contact occurred for nearly half (48% or n=9) of the youth/families for whom it was indicated.

Table 19: IHT Supplemental Question Results

Question	Results	
	Response	(n) %
1. Youth needs or receives multiple services from the same or multiple providers AND needs a CSA Wraparound care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof.	No	(38) 64%
2. Youth needs or receives services from state agencies, special education, or a combination thereof AND needs a CSA Wraparound care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof.	No	(41) 69%
3. Youth is receiving the amount and quality of care coordination his/her situation requires.		
Disagree Very Much (n) % (9) 15%	Disagree (n) % (18) 31%	Neither (n) % (10) 17%
Agree (n) % (18) 31%	Agree Very Much (n) % (4) 7%	
4. Has the youth previously been enrolled in ICC?	No	(49) 83%
5 a.) According to the CAREGIVER, has the IHT team ever discussed the option of ICC with the youth/family?*	Yes	(26) 50%
5 b.) According to the IHT Clinician, has the team ever discussed the option of ICC with the youth/family?*	Yes	(30) 58%
6 a.) Youth and family need the IHT provider to coordinate/ collaborate with school personnel.	Yes	(52) 88%
6 b.) If yes, the IHT is in regular contact with school personnel involved with the youth and family.*		
Disagree Very Much (n) % (9) 17%	Disagree (n) % (15) 29%	Neither (n) % (7) 13%
Agree (n) % (21) 40%	Agree Very Much (n) % –	
7 a.) Youth and family need the IHT provider to coordinate/ collaborate with other service providers (e.g. TM, OP, psychiatry, etc.)	Yes	(42) 71%
7 b.) If yes, the IHT is in regular contact with other providers (e.g. TM, OP, psychiatry, etc.) involved with the youth and family.*		
Disagree Very Much (n) % (4) 10%	Disagree (n) % (14) 33%	Neither (n) % (7) 17%
Agree (n) % (15) 36%	Agree Very Much (n) % (2) 5%	
8 a.) Youth and family need the IHT provider to coordinate/collaborate with state agencies (e.g. DCF, DYS, DDS, etc.)	No	(40) 68%
8 b.) If yes, the IHT is in regular contact with state agencies (e.g. DCF, DYS, DDS, etc.) involved with the youth and family.*		
Disagree Very Much (n) % (3) 16%	Disagree (n) % (2) 11%	Neither (n) % (5) 26%
Agree (n) % (7) 37%	Agree Very Much (n) % (2) 11%	

*"Not applicable" responses changed the n used for calculating these percentages.

Key Themes from Summative Responses

Overall, the results of the FY16 MPR reviews indicated that youth experienced Fair practice or better in 78% of practice instances (total = 1,440 instances) across both IHT and ICC services. Youth experienced Good or better practice in 43% of instances. For ICC the percentage of practice Fair and above was 83%, while for IHT it was 73%.

The following discussion considers the quantitative data summarized in earlier sections of this report along with qualitative data compiled from reviewer comments (See [Appendix A](#)), and key themes from the five debriefing meetings held during each review round. Many of the findings in FY16 are consistent with previous years' quality reviews; areas of strong past practice continue to hold, while areas needing improvement in the past continue to present challenges.

Areas where practice was relatively strong across both IHT and ICC services are summarized below and reflect overall strengths of the CBHI service system.

Practice Strengths

Youth and Family Engagement

Across programs and over time, the Area of Family and Youth Engagement has demonstrated consistently strong practice. This indicates that providers both value and have the skills to build a relational foundation with youth and caregivers. Every family presents with unique strengths and challenges, yet staff have shown the capacity to build bridges – a critical first step in the course of care. Additional complexity within this Area arises when a youth has caregivers in multiple settings. This often presents logistical obstacles and requires sophisticated clinical skills in order to support youth and families with various compositions. Results have begun to demonstrate a positive trend in the inclusion of caregivers across multiples homes. It is important to note that while this component captures both caregiver and youth together, positive results are likely skewed toward the family as all reviews included a caregiver interviewee but only a small number of youth were interviewed. Youth participation has been noted as a theme requiring further attention and development.

Service Accessibility

Findings in the Area of Service Accessibility continue to reveal that providers structure the work based upon the family's needs. This would include the operational components of care such as meeting times and locations designed to best accommodate the family's needs and preferences. Additionally, access was evident regarding the family's language needs such as document translation, bilingual / bicultural staff, and interpreter services. This flexibility has also extended to the consideration of other providers by holding meetings in locations such as schools and outpatient clinics to allow for greater participation. Findings in this Area should be considered in light of these services being designed to be delivered in the community. That being said, the notion of delivering services that are accessible to families has taken hold.

Family/Caregiver Progress

Within the Progress Domain, many of the scores and reviewers noted Good progress for families/caregivers. This encompasses the caregiver's own ability to cope with and manage youth's behavior as well as improvements in the family's overall quality of life. Parents continue to report that they feel supported, they are gaining skills, and that they have found the services to be helpful. One reviewer described a parent's experience as follows: "Mom acknowledged that in the past she didn't know how to speak with providers but now she answers her phone and advocates for her child's needs." The advancement of caregiver skills is a critical component to sustained improvements for the family overall.

Opportunities for Practice Improvement

In addition to identifying practice Areas where providers show relatively strong practice, the MPR also serves to identify Areas where practice is in need of improvement. The following summarizes the Areas identified as presenting opportunities for practice improvement. The first two Areas, Assessment and Transition, demonstrated inadequate practice across both IHT and ICC services; subsequent Areas discussed here as needing practice improvement are specific to IHT only.

Assessment

Ratings, reviewer comments, and debriefing discussions all consistently identified concerns regarding the quality of the assessments. Assessment is understood to include the initial and ongoing process by which the clinician understands the youth and family which then informs the written comprehensive document. Considering all the components of care, a poor initial assessment is particularly problematic as it sets in motion a process that is impaired from the start and limited at best. Particular components of the Assessment that were noted as weaknesses included clinical formulation, trauma history, family/youth strengths, and collaboration with other providers. Additionally, staff often demonstrated a diminished appreciation for the assessment process and its critical role in their capacity to deliver high quality care.

Transition

A variety of changes, both anticipated and unexpected, invariably occur throughout the course of care. These junctures require prospective discussion, contingency planning, and coordination among families and providers alike. While 65% of families experienced Fair to Exemplary practice identified through the reviews, 35% of families experienced a fractured transition process where care was Adverse or Poor. This included staff changes, movement from child to adult services, in/out of acute levels of care, and, most notably, termination from services. During the interviews, it wasn't uncommon for families to express concern and confusion to the reviewer as to when services might end. Similarly, reviewers encountered staff who reported that it is appropriate to only discuss transition with families when approaching the end of services. Further, staff turnover was a pervasive theme and undoubtedly an ongoing frustration for both families and provider systems. While staff departures are difficult for all involved, it is possible to mitigate many of the unintended consequences with strategic and thoughtful planning, examples of such are included in [Appendix A](#).

IHT: Team Formation, Team Participation, and Care Coordination

These three components related to IHT's function as a team facilitator should be a focus of improvement. All three were Fair or above less than 70% of the time. Insufficient contact with both formal providers and natural supports was pervasive. In particular, additional outreach and inclusion was indicated as being needed yet absent with regard to schools, the Department of Children and Families (DCF), and prescribers of psychopharmacology. It should be noted that a lack of contact with the providers managing the youth's medication, such as primary care doctors or psychiatrists, was not exclusive to IHT as it was also problematic in the ICC reviews as well.

IHT: Cultural Sensitivity and Responsiveness

The MPR considers the extent to which providers understand and incorporate culture in the broad sense, including such characteristics as the family's belief, cultures, traditions, in addition to housing instability, history of victimization, and differing beliefs within the family. Many providers dismissed the importance of culture, some struggled to respond, and some reported that it had no bearing on their work. In other instances, culture was seen with a very narrow lens, equating the notion of culture with race alone. Similar to the assessment process, a cultural discovery with the family requires skillful facilitation; however, culture brings with it many layers of complexity. Staff must first appreciate, acknowledge, and understand their own culture and beliefs. Only then can they begin to explore how culture shapes the ways services are delivered and received.

Recommendations & Next Steps

Continue/Expand Provider Training & Coaching to Support Practice Improvement

The Commonwealth has demonstrated a commitment to continuous quality improvement by sustaining previous training mechanisms and adding innovative new strategies to support the CBHI service delivery system over the past year. Many of the trainings and other initiatives currently underway are closely aligned with the goal of supporting practice improvements in the areas identified as not meeting established standards and best practices during the FY16 MPR reviews, as well as during previous quality reviews. These initiatives, which are briefly summarized below, should continue to be supported and expanded upon in order to bring service delivery practice more in line with CBHI values and principles.

Wraparound Coaching

For the CSAs, the Wraparound training and coaching team continues to support fidelity to the model for ICC. In the past year and moving forward, the ICC and Family Partner coaches will offer Family Partner Leadership Forums, Regional CSA Meetings, and Individualized Coaching. In addition, coaches will facilitate Family Voice Forums at each CSA throughout the coming year. This will be an opportunity to hear from families about their experiences with the behavioral health system.

IHT Practice Profile

CBHI, in conjunction with the DMH Children's Behavioral Health Knowledge Center, has developed an IHT Practice Profile that identifies nine core components of IHT including:

- **Practicing Cultural Relevance**
- Engagement
- **Assessment and Clinical Understanding**
- Risk Assessment and Safety Planning
- Collaborative Intervention Planning
- Intensive Therapeutic Intervention
- **Care Coordination and Collaboration**
- Engaging Natural Supports and Community Resources
- **Preparing to Exit**

Four of the competencies, indicated in bold above, directly relate to the areas identified in this report as needing practice improvement (Assessment, Team Coordination (et. al), Cultural Sensitivity and Responsiveness, and Transition). The Practice Profile includes a detailed matrix for each item that rates practice as either: Ideal, Developmental, or Unacceptable. CBHI is currently designing the activities to support the initial training and ongoing learning associated with the Practice Profile. While it is anticipated that this resource will have a significant impact on the quality of services, it remains in the early stages of implementation. It should also be noted that the IHT Practice Profile labels correspond to the Practice Indicators in the MPR. Ideal practice would be Exemplary/Best Practice, Developmental corresponds to ratings in the Fair-Good range and Unacceptable Practice would be considered Poor or Adverse. This will be a useful tool for future analysis.

Trauma Training

Also in partnership with the Knowledge Center, CBHI has begun to offer Attachment, Regulation and Competency (ARC) trainings to 30 IHT and ICC providers across the state. The Trauma Center at the Justice

Resource Institute (JRI) is delivering the in-person training content at three geographical cohorts. Additionally, the implementation also includes ongoing consultation and support to direct care workers as well as supervisors and senior leaders. As outlined previously, the identification and exploration of trauma with families was an area that needs further development, particularly as it relates to Assessment. The ARC model provides a guiding framework for thoughtful clinical intervention with regard to complex trauma for youth and their caregiving systems. This should serve to inform and improve the Assessment overall.

Cultural Competency

CBHI continues to support initiatives to bolster cultural competency as it relates to workforce development and also to enhance clinical practice. Led by Dr. Ken Hardy, *Supervising Family Therapy, A Multicultural Perspective*, and *Family Therapy: The Hidden Wounds of Racial Trauma* were delivered in three regional IHT cohorts this past year. Dr. Hardy will offer an additional training for IHT providers in the central region this fall. The delivery of culturally competent services is critically important yet an incredibly complicated endeavor. While these and other learning opportunities provide a strong knowledge base, this work will need to be continuous as issues of culture are extraordinarily complex.

Supervision Supports

Supervision is a key point in the service delivery system and change at this juncture can generate widespread improvements both for quality of care as well as staff satisfaction. As such, CBHI and the Knowledge Center have embarked on two initiatives. The first, *Reflective Supervision Learning Community*, will serve to broaden and enhance reflective practice within six IHT programs. While this opportunity will bolster a multitude of service components, it targets trauma-informed care through its model of collaboration. The second initiative, *Yale Strengthening Supervision*, will focus on agency standards, policies, and procedures related to supervision at four provider agencies. As a tiered-approach, it will include training frontline supervisors, mid-level managers, and also interface with senior leadership to effect agency-wide improvements.

Support Practice Improvement in the Areas of Assessment & Transition for ICC

Despite the efforts noted above, the Areas of Assessment and Transition across CSAs remain unaddressed. TAC recommends several options that the state could consider to bring practice in line with established standards and best practices. The first would be to develop a best practice guide utilizing examples from the MPR qualitative data. This would emphasize core competencies and also include creative strategies to overcome common challenges. If useful, this tool could also be expanded to highlight other promising practices identified by the MPR. In addition, Assessment and Transition could be targeted through the coaching model. The existing structure offers regional opportunities for sharing best practices as well as working 1:1 with each CSA. Since the Learning Collaborative model in FY15, CSAs have continued to promote the use of transition indicators for youth and families. It may be useful for these tools to be implemented more consistently and also expanded in scope to include staff changes and shifts in life domains. Finally, once the IHT Practice Profile moves into full implementation, some components could be modified to support the CSAs. In particular, Assessment and Clinical Understanding could serve to bolster CSAs' comprehensive assessments and the Strengths, Needs, Cultural Discovery processes.

Appendix A

The table below consists of qualitative data compiled from MPR reviewer comments used to support their ratings. These comments serve to demonstrate the spectrum of quality from Exemplary or Good practice to Poor or Adverse. In several Areas, the examples of practice meeting or exceeding established standards and best practices should be understood as isolated instances, not necessarily indicative of larger trends. In other Areas, comments describe practice not meeting established standards and best practices and are examples of pervasive patterns. These qualitative themes and reviewer comments provide a rich look into the experiences of families, their perception of the services, and their assessment of their own progress. They also highlight examples of provider ingenuity, as well as the challenges to service delivery that persist in many areas.

Appendix A: Qualitative Comments by Reviewers by Domain/Area			
Domain/Area	Mean	Qualitative Themes & Selected Reviewer Comments	
		Practice Strengths	Practice Needing Improvement
Family Driven & Youth Guided			
Assessment	3.0	<p>The initial and ongoing assessment of this youth and family was incredibly thorough, both in depth and breadth. Each area was thoughtfully explored and expressed in a strength-based, culturally competent manner. There was a commitment to a continuous and circular learning process that united the family, clinician and TT&S in this shared growth experience.</p> <p>The initial assessment for this Youth was exceptionally thorough and thoughtful. All relevant sources of information were acknowledged and included. The CANS had clarifying narrative for every item. Strengths and cultural considerations were both documented fully for Youth and family. The whole assessment gave sufficient history and current observation to provide an overall picture of the family and clear reasoning behind the change in diagnosis.</p> <p>The assessment offered a comprehensive report on history and current functioning. Most impressively, the ICC collected scads of reports to inform the process both initially and ongoing such as previous school's FBA, IHBS FBA, IEP, hospital discharge, speech and language assessment, previous ICC/FP files, and info from primary care doctor. CA also explores the relationship and efficacy of past providers/placements. While the needs of this youth were plenty, the ICC appropriately honed in on the most critical calling for safety and stability through the development of a strong, skilled team.</p>	<p>Documentation was poor: assessment and CANS lacked depth, no strengths, no mention of family culture, lack of history, primarily problem focused, and no diagnostic formulation.</p> <p>The clinician accepted the diagnosis of autism from the parent. There was no evidence the clinician consulted with a licensed clinician or psychiatrist on the diagnosis.</p> <p>Initial assessment noted that quality was limited due to poor initial engagement. Once the team was able to establish rapport, it would have been important to revisit the assessment process rather than view it as a static task. No outreach to other providers to obtain external assessments, treatment plans, etc. (example: school therapist with whom he had been working for 2 years).</p> <p>In particular, the area of trauma was insufficiently assessed, documented and considered in the course of treatment planning. This family's pervasive experience of trauma should have informed this work at all levels. This was a significant failure.</p> <p>Both the written documentation as well as the process of gathering the information was poor. The ICC did not request any external documentation from existing providers.</p>
Service Planning	3.1	<p>ICC/FP astutely engaged the caregiver actively in the service planning process. The team was responsive to the unpredictable and changing needs of this youth, containing crisis on a daily basis. The ICC utilized the OP and IHT Treatment Plans to generate consistent and focused goal planning and interventions.</p> <p>The clinician's approach was astutely attuned to the lens of trauma, loss and instability for the children and multiple caregivers in this family system. This perspective served as the foundation for the service</p>	<p>Did not include youth or father in the planning process, strengths were not incorporated in the plan, plan did not change when child transitioned to father's care, no safety plan was found in the record.</p> <p>The caregivers had never seen a treatment plan, and each team member articulated different goals of the treatment process.</p> <p>The service plan was unable to flow from the</p>

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		<p>planning. The clinician outreached the youth's biological mother to discuss services and explore her interest in involvement. This is a critical step that can be overlooked when a caregiver is not in the home.</p> <p>Safety plan was reviewed at every CPT meeting and updated often and ICC would then send to MCI. The ICC generated a list of strengths for every member of the family in all domains such as spiritual, educational, etc. Needs were prioritized and assessed on a rating scale and corresponded with what was reflected in the CA and SNCD as well as the CANS.</p> <p>ICP was thorough and updated. It included strengths of each team member. It also included measurement strategies defined as "first signs of success".</p>	<p>needs identified in the comprehensive assessment, since the assessment recommended services (i.e. individual therapy, TM, neuropsych and OT evals, etc.) and did not identify needs.</p>
Service Delivery	3.5	<p>At the first CPT meeting, the ICC noticed that the youth responded quite well to hearing his family identify his strengths. As such, the ICC then added this item to the weekly emails shared among the family and team to continue to bolster the youth.</p> <p>The clinician and TT&S functioned as a singular unit delivering high quality in-home therapy. This team employed a variety of modalities including role playing, psychoeducation, telephonic coaching, and household structural support - all of which were responsive to the emerging needs of the family. The IHT team conducted consistent and thoughtful in-person sessions that included the entire family as well as subsets.</p> <p>The clinician uses creative interventions that match the families strengths, interests and adapts to their changing needs. She has been successful with using art therapy to increase communication and strengthen the relationship between the mother, the youth and her sister. The IHT clinician, TM and parents are also using creative interventions with the local horse farm to help the youth self regulate.</p>	<p>While the ICC was responsive when the youth was admitted to acute care, the overall intensity and frequency of contact was inadequate. The CPT meetings occurred approximately every 3 months and in-person contact with the caregiver appeared to be every 1-2 months. Brief phone or email check-ins occurred in between. This pattern of contact was incongruent with the family's needs.</p> <p>Safety assessment and planning is also an area that needs improvement. The ICC noted no safety concerns; however, IHT and the caregiver expressed ongoing safety concerns with regard to verbal and physical aggression between the siblings. Additionally, the caregiver is worried about the youth's cutting. The only safety plan on file was completed by a TM. The ICC/FP seemed satisfied that if a crisis occurred, the caregiver would call emergency services and that was a sufficient safety plan.</p>
Youth & Family Engagement	3.7	<p>IHT clinician's persistence and ongoing commitment to engaging youth and family allowed mother to feel supported. This also allowed mother to trust provider and be open to new providers such as ICC.</p> <p>The ICC and FP were incredibly thoughtful in their strategy to build rapport with this family. Their initial assessment outlined the caregiver's concerns with previous providers and other systems. They also considered the family's immigration status and were sensitive to those concerns. The ICC sought out ways to solicit participation from the youth and noted that he enjoyed contributing to the family vision and talking about one another's strengths.</p> <p>The ICC was persistent and creative with her engagement attempts. One of the long-term goals for the youth was to get a job. The ICC was able to</p>	<p>Youth and caregiver participated in meetings with CC and FP when they are able to meet. However, they frequently cancelled, didn't seem to understand how interventions will help, and shared not feeling heard at times.</p> <p>Most significantly, the ICC never outreached the youth's father. Given his relationship with the youth and possible concerns with regard to the supervision at his home, this was a critical misstep.</p> <p>The youth and family engagement did not meet expectations on this case. The team has never met with the youth and just recently started to try to get him to join CPTs. However, no effort has been put into making his voice heard, preparing him for meetings, and helping him</p>

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		develop a relationship with the youth while also providing her an opportunity to learn a new skill [relevant to the type of job youth was interested in.]	further engage in this process.
Team Formation	3.0	<p>ICC made efforts to understand and accommodate team schedules so as to have the greatest meeting attendance and participation. OP provider noted how helpful this was in order to get provider buy-in to the process. Utilized team strengths as well as those of the family.</p> <p>Team was made up of both formal providers (ICC, FP, TM, PM, IHT, psychiatrist) and Natural Supports (2 of the youth's friends).</p> <p>The ICC was incredibly thoughtful in the development and ongoing participation of all team members. For example, the caregiver's partner traveled significantly for employment reasons and the OP therapist was often unable to attend due to a limited schedule. The ICC consistently brought their celebrations and concerns to the care planning process and utilized the absent partner form.</p>	<p>There was no engagement of formal providers or natural supports in the service planning. There is no indication in the file of meetings with DCF.</p> <p>The team didn't effectively coordinate with the protective service agency to obtain details or assessments of their services.</p> <p>The ICC and FP did not identify or explore engaging youth's previous foster mother, who child was still placed with for first few months of the case and who mother identified as a natural support.</p> <p>No natural supports have been identified for the team, and there is minimal effort to develop or find out about natural supports (despite a teacher at school who is very connected to Youth, and family involvement in their local church).</p>
Team Participation	3.1	<p>Good collaboration between OP and IHT both in terms of family assessment as well as to inform treatment planning around a trauma-informed model of care.</p> <p>Care Plan meetings take place in early evening when parents return from work. DCF, PP Coach, ICC, FP and both parents always attend. School is not able to attend due to the time and location but they have a task on the plan. - ICC obtains updates from school guidance counselor prior to the CPT and then updates her following the CPT.</p>	<p>Didn't consult school when developing the plan, despite school concerns were indicated as a priority need at referral.</p> <p>The ICC did not have any contact with the prescriber. In fact, the ICC could not give any identifying information about the prescriber. The caregiver reported that in this area "communication broke down".</p> <p>The ICC did have regular contact with the school; however, they were not included in the care planning process. The ICC had infrequent contact with DCF and the worker was not invited to attend CPT meetings nor was she provided any ongoing information such as ICP, safety plan, successes/challenges, etc.</p>
Care Coordination	3.2	<p>Family, IHT and OPT consistently reported that the team had excellent communication. ICC did a great job keeping everyone on the same page and ensuring that team members talked weekly. ICC also made sure that the OPT and psychiatrist kept in good communication (OPT was the designated team member to consult with psychiatrist).</p> <p>ICC was the point person for communication and communicated weekly with all team members. Youth reported that she loved having one person to go to and that would make sure everyone was on the same page. IHT and FP reported that communication was excellent. IHT was in consistent contact with the psychiatrist. At the end of service the youth began to help the ICC coordinate.</p>	<p>IHT clinician did not see it as her role as HUB to coordinate services and did not initiate contact with any providers, except telephone VM messages to the outpatient therapist.</p> <p>When reviewing with all team members who was in charge of the care coordination the parent and TT&S both reported the clinician and TT&S were the point people. However the clinician indicated the TT&S is the point person.</p> <p>The clinician has not had any contact with prescriber, despite this youth being on five medications.</p> <p>The youth is currently prescribed two medications and a PRN. The ICC was unsure if</p>

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		<p>The ICC held Care Plan meetings every month, at first with only the small group (family, ICC, FP, and therapist) but with a plan to add others as they came on board. This included both natural supports (especially Father) as well as formal supports. Since school was unwilling to participate in Care Plan meetings, the ICC and FP accompanied Mother to school meetings and addressed family vision and progress at home in the school meeting context.</p>	<p>the youth was on medication. Other team members also had little to no information. The youth is overweight and pre-diabetic and mother is concerned this could be the result of his medications.</p>
Transition	2.9	<p>The IHT clinician has done a great job talking about transition early in the process and has been working with the family on a transition plan that involves sustainable supports.</p> <p>Interventions focused on the impact of the youth's transition to and from visits with her father. A new plan was developed that minimized dysregulation. Transition indicators were used with the mother to assess her skills and ability to manage her daughter's mental health needs. The use of the indicators assisted the team in moving through the transition phase. Also, the transition phase was documented well in the ICP.</p> <p>Reviewer felt that there were many transitions on this case and they were all handled exceptionally. The ICC transition went smooth with the new one shadowing the first one. The change in IHT clinician went very well, since the previous IHT clinician became the youth's outpatient clinician and was able to stay on the team. Any plans for changes in schools, including her return from hospitals were all planned for accordingly. Also, the family's graduation from wraparound services once youth was on track for DMH placement was planned for and done gradually with providers phasing out of the family's life.</p>	<p>A change in IHT team (both clinician and TT&S) was done without any planning or notice to the youth/ family. Youth is also in the process of changing schools, and IHT team has not done anything to assist with this transition especially with much needed educational advocacy and planning.</p> <p>The family was totally unaware as to when services might end. Although the ICC crafted a thoughtful vision that appeared to be in the family's own voice, there was no connection made between the vision and graduation. When asked about when services might end, caregiver stated "your [reviewer] guess is as good as mine".</p> <p>According to the record, the gap in services between clinicians due to staff turnover was almost 2 months. The previous clinician's last note with the family did not even mention she was leaving the position or prepared the family for such transition.</p>
Community-Based			
Responsiveness	3.5	<p>This clinician was very responsive to the family when in need. He was flexible with scheduling sessions and available for support by phone. They were able to meet 2-3 times per week.</p> <p>The team, and FP in particular, did excellent work assisting the parent on accessing a range of supports including: summer camp, school placement for sibling, applying for SSI, furniture, rent assistance, loss/grievance group after miscarriage, clothing/winter coats, and holiday gifts. Even better, the FP was proactive with identification of possible needs but also responsive to requests from caregiver. Finally, the FP cited the "do for, do with, cheer on" mantra and discussed the process to move the parent towards self-sufficiency.</p> <p>Very prompt response to the referral; Excellent advocacy skills on the part of the ICC to obtain testing quickly.</p>	<p>Family and providers are in support of OP for this youth. Given her temperament and trauma history it may be a far more accessible option for her. It also would have been helpful to explore other community supports and resources for sustainability.</p>

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Service Accessibility	3.9	<p>Both fathers work full-time with stepfather at regular hours and Father with sometimes unpredictable hours. The record is full of times that Father had to change his work schedule on short notice and ICC rescheduled her own visits or even a whole CPT to accommodate the change.</p> <p>ICC and FP were attentive to the language needs of the family. In addition, they were creative about finding ways to incorporate the caregiver's English lessons as a part of the service delivery process. For example, they gave the caregiver both the English and Spanish versions of the ICP so she could use the English version for practice.</p>	<p>Did not engage father in the assessment, treatment plan or service delivery due to clinician's inability to meet after 4:30.</p> <p>The preferred language of the family was CV Creole, but all documentation was done in English, safety plan included.</p> <p>Both parents said that they received the first service plan in Spanish because they asked for it, but do not recall receiving any future ones in Spanish.</p>
Culturally Competent			
Cultural Awareness	3.2	<p>The ICC was clearly able to describe the unique culture of this family and how the entire approach to care was impacted. It was evident that culture was embedded in the work and was an ongoing area of discussion with the team and family.</p>	<p>There was no evidence that the clinician explored family/ cultural/ religious beliefs or values- documented on Comprehensive assessment as "denied."</p> <p>The ICC expressed that the culture for this family was not incorporated into the work because "most of it is the same for most clients".</p> <p>Both the IHT clinician and TT&S worker struggled to describe the family's culture and values. The TT&S worker described the family's culture by stating "not a lot of significant cultural issues," "regular traditional values," and "nothing I have seen or identified."</p>
Cultural Sensitivity & Responsiveness	3.0	<p>The ICC and FP did very well with their cultural awareness of this family. They have a great understanding of this family's values, beliefs and traditions. An example of this is their understanding and support to the parents and their relationship.</p> <p>ICC/FP demonstrated an understanding of the impact of homeless, frequent moves, relationship disruptions, incidents of physical abuse, parent conflict and the parents' own family history.</p>	<p>Cultural sensitivity and awareness was not explored as needed. Possible areas such as languages spoken in the home and extended family, early victimization, adoption, biological parents were largely left untold. In addition, differences between clinician and family as well as generationally across the family were also not explored and appeared to this reviewer to be prominent and influential.</p> <p>Areas such as the father's move to the US, substance use, trauma, and discrimination based on race were largely untouched.</p>
Youth/Family Progress			
Youth Progress	3.1	<p>Mom indicated progress in the area of the youth learning coping skills and identifying his emotions better. Mom reported he was not able to describe his feelings and the IHT provider developed a point scale to utilize that was based on "Minecraft" which is one of the child's favorite things. She reported this allowed him to work with the IHT providers and has worked to allow him to express himself and tell people why he is feeling upset.</p> <p>Mother reports "she [youth] is able to go to school</p>	<p>Overall, there was little to no progress in any domain; despite solid efforts by the ICC and other team members. The ICC did note improvement in the youth's functioning at home evidenced by less conflict. However, the ICC expressed concern with regard to the family's overall connectedness and the youth's diminished sense of hope for the future.</p> <p>IHT clinicians were in agreement that the youth's explosive/aggressive episodes are</p>

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		<p>now for months at a time and not get into a fight or kicked off the bus, and she also leaves here each morning caring about her hygiene and personal appearance, she is a much happier girl".</p> <p>Both parents rated youth's ability to use his coping skills as exceptional, especially when it comes to anxiety. He now knows that when he feels his chest hurt, that he needs to breathe, close his eyes, step away from the situation, etc. The youth and parents all agree that there has been good progress in his emotional functioning at home as well as an increase in socializing with the family. A noted change in youth's community and school life is that he now has his first friend that has even come over to the house a couple times.</p> <p>Youth's mother was very satisfied with the progress the youth and family have made as a result of the IHT services. She reported that the youth is now in a small classroom with an IEP that meets her needs and is making great gains. She credits the support and advocacy by the IHT clinician for making that happen.</p>	<p>significant and warrant a higher intensity of services than IHT can provide. Therefore, IHT referred the youth back to the Continuum.</p> <p>Overall, reviewer has significant concerns regarding the lack of progress with this youth and family. Youth's poor academic performance is of serious concern and there was little attention as to the cause and pursuit of possible accommodations.</p>
Family Progress	3.2	<p>Mother reports feeling less depressed and more empowered. Was able to get her citizenship and drivers license. Feels more supported and comfortable with decision she made to help her family.</p> <p>The youth's mother expressed that being involved with services was "one of the best decisions I could have made for my family". She noted that the work has been challenging and, at times, has felt as though there are too many providers but she sees good outcomes now. She reported that the team has given them tools to better understand their son's needs.</p> <p>Caregiver also shared that there was significant progress in her ability to manage the youth's behavior and the family's overall quality of life. She said that everybody got better with this service.</p>	<p>Youth continues to demonstrate concerning behaviors. It appears that treatment provided has been ineffective given ongoing concerns. A missed opportunity to strengthen parenting amongst all adults in the home.</p> <p>The clinician and the family have different views of the progress made. This is due to several factors including the lack of a therapeutic relationship and bond between the clinician and mother and the lack of service delivery for over a month by the IHT team. Mom reported struggles to engage because the clinician would "tell us what to do and just try things. She wouldn't give me ideas or options like my other clinician" and the clinician reported "I told her the things to do but she wouldn't follow through".</p> <p>It doesn't appear to the reviewer that any significant progress has been made. The ICC/FP have successfully established a rapport with the family but beyond that, interventions have been limited. This youth and family have strengths that haven't fully been developed.</p>