



**FISCAL YEAR 2018**  
**MASSACHUSETTS PRACTICE REVIEW (MPR)**  
**PRACTICE SUMMARY REPORT**

**MassHealth**  
CHILDREN'S BEHAVIORAL HEALTH INITIATIVE (CBHI)



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## Introduction

The MPR is a qualitative case review tool that is implemented by trained reviewers who examine the clinical record and interview multiple stakeholders, including the CBHI service provider, the caregiver, the youth (if over 12), and other formal providers who work with the youth and family. MPR reviews are specifically focused on In-Home Therapy (IHT) and Intensive Care Coordination (ICC) services.

The MPR reviews are one of the many sources used to assist the Commonwealth and MassHealth to identify service delivery challenges experienced by providers and ways to achieve the standards of care established for CBHI services. The MPR data is useful for the purpose of identifying areas for targeted and general provider improvement efforts.

## MPR Protocol Description & Methodology

### 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. Trained reviewers use the MPR protocol to elicit specific information on 12 Areas of practice quality (Areas of Practice) and 2 Areas that examine the progress of a youth and their family since enrollment in IHT or ICC services (Areas of Progress).

By triangulating responses from the record review and other informants, MPR reviewers obtain a comprehensive picture of services delivered for the sampled families at the practice level. Reviewers are then asked to rate each of the Areas by assigning a numerical score that reflects the extent to which practice is meeting established standards and best practice for the service. Quotes, specific examples, and other qualitative information may also be recorded by reviewers to support their numerical ratings.

### Practice Domains/Areas

**Table 1** summarizes the factors, prompts, and considerations for each of the 12 Areas of Practice used to guide reviewers in scoring across the 3 MPR Practice Domains, as described below.

**Table 1: MPR Practice Domains/Areas & Reviewer Scoring Prompts**

Practice Domain/Area:	Domain 1: Family-Driven & Youth-Guided
Area 1: Assessment	<ul style="list-style-type: none"><li>• Relevant data/information about the youth and family was diligently gathered through both initial and ongoing processes.</li><li>• The needs of the youth and family have been appropriately identified and prioritized across a full range of life domains.</li><li>• Actionable strengths of the youth and family have been identified and documented.</li><li>• The provider has explored natural supports with the family.</li><li>• The written assessment provides a clear understanding of the youth and family.</li></ul>
Area 2: Service Planning	<ul style="list-style-type: none"><li>• The provider actively engages and includes the youth and family in the service planning process.</li><li>• The service plan goals logically follow from the needs and strengths identified in the comprehensive assessment.</li><li>• Service plans and services are responsive to the emerging and changing needs of the youth and family.</li><li>• An effective risk management/safety plan is in place for the youth/family.</li></ul>

Practice Domain/Area: Domain 1: Family-Driven & Youth-Guided	
Area 3: Service Delivery	<ul style="list-style-type: none"> <li>The interventions provided to the youth and family match their needs and strengths.</li> <li>The provider incorporates the youth's and family's actionable strengths into the service delivery process.</li> <li>The intensity of the services/supports provided to the youth and family match their needs.</li> <li>Service providers assist the youth and family in understanding the provider agency and the service(s) in which they are participating.</li> </ul>
Area 4: Youth & Family Engagement	<ul style="list-style-type: none"> <li>The provider actively engages the youth and family in the ongoing service delivery process.</li> </ul>
Area 5: Team Formation	<ul style="list-style-type: none"> <li>The provider identifies, outreaches, and engages formal providers, including prescriber (if applicable), in the initial service planning process.</li> <li>The provider identifies, outreaches, and engages natural supports in the initial service planning process.</li> </ul>
Area 6: Team Participation	<ul style="list-style-type: none"> <li>The provider actively engages a team including school personnel, other agencies, and natural supports in the ongoing effort to plan and deliver services.</li> </ul>
Area 7: Care Coordination	<ul style="list-style-type: none"> <li>The provider (i.e. IHT clinician, ICC) successfully coordinates service planning and the delivery of services and supports.</li> <li>The youth is receiving the amount and quality of care coordination his/her situation requires.</li> <li>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.</li> </ul>
Area 8: Transition	<ul style="list-style-type: none"> <li>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.</li> </ul>
Domain 2: Community-Based	
Area 9: Responsiveness	<ul style="list-style-type: none"> <li>The provider responded to the referral (for its own service) in a timely and appropriate way.</li> <li>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.</li> </ul>
Area 10: Service Accessibility	<ul style="list-style-type: none"> <li>Services are scheduled at convenient times for the youth and family.</li> <li>Services are provided in the location of the youth and family's preference.</li> <li>Service providers verbally communicate in the preferred language of the youth/family.</li> <li>Written documentation regarding services/planning is provided in the preferred language of the youth/family.</li> </ul>
Domain 3: Culturally Competent	
Area 11: Cultural Awareness	<ul style="list-style-type: none"> <li>The service provider has explored and can describe the family's beliefs, culture, traditions, and identity.</li> <li>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.</li> </ul>
Area 12: Cultural Sensitivity & Responsiveness	<ul style="list-style-type: none"> <li>The provider has acted on/incorporated knowledge of the family's culture into the work.</li> <li>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.</li> <li>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.</li> <li>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.</li> </ul>

## Practice Indicator Rating Scale

**Table 2** shows the scoring for the 12 MPR Areas of Practice on a 5-point rating scale.

**Table 2: 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

**Table 3** summarizes the factors, prompts, and considerations for each of the 2 Areas of Progress used to guide reviewers in scoring across the MPR Progress Domain, as described below. Reviewers are also asked to rate two 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 3: MPR Progress Domain/Areas & Reviewer Scoring Prompts**

Progress Domain	Domain 4: Youth & Family Progress
Area 13: Youth Progress	<ul style="list-style-type: none"> <li>Since the youth's enrollment in the service being reviewed, he/she has developed improved coping or self-management skills.</li> <li>Since the youth's enrollment in the service being reviewed, he/she has made progress in their social and/or emotional functioning at school.</li> <li>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.</li> <li>Since the youth's enrollment in the service being reviewed, he/she has made progress in their social and/or emotional functioning at home.</li> <li>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.</li> </ul>
Area 14: Family Progress	<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>

## Progress Indicator Rating Scale

**Table 4** shows the scoring for the 2 Areas of Progress on a 5-point rating scale.

**Table 4: 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



## **MPR Methodology**

### **Review Team**

The Technical Assistance Collaborative, Inc. (TAC), MassHealth's MPR review contractor, recruits and maintains a core team of qualified MPR 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. Training for reviewers consists of didactic presentation, role playing, and experiential scoring. Reviewers also have the opportunity to shadow one another for ongoing learning and development.

### **FY18 Provider Sampling & Selection**

The Commonwealth conducts at least 120 MPR reviews of IHT and ICC services annually. Two MPR reviews are conducted from each of the 32 CSAs (64 reviews in total). In FY 2018, all 64 ICC reviews were completed. For IHT, 21 provider sites out of 159 sites statewide (63 reviews in total) were sampled in FY 2018, with 61 IHT reviews completed. IHT provider selection and stratification is based on both capacity and location. That is, all of the state's IHT providers are sorted by their total capacity and location prior to being randomly sampled. Providers are stratified in this way to ensure that high volume providers have more reviews completed than low volume providers, and that reviews aren't concentrated in one area of the state.

### **Youth Sampling, Consent & Interview Process**

Once the provider sites were determined as described above, enrolled youth at those sites are randomly selected to participate. Youth who are concurrently enrolled in ICC are ineligible for an IHT MPR review in order to evaluate IHT as a "hub" of care coordination for that youth. Providers are trained on the MPR process, obtaining informed consent of participants, and MPR scheduling procedures.

After obtaining informed consent to participate, the reviewers review the clinical record at the provider agency, and interview key informants, including: 1) the parent or caregiver; 2) the youth, if 12 or older; 3) the In-Home Therapist (IHT) or Intensive Care Coordinator (ICC); and 4) up to 3 additional service providers familiar with the care provided to the youth (e.g. family partner, DCF worker, outpatient therapist, etc.). An MPR review is considered valid only if the record review and at least three additional interviews are completed.

### **Review Debriefings & Data Management/Analysis**

Monthly meetings are facilitated during MPR review months, during which reviewers join MassHealth, TAC, managed care entity's representatives, the *Rosie D.* Court Monitor, and other system partners to debrief on the review findings. Relevant historical, demographic, diagnostic, and service history of each youth/family are presented, followed by in-depth discussion regarding practice strengths/challenges, and youth/family satisfaction with services and progress. Reviews are scored in advance, enabling a review of scoring accuracy based on the information presented.

The reviewers enter the MPR data into a HIPAA-compliant database. TAC then extracts and analyzes the IHT and ICC reviews separately, and then holistically. That data is used to produce provider-level reports that include a rating for each Area of Practice and Area of Progress, as well as qualitative comments offering feedback on components of the work as well as performance. These reports are produced following each monthly debrief resulting in timely feedback for providers.

## Quantitative Results

### Select Demographic Characteristics

**Table 5: Demographics of Youth/Families Reviewed**

(n) %				(n) %			
Status of Case at Time of Review	Open	(106)	85%	Gender	Male	(75)	60%
	Closed	(19)	15%		Female	(47)	38%
					Other	(3)	2%
Age of Youth	0-4 years	(2)	2%	Race/Ethnicity	White	(54)	43%
	5-9 years	(41)	33%		Latino/Hispanic	(32)	26%
	10-13 years	(47)	38%		African-American/Black	(20)	16%
	14-17 years	(31)	25%		Biracial/Mixed	(14)	11%
	18-21 years	(4)	3%		Other	(4)	3%
			Asian		(1)	1%	
>1 Behavioral Health Condition	Yes	(81)	65%	Interventions (Current)	In-Home Therapy (IHT)	(77)	62%
Behavioral Health Conditions	No	(44)	35%		Psychopharmacology	(77)	62%
	ADD/ADHD	(67)	54%		Individual Counseling	(73)	58%
	Trauma/Stressor-related disorder	(54)	43%				
	Anxiety Disorder	(42)	34%		Therapeutic Mentoring	(57)	46%
	Mood Disorder	(33)	26%		Intensive Care Coordination (ICC)	(52)	42%
					FS&T (Family Partner)	(48)	38%
	Disruptive Behavior Disorder	(22)	18%				
	Autism/Autism Spectrum Disorder	(18)	14%		Therapeutic Training & Support	(43)	34%
	Anger/Impulse Control	(14)	11%		Recreation activities	(12)	10%
	Learning Disorder	(9)	7%				
					In- Home Behavioral Services (IHBS)	(10)	8%
	Communication Disorder	(2)	2%		Other	(7)	6%
	Thought disorder	(2)	2%				
	Intellectual Disability	(1)	1%		Mobile Crisis Intervention	(3)	2%
Other	(1)	1%	Group Counseling		(3)	2%	
Service System Use (Current)	Special Education	(77)	62%		Family Counseling	(2)	2%
	DCF	(43)	34%	Inpatient/CBAT	(2)	2%	
	DDS	(10)	8%	Peer Mentor	(2)	2%	
				Day treatment/partial hospital	(1)	1%	
	Other	(5)	4%	DCF Involved (Past Year)*	No	(68)	83%
	DMH	(3)	2%		Yes	(14)	17%
	Child Requiring Assistance (CRA)	(2)	2%	*Excludes those with current DCF involvement			
	Probation	(1)	1%				

### Practice Domain Results

Areas of Practice scoring is described above in **Table 2**. **Table 6** summarizes the Areas of Practice Domain mean scores.

**Table 6: MPR Practice Mean Scores – By Domain**

Domain	Min	Max	Mean	Standard Deviation
<b>Practice Overall</b>	<b>1.9</b>	<b>4.7</b>	<b>3.4</b>	<b>.64</b>
-ICC	2.3	4.7	3.6	.63
-IHT	1.9	4.4	3.2	.59
<b>Domain 1: Family Driven &amp; Youth Guided</b>	<b>1.6</b>	<b>4.9</b>	<b>3.3</b>	<b>.74</b>
-ICC	2.0	4.9	3.5	.73
-IHT	1.6	4.6	3.1	.71
<b>Domain 2: Community-Based</b>	<b>2.5</b>	<b>5.0</b>	<b>3.7</b>	<b>.54</b>
-ICC	2.5	5.0	3.9	.49
-IHT	2.5	5.0	3.5	.53
<b>Domain 3: Culturally Competent</b>	<b>2.0</b>	<b>5.0</b>	<b>3.4</b>	<b>.67</b>
-ICC	2.0	5.0	3.6	.69
-IHT	2.0	4.0	3.2	.59

**Table 7** summarizes the mean scores and frequencies for the 8 Areas of Practice within Domain 1: Family Driven and Youth Guided.

**Table 7: Family Driven & Youth Guided - Area Mean Scores & Frequencies**

Area	Mean	Frequencies (n) %*				
		Adverse Practice 1	Poor Practice 2	Fair Practice 3	Good Practice 4	Exemplary/ Best Practice 5
<b>Assessment</b>	<b>3.1</b>	<b>(3) 2%</b>	<b>(31) 25%</b>	<b>(49) 39%</b>	<b>(33) 26%</b>	<b>(9) 7%</b>
-ICC	3.3	(1) 2%	(13) 20%	(25) 39%	(18) 28%	(7) 11%
-IHT	3.0	(2) 3%	(18) 30%	(24) 39%	(15) 25%	(2) 3%
<b>Service Planning</b>	<b>3.1</b>	-	<b>(31) 25%</b>	<b>(50) 40%</b>	<b>(39) 31%</b>	<b>(5) 4%</b>
-ICC	3.3	-	(16) 25%	(19) 30%	(25) 39%	(4) 6%
-IHT	3.0	-	(15) 25%	(31) 51%	(14) 23%	(1) 2%
<b>Service Delivery</b>	<b>3.6</b>	<b>(2) 2%</b>	<b>(11) 9%</b>	<b>(45) 36%</b>	<b>(50) 40%</b>	<b>(17) 14%</b>
-ICC	3.7	-	(4) 6%	(22) 34%	(26) 41%	(12) 19%
-IHT	3.4	(2) 3%	(7) 11%	(23) 38%	(24) 39%	(5) 8%
<b>Youth &amp; Family Engagement</b>	<b>3.7</b>	-	<b>(8) 6%</b>	<b>(36) 29%</b>	<b>(63) 50%</b>	<b>(18) 14%</b>
-ICC	3.8	-	(4) 6%	(17) 27%	(30) 47%	(13) 20%
-IHT	3.6	-	(4) 7%	(19) 31%	(33) 54%	(5) 8%
<b>Team Formation</b>	<b>3.1</b>	<b>(5) 4%</b>	<b>(31) 25%</b>	<b>(43) 34%</b>	<b>(35) 28%</b>	<b>(11) 9%</b>
-ICC	3.4	(1) 2%	(10) 16%	(21) 33%	(24) 38%	(8) 13%
-IHT	2.8	(4) 7%	(21) 34%	(22) 36%	(11) 18%	(3) 5%



Area	Mean	Frequencies (n) %*				
		Adverse Practice 1	Poor Practice 2	Fair Practice 3	Good Practice 4	Exemplary/ Best Practice 5
Team Participation	3.3	(2) 2%	(24) 19%	(39) 31%	(52) 42%	(8) 6%
-ICC	3.6	-	(7) 11%	(15) 23%	(38) 59%	(4) 6%
-IHT	3.0	(2) 3%	(17) 28%	(24) 39%	(14) 23%	(4) 7%
Care Coordination	3.2	(6) 5%	(25) 20%	(40) 32%	(40) 32%	(14) 11%
-ICC	3.5	(3) 5%	(6) 9%	(20) 31%	(23) 36%	(12) 19%
-IHT	2.9	(3) 5%	(19) 31%	(20) 33%	(17) 28%	(2) 3%
Transition	3.1	(6) 5%	(31) 25%	(43) 34%	(36) 29%	(9) 7%
-ICC	3.2	(2) 3%	(14) 22%	(20) 31%	(23) 36%	(5) 8%
-IHT	2.9	(4) 7%	(17) 28%	(23) 38%	(13) 21%	(4) 7 %

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

**Table 8** summarizes the mean scores and frequencies for the 2 Areas of Practice in Domain 2: Community-Based.

**Table 8: Community-Based - Area Mean Scores & Frequencies**

Area		Mean	Frequencies (n) %*				
			Adverse Practice 1	Poor Practice 2	Fair Practice 3	Good Practice 4	Exemplary/ Best Practice 5
Responsiveness		3.5	(2) 2%	(9) 7%	(46) 37%	(62) 50%	(6) 5%
-ICC		3.7	-	(3) 5%	(17) 27%	(39) 61%	(5) 8%
-IHT		3.2	(2) 3%	(6) 10%	(29) 48%	(23) 38%	(1) 2%
Service Accessibility		3.9	-	(3) 2%	(21) 17%	(90) 72%	(11) 9%
-ICC		4.0	-	-	(8) 13%	(48) 75%	(8) 13%
-IHT		3.7	-	(3) 5%	(13) 21%	(42) 69%	(3) 5%

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

**Table 9** summarizes mean score and frequencies for the 2 Areas of Practice within Domain 3: Culturally Competent.

**Table 9: Culturally Competent - Area Mean Scores & Frequencies**

Area		Mean	Frequencies (n) %*				
			Adverse Practice 1	Poor Practice 2	Fair Practice 3	Good Practice 4	Exemplary/ Best Practice 5
Cultural Awareness	3.5	-	(7) 6%	(55) 44%	(59) 47%	(4) 3%	
-ICC	3.6	-	(3) 5%	(21) 33%	(36) 56%	(4) 6%	
-IHT	3.3	-	(4) 7%	(34) 56%	(23) 38%	-	
Cultural Sensitivity & Responsiveness	3.3	-	(20) 16%	(56) 45%	(43) 34%	(6) 5%	
-ICC	3.5	-	(7) 11%	(25) 39%	(26) 41%	(6) 9%	
-IHT	3.1	-	(13) 21%	(31) 51%	(17) 28%	-	

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

## Youth & Family Progress Domain Results

**Table 10** summarizes the Areas of Progress Domain mean scores.

**Table 10: Youth & Family Progress Domain Mean Scores**

Domain	Min	Max	Mean	Standard Deviation
Domain 4: Youth/Family Progress	1.5	5.0	3.1	.66
-ICC	2.0	4.5	3.2	.65
-IHT	1.5	5.0	3.0	.67

**Table 11** summarizes the mean scores and frequencies for the 2 Areas of Progress in Domain 4: Youth and Family Progress.

**Table 11: 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
Youth Progress	3.1	(1) 1%	(23) 18%	(65) 52%	(32) 26%	(4) 3%
-ICC	3.1	(1) 2%	(13) 20%	(33) 52%	(14) 22%	(3) 5%
-IHT	3.2	-	(10) 16%	(32) 52%	(18) 30%	(1) 2%
Family Progress	3.1	(1) 1%	(22) 18%	(65) 52%	(35) 28%	(2) 2%
-ICC	3.3	-	(7) 11%	(32) 50%	(24) 38%	(1) 2%
-IHT	2.9	(1) 2 %	(15) 25%	(33) 54%	(11) 18%	(1) 2%

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

## IHT Supplemental Question Results

**Table 12** summarizes responses to the eight supplemental questions added to the MPR protocol to ascertain specific information regarding care coordination delivered as part of the IHT service.

**Table 12: IHT Supplemental Question Results**

Question	Results	
	Response	(n) %
<b>1.</b> 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.	Yes <b>No</b>	(15) 25% <b>(46) 75%</b>
<b>2.</b> 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.	Yes <b>No</b>	(12) 20% <b>(49) 80%</b>
<b>3.</b> Youth is receiving the amount and quality of care coordination his/her situation requires.		
<b>Disagree Very Much</b> (n) % (5) 8%	<b>Disagree</b> (n) % (20) 33%	<b>Neither</b> (n) % (11) 18%
	<b>Agree</b> (n) % (22) 36%	<b>Agree Very Much</b> (n) % (3) 5%
<b>4.</b> Has the youth previously been enrolled in ICC?	Yes <b>No</b>	(13) 21% <b>(48) 79%</b>
<b>5 a.)</b> According to the CAREGIVER, has the IHT team ever discussed the option of ICC with the youth/family?	Yes <b>No</b> NA*	(27) 44% <b>(28) 46%</b> (6) 10%
<b>5 b.)</b> According to the IHT Clinician, has the team ever discussed the option of ICC with the youth/family?	<b>Yes</b> No NA*	<b>(35) 57%</b> (19) 31% (7) 11%
<b>6 a.)</b> Youth and family need the IHT provider to coordinate/ collaborate with school personnel.	<b>Yes</b> No	<b>(55) 90%</b> (6) 10%
<b>6 b.)</b> If yes, the IHT is in regular contact with school personnel involved with the youth and family.**		
<b>Disagree Very Much</b> (n) % (11) 20%	<b>Disagree</b> (n) % (11) 20%	<b>Neither</b> (n) % (5) 9%
	<b>Agree</b> (n) % (23) 42%	<b>Agree Very Much</b> (n) % (5) 9%
<b>7 a.)</b> Youth and family need the IHT provider to coordinate/ collaborate with other service providers (e.g. TM, OP, psychiatry, etc.)	<b>Yes</b> No	<b>(51) 84%</b> (10) 16%
<b>7 b.)</b> If yes, the IHT is in regular contact with other providers (e.g. TM, OP, psychiatry, etc.) involved with the youth and family.**		
<b>Disagree Very Much</b> (n) % (4) 8%	<b>Disagree</b> (n) % (12) 24%	<b>Neither</b> (n) % (8) 16%
	<b>Agree</b> (n) % (19) 37%	<b>Agree Very Much</b> (n) % (8) 16%
<b>8 a.)</b> Youth and family need the IHT provider to coordinate/collaborate with state agencies (e.g. DCF, DYS, DDS, etc.)	Yes <b>No</b>	(21) 34% <b>(40) 66%</b>
<b>8 b.)</b> If yes, the IHT is in regular contact with state agencies (e.g. DCF, DYS, DDS, etc.) involved with the youth and family.**		
<b>Disagree Very Much</b> (n) % -	<b>Disagree</b> (n) % (12) 57%	<b>Neither</b> (n) % (2) 10%
	<b>Agree</b> (n) % (6) 29%	<b>Agree Very Much</b> (n) % (1) 5%

The most common response is indicated in **bold**

\*"NA" responses indicate youth is not eligible for ICC or youth transitioned from ICC to IHT

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

## Qualitative Results

MPR reviewer comments are highlighted below to demonstrate the spectrum of service quality in the families reviewed. The MPR reviewer comments provide a more detailed look into the experiences of families and providers and their perception of the service provision.

**Table 13: Reviewer Comments**

Area	Strong Practice	Practice Needing Improvement
Assessment	<p><b>ICC</b></p> <p>The ICC demonstrated a thorough understanding of this youth and his family. She gathered information from the outpatient therapist, IHT clinician, court reports, DCF, a current psychological evaluation from the school, observations between the youth and his siblings, and the youth's grandmother. The assessment and CANS was very comprehensive with descriptive information across all life domains, including functional strengths, trauma history, family dynamics and culture. Formulation, interpretive summary and diagnosis demonstrated a clear understanding of how this youth has been impacted by developmental trauma due to parental substance abuse.</p> <p>The assessment shows all the characteristics that characterize best practice: ICC talked with all providers, including the prescriber, as part of the initial assessment. She obtained the discharge summary from the previous CBAT placement, the treatment plan from IHT, and the existing IEPs for the assessment. A copy of the fire-setting assessment and the last progress report from school were both added when done. The assessment covers all life domains, youth and family strengths, and natural supports, includes the CANS, and prioritizes needs. Family history of mental health problems and trauma are incorporated. Most significantly, the assessment reflects deepening understanding of youth and family, in keeping with the ICC's approach of deliberately proceeding slowly to build trust. The diagnosis changed in the assessment as youth's symptoms worsened. Concerns with school issues, playing with fire, reports of hallucinations, and sexual behavior were all added when disclosed. CANS were reviewed and updated at 3-month intervals.</p> <p><b>IHT</b></p> <p>On her first day of meeting the family, IHT completed a Collaborative Helping Map and genogram to ground the initial work. She then based her comprehensive assessment on the recent assessment done by the OP at the same agency, updating it with new information and completing a new CANS. For her initial update, she spoke with the OP clinician, the special education director, youth's 1:1 aide at school, and the medical specialist. She met with both grandmothers and talked with youth both alone and with the family. Strengths, natural supports, and family history were all covered. The interpretive summary was especially thoughtful in discussing not only what problems were present but also the underlying emotional issues (loss of mother, different kind of loss of father, recovery from abusive parenting, adjustment to her medical conditions) which impacted her behavior. CANS was done again twice at 3-month intervals with further discovery of the issues around the gender identity question.</p> <p>The initial Collaborative Helping Map allowed IHT to begin purposeful work right away. The full assessment was timely, broadly inclusive of information about both strengths and needs,</p>	<p><b>ICC</b></p> <p>The assessment was skimpy and did not change over time. It lacked more than the most cursory information on family history, placement history, past services (if any), and reported education challenges. There were no updates to the assessment (other than CANS with little or no narrative), even when the DCF goal changed between adoption and reunification and the youth's diagnosis changed. There was also conflicting information (between assessment and interviews) about the prescriber, length of placement in foster care, and extent of visits with mother. There was minimal exploration of culture; what there was focused almost exclusively on the caregiver's culture (though she was temporary) and not at all on the youth's culture.</p> <p><b>IHT</b></p> <p>The record did not contain an initial assessment, but there was a comprehensive assessment done approximately one month after services began. Despite the youth being enrolled in services for sixteen months, there have not been any updates done to the comprehensive assessment, lacking evidence that assessment is viewed as an ongoing process. The assessment process has not brought about diagnostic clarification. The record contains the diagnosis of ADHD throughout. However, the IHT clinician reported initially using a diagnosis of Adjustment Disorder, but is now using Opposition Defiant Disorder, though she suspects Autism Spectrum Disorder because of a family history. The assessment did not include a clinical formulation. Instead, there was a clinical summary section that included the progress note narrative from the first session. Overall, there was minimal understanding of the youth and family information was absent. This area could be improved with greater depth, a clinical formulation, the identification of actionable strengths, further purposeful exploration of natural supports, and more family information.</p> <p>Practice is absent as demonstrated by the lack of consolidating all of the need areas to arrive at a diagnosis and clinical formulation. It was reported that the youth's experiences up to the age of 15-months are not relevant to her behavior. Need areas are identified; however, evidence for why these are need areas does not provide insight. For example, anger and aggression was selected as a need area and the explanation was that the youth sometimes gets angry and doesn't listen. The Risk Assessment Addendum was completed but lacked detail. The information in the assessments was strictly from the point of view of the caregiver without information gathered through clinician observation or clinical interpretation. The diagnosis of Oppositional Defiant Disorder is given without explicit justification based on the DSM-5. The implicit justification was that the youth doesn't listen to her grandparents and has aggressive behavior with her siblings. It is noted that the caregiver wonders if the youth has Reactive Attachment Disorder, but this is not pursued in</p>

Area	Strong Practice	Practice Needing Improvement
	<p>and kept up to date with new developments. For example, IHT notes that she is now exploring the influence of father's punitive parenting approach, the bitter conflict between parents, and youth's statements about questioning gender identity as contributing factors to his emotional challenges. The interpretive summary is sufficient to give a picture of this child and family. It is clear that multiple sources provided insight, including youth, mother, stepfather and father, school personnel, and outpatient therapist. The assessment also included: a copy of the extensive discharge summary from the longest CBAT/hospital stay, the neuro-psych testing report, a detailed risk assessment, and CANS from January and April. IHT has requested most recent IEP.</p>	<p>the initial assessments or the reassessments. No relevant comments were included in the diagnosis section of the assessments. Other need areas identified in the assessments, such as sexual acting out behaviors are not addressed. There was no clinical summary synthesizing all of the information gathered which could lead to a more robust clinical understanding of the youth. In the course of treatment there was only one CANS reassessment. The Collaborative Helping Map would be strengthened by more fully identifying the family's vision and the youth's and family's strengths.</p>
Service Planning	<p><b>ICC</b></p> <p>Goals on the Care Plans exactly match prioritized needs which in turn flow directly from the assessment. The overarching goal is to reduce Youth's anxiety which interferes with emotional regulation, regular school attendance, community connections, and social interactions. A combination of medication, further exploration of diagnosis, behavioral health services, building of caregivers' capacity, and community resources are logically knit together to address the goal. Objectives are clearly measurable – for example, tracking number of days of school attendance and hours in class (rather than early dismissal), number of community activities, and use of at least 2 coping skills per week. Service planning shows participation by DCF, the school psychologist, Youth, Mother and grandparents. DCF service plan and Care Plans are well aligned, as are the supports at school. The safety plan that ICC made with the family was joined with the safety plan developed on discharge from CBAT in February, and both youth and mother had shared the plan with other family members (hanging on refrigerator) and knew in detail what it entails.</p> <p>From the start, the ICC led a very thorough, thoughtful planning process. Despite pressure from the school clinician (by her own report) to quickly get services in place, ICC followed Wraparound principles in developing a process based on family vision and clear understanding of the youth's challenges. Planning centers around youth and family and includes input from youth, mother, siblings, school personnel, prescriber, and subsequent providers as added. The initial and all subsequent Care Plan meetings have focused on determining youth and family priority needs (not just assigning services), brainstorming of services and supports that might help, and applying strengths (such as musical ability) to help meet needs. ICC is prompt in responding to changing needs, including hospitalizations, need for education about safe sex and birth control, school refusal, and psychosomatic illnesses. The school has been engaged in all planning in order to ensure consistency across environments, and this is especially valuable as two of the emergencies resulting in hospitalization occurred at school. ICC made a safety plan immediately in response to youth's original precipitating event and ongoing concerns about her judgment. Plan was shared with family and all providers and has been updated regularly as well as in response to crises. Plan includes both interventions that can be done at home or school and emergency contacts. Mother reports that ICC and FP have helped her to understand when to call MCI and when she can try other de-escalation tactics.</p> <p><b>IHT</b></p> <p>Service planning followed directly from needs identified in the assessment as well as from further discussion with caregiver and</p>	<p><b>ICC</b></p> <p>The ICC actively engaged the youth and her mother in the service planning process, but not her father. The service plans only have one goal about the youth's interaction with family members and peers. When asked about how the goal was created, the ICC said it was from the parents. She said the goal, objectives and tasks are not linked to the assessments. This area could be strengthened with changes to the plan as new needs emerged throughout the course of care.</p> <p>Service planning could have been much stronger with a more active role by ICC. Leaving all contact with the school (other than a voicemail in May) to DCF was not effective, given the turnover at DCF and the apparent differences about whether or not there were school issues. When ICC finally spoke directly to the Special Education coordinator after many months, she learned that the school flatly denied any needs. The outpatient therapist was included in planning after 3 months but might have been helpful before that since she had known the child for the longest. Contact with the prescriber could have clarified the role of that person and the reason for the medication. Also, the referral to IHT was puzzling and was declined by the whole team when IHT became available.</p> <p><b>IHT</b></p> <p>IHT develops the family contract and treatment goals with the family in a consultative role. The youth and family are not engaged in the service planning process in a meaningful way. The IHT Clinician obtained information from the TT&amp;S, and developed the service plan on his own. He said he shared the goals with the caregiver who agreed with them. However, the caregiver said she never saw a service plan and had difficulty articulating the goals. It does appear that the clinician asks the caregiver about progress and what she wants to work on about once a week. She also said that he will then tell the TT&amp;S during sessions to alter her activities with the children accordingly. The IHT Clinician also appeared to have done the safety plan on his own, making it quite ineffective. The caregiver, TT&amp;S, and TM were not aware of this plan. The caregiver said she would call the police if there was a safety concern. Overall, the planning tools were not strength-based nor did they use language that would be accessible to all members of this family.</p> <p>The IHT Clinician said she comes up with the goals on her own from her conversations, and shares them with the family. She does not seem to use the needs identified in the CANS or the SNAP Scale. She explained that she usually gets their approval on the "problem areas/needs" addressed, before coming up with the rest</p>

Area	Strong Practice	Practice Needing Improvement
	<p>youth. IHT listened to their ideas first and then compared their goals to those that she had thought of and that OP was working on with the youth. Goals reflected youth and family priority needs. IHT and family discussed all possible interventions that might help, and family chose what made sense to them. When IHT became aware of youth's pattern of rejecting past helpers who were mothers, she was careful to select a TM without children. Everyone interviewed was clear about what goals were addressed and who did what. Safety planning was especially creative. Given an observed family communication pattern, IHT worked out the safety plan in great detail with youth. It listed not only coping skills that she could use on her own but also the exact questions about her safety that family members could ask; IHT then had youth contract to accept those questions without attitude and family members contract to stick to those allowed questions. IHT also put the Suicide Hot Line in the safety plan as a more youth-friendly alternative to calling MCI.</p>	<p>of the treatment plan. The youth does not seem to be involved much in service planning though he is asked what he wants to do better at and usually says he wants to improve his behavior. There have been three treatment plans thus far, with the addition of 1-2 problem areas with each plan. Plans are not very responsive to emerging needs, because the IHT said she only makes changes at the time the plans are reviewed. The most recent plan is 26 pages long with 25 long-term goals and multiple pages of short-term goals and interventions. This plan could be strengthened by being more family friendly with prioritization of goals addressed so that there is not so much happening all at once. There was a safety plan created at intake but it does not seem to be effective since no one interviewed knew of its existence.</p>
Service Delivery	<p><b>ICC</b></p> <p>Wraparound process was delivered in exemplary manner, with mother at the center of decision-making, all stakeholders involved, and flexibility in adapting to changes. For example, one CPT was planned but ICC was unexpectedly unable to attend. Rather than reschedule, the ICC supervisor (Spanish speaking, well informed on the situation, experienced in Wraparound) went in her place. ICC got DCF worker, DCF supervisor, and DCF clinical manager all involved well ahead of time in making decisions for placement. When Special Education coordinator at school was not responsive, ICC called Director to intervene and finally appealed to DECE to nudge the school into compliance with time lines. ICC and FP visited the two residential placement choices with mother and youth to help in translating, framing questions, making informed choice. ICC and FP opened separate service with older brother to help in dealing with his trauma. When school was resisting changes to IEP, ICC searched for Spanish speaking Education Advocate, but found none, so OP (who happened have Sp Ed background) and ICC worked together to help prepare mother to make requests for herself.</p> <p>Service delivery is exemplary with this youth and family. Services and supports clearly match the youth's needs, with outpatient treatment for both youth and mother as keys to recovering from the trauma which upended the whole family. The recent crisis around suicidality prompted ICC to arrange for providers to immediately increase their time. IHT had been meeting 1x per week and increased to 2x. OP therapist at school added a half hour of time on another day. The record shows that Care Plan Team meetings were held every month since the start with very few exceptions when court proceedings prevented mother from being available. In addition, ICC had met weekly with the family, including youth and grandmother as often as possible. Since the departure of the FP, ICC has also taken on some functions (such as connecting to the Family Resource Center and information about trauma written in Haitian Creole) which are typically done by a FP.</p> <p><b>IHT</b></p> <p>Service delivery is excellent in several respects. The team has developed very creative interventions which respect the family's need to be active (games, art projects etc.), not "just talk" which mother clearly stated was not helpful in several attempts at outpatient therapy in the past. Examples of successful strategies have been to create a "pause button" to help everyone take space,</p>	<p><b>ICC</b></p> <p>The first CPT occurred in early April. The next was in September with only ICC, FP and Mother (not really a CPT configuration). A 3rd CPT was apparently held in October, documented only by a sign in sheet (mother and providers), with no Care Plan. Progress notes indicate that the ICC and Family Partner made efforts to schedule CPTs on a more regular basis but were thwarted by difficulty with Mother's schedule, partly due to other providers in the home. Current ICC met Youth only twice from May to November. At the time of the review, a plan had been made to close services, but the decision was made to wait until two new services started - IHBS and outpatient therapy. Youth is currently on waitlist for IHBS. ICC and Mother are working to connect with an outpatient clinician through school. Mother reports that her other ICC team (for older brother) has big team meetings at her house, which include everyone which she founds helpful.</p> <p><b>IHT</b></p> <p>It did not appear that the service intensity matched the needs of this youth and family. There was evidence of creativity on the part of the therapist in attempting to leverage the youth's strengths and interests to engage him in therapy. The therapist appeared to have demonstrated flexibility in attempting to reschedule with the family that appeared to cancel many sessions. However, the frequency of meetings seemed restricted to once a week appointments--even during times when the family may have needed or wanted more support. Most importantly, there were 2 gaps in service of about one month each. It was unclear what, if any, support the family was offered or given during these gaps. These gaps seemed to negatively impact both engagement and momentum.</p> <p>There was a lack of clear evidence that family was given information regarding the process for filing a complaint or reaching the IHT on-call system. Behavior charts were attempted to target hygiene and chore completion. However, caregiver was unable to consistently follow through and youth was not motivated by it. There was also evidence of IHT providing some behavior management psychoeducation. Previous IHT clinician's session structure involved more 1:1 interventions with youth. While there was evidence of some shift and adjustment of targeted interventions over time, there was a lack of evidence of reconsideration of IHT's goodness of fit of clinical framework and</p>



Area	Strong Practice	Practice Needing Improvement
	<p>developing a healthy options box of coping skills, and setting up games in which everyone (including IHT) takes turns sharing bits of personal experience. Family sessions include all family members as much as possible. Mother and 2 older siblings are always engaged. At the start, IHT tried to hold some family meetings at the father's house, though father ultimately refused to participate. The team has incorporated youth's strengths into service delivery, using many analogies to football (such as, discussing how 2 coaches fighting would affect morale). The team has successfully matched the TT&amp;S with the sister and the IHT clinician with the youth to build trust and teamwork. All report that the intensity is just right (2 hrs. one time per week), given work and football schedules.</p> <p>Service delivery has been excellent in several ways. For one, the IHT team has walked a fine, respectful line with the family between the parents' encompassing devotion to their religious beliefs and the reality of their daughter's questioning of sexual identity. The IHT clinician has carefully allowed both views to co-exist while also helping each to understand the other. Another area of excellence has been the focus on a conscientious use of the ARC GROW model with intensive psychoeducation for mother concurrent with practicing coping elements (identifying, modulation etc) with the youth. The coping skills that they have developed build directly on youth's strengths of writing and drawing. Third, IHT made sure that work from the start coordinated with the ABA team, including having shared sessions at times. IHT also made persistent efforts to include both parents and youth, although there was no time during school year when all three were available at the same time. Over the summer when school was out, the team flexed their hours in order to be able to work with the whole family.</p>	<p>approach for this family despite noted lack of progress. There wasn't use of incorporating youth's actionable strengths and family's strengths into the service delivery process. In addition, there were missed opportunities to support the caregiver in developing skills to help youth regulate youth's emotions, understand the impact of youth's experiences and the function of youth's maladaptive coping/behavior.</p>
Youth & Family Engagement	<p><b>ICC</b> This is a family that had a history of feeling judged by providers and who used avoidance as a primary strategy when feeling anxious or depressed. The team has done a wonderful job of gently pushing the family and working hard to communicate the importance of the family's voice in planning. This has greatly helped this family make use of the services offered to them. In addition, this team appears to have done a very nice job balancing what is needed for the family and the family's voice and priorities.</p> <p>ICC has done a particularly fine job of gradually building trust with this family, respecting the mother's concerns about privacy, and recognizing the grandmother as a key force in the family. Privacy concerns led to a very careful approach to sharing with school personnel about the youth's situation. Including grandmother has helped to narrow the gap between some traditional superstitions and understanding the effects of trauma. While mother clearly values ICC and communicates regularly and openly with her, there was no indication of excessive reliance on this service. For example, she is taking an English class to be more self-reliant and has managed her search for an apartment on her own.</p> <p><b>IHT</b> Engagement is especially noteworthy. The family has had several negative experiences with providers in the past, which left the mother wary about trying a new service. Also, this youth has been very anxious and introverted with all service providers in the past. IHT has built a trusting relationship with youth partly on shared interests (music, anime) but also on acceptance of youth's identity and complete transparency about each step. Evidence indicates that IHT consults with youth on all decisions, explains options, and</p>	<p><b>ICC</b> The ICC actively engaged the caregiver in the ongoing service delivery process. The mother's fiancé has been included sometimes if he happens to be around, but it is not done in an intentional way. The ICC and team have not yet thought of including the youth's biological father in the service, even though he is an active part of the youth's life and visiting with him regularly. This area could have been strengthened with some effort to engage the youth and bring his voice to the table. There were times when the youth was at home during meetings, and he was not asked to participate.</p> <p>Caregiver was polite in reporting that ICC was doing her job but also quite outspoken about feelings that she isn't taken seriously as a foster parent; feeling that she had no opportunity for input as DCF made all the decisions, and she was given more service than she wanted. For example, she felt that TM was not necessary as Caregiver had already enrolled Youth in dance and karate. However, the most serious concern with engagement is that there was none with either the Youth or the Mother to whom she is returning. Youth was not observed in school or at home, and ICC met her only twice. ICC had no contact with Mother until about a month before the return home date. ICC reports that she never asked DCF about contacting Mother directly, although she encouraged the Caregiver to share what she knew.</p> <p><b>IHT</b> It appears that the work with this family got off to a strong start and that early engagement was positive and functional. At the time of the review however, it appeared that this engagement had</p>

Area	Strong Practice	Practice Needing Improvement
	<p>respects youth's input. IHT has balanced parental perspectives with youth's input in ways that allows mother also to feel in control of their care. Mother could not say enough nice things about IHT, especially mentioning how IHT respects the family values around their spiritual life. She states that she copies IHT's calmness and has learned from her how to approach her daughter. There have been no cancellations of family meetings. While Mother was away caring for her own mother, youth and father met with IHT to further strengthen his engagement.</p> <p>From the start, IHT fully engaged both grandmothers along with the youth. All three were consistently part of family discussions with some planned attendance of brother, grandfathers and a close aunt. This inclusive approach was evidence of IHT's recognition of the importance of the shared custody roles and the need for consistency across environments. Youth especially appreciated the meetings alone with IHT to practice before discussing sensitive topics with caregivers. Caregiver described engagement with the youth as "amazing."</p>	<p>significantly eroded. A lack of clarity about treatment goals, previous gaps in services, the clinician's judgements about the family, and challenges that the family presents all seemed to have negatively impacted engagement. Practice in this area might be strengthened with an updated assessment of current needs and a revision of the treatment plan to address these needs. In addition, more effort to engage and involve natural support people, like the grandmother, would also strengthen practice in this area.</p> <p>The IHTs have somewhat engaged the youth and family in service delivery. The family frequently no shows appointments (i.e. six times in a two months window), and the IHT has never addressed this with them. The IHT believes it is happening because the caregiver "has a full plate" and the caregiver said "cancellations are on me." The youth and family do not have any assigned tasks in the service plans, and they are not asked to practice skills in between sessions.</p>
Team Formation	<p><b>ICC</b></p> <p>ICC collaborated with caregiver and sought additional providers and community activities to support goal achievement. Caretaker and ICC were particularly interested in engaging family with IHT with a specific focus on ARC. Caretaker had learned about ARC from providers and through her own reading and felt it would be helpful for her and her family. ICC referred to one agency for IHT with specific ARC focus but the family was assigned an IHT with a TF-CBT focus. Caretaker refused this referral and was disappointed with the wait for ARC focused IHT. ICC researched and referred to a second agency for IHT with ARC focus and the family was engaged with that agency/IHT. ICC continually looked for appropriate social opportunities for youth in the community due to his lack of peer/social engagement, and arranged for him to participate in several summer camps, including a basketball clinic which he enjoyed. ICC negotiated funding with DCF worker for each opportunity. ICC has made referral to DMH for services for youth to ensure ongoing service/case management subsequent to DCF closing the voluntary.</p> <p>The ICC has built an excellent team of providers, other formal supports, and natural supports. The team changes over time as needs have changed, but it always includes: Youth and Caregiver, sister, grandparents, ICC and FP. IHT participated until they closed in summer 2017. During out-of-home placement, both DCF social worker and Guardian ad Litem were invited. The school psychologist and Special Education coordinator participated while school refusal was the focus. A CPT was scheduled for the week following the review, and the new OP therapist is invited. The prescribing psychiatrist is always invited and participates via email to the team and consultation when emergency services are used.</p> <p><b>IHT</b></p> <p>All sources agree that IHT has established a strong team – including "everyone" at Youth's old school, the social worker at the new school, Youth's psychiatrist, TT&amp;S (during brief involvement), and the whole family living together. Teamwork is evident in all parties reporting the same prioritized needs and goals and each doing a piece of the overall plan to improve school functioning and family communication.</p> <p>IHT has done an excellent job of forming a team around this family with inclusion (at varying amounts) of all family members, school</p>	<p><b>ICC</b></p> <p>The inclusion of school personnel at Youth's former school is a strong point in team formation. However, there are significant omissions. An obvious one is the in-home therapy clinician who has known the family for 5 plus years. The prescriber was left out, despite the concerns about medication compliance. The social worker at the health center reports that she was never at a CPT despite being the liaison with the PCP. The housing specialist for the scattered site housing was not contacted or included, despite "basic needs" (especially housing) indicated as a priority goal. Natural supports were not included, although Mother reports that Youth spent large parts of the summer with his paternal grandparents and that she would like to have Youth's father more engaged. Diagnostic work to understand the Youth's medical condition was done but apparently not shared with the team members, nor was there effort to include medical specialists in any team meeting.</p> <p><b>IHT</b></p> <p>There was no team after the TT&amp;S and TM were no longer involved. Even before their termination, there was minimal evidence of outreach to school personnel, prescriber, ongoing OP, TM, or any natural supports by the IHT clinician. For example, IHT reported that there was no extended family, although this conflicted with Caregiver reports of a very helpful paternal grandmother and many adult relatives on both sides of the family in proximity. Other natural supports, such as the baseball coach, were not explored.</p> <p>Practice is absent as demonstrated by there being no contact with the school or PCP despite releases being obtained. Services began during the summer, but the youth did return to school in the fall and there was no outreach to the school. This is particularly concerning given that the caregiver removed the youth due to behavioral concerns with her peers. While there was a good understanding of the natural supports, they did not appear to be included in any significant way. Verbal reports indicate that there was an OT involved at the beginning of IHT services, but there is no indication that the IHT was aware of this. While the IHT did have two conversations with the outpatient provider, there was no evidence that information gathered was incorporated into the assessments or treatment plan.</p>

Area	Strong Practice	Practice Needing Improvement
Team Participation	<p>personnel at both former and current schools, psychiatrist, OP, and other providers as they have joined the team. She has explored and considered natural supports and understands the support offered by Mother's friend who provides respite. Interviews indicate that all team members were consulted on goals and interventions, including a review of service planning as TT&amp;S and IHBS started. It is evident that everyone knows who all the major players are and what their roles are.</p> <p><b>ICC</b> All members of the team are actively engaged and regularly participate in the team meetings. ICC begins and ends each team meeting by discussing strengths of the youth/family. The IHT/ARC has been successful in engaging the youth in home visits and therapeutic activities, whereas previously he has been reticent to participate. ICC drafts a summary following each team meeting summarizing the discussion and "to-do" list identifying who is responsible for following through. Team is very engaged and all team members interviewed acknowledged the success with which the ICC maintains engagement of all members.</p> <p>The ICC actively engages an inclusive team including school personnel, other agencies- all of whom actively participate in scheduled ICP meetings. ICP meetings are also scheduled at the youth's school to include school personnel in service planning. Caregiver has worked collaboratively with the ICC to identify appropriate providers, including a psychiatrist who specializes in ASD and comorbidities as well as specialists for youth's medical conditions.</p> <p><b>IHT</b> IHT did an especially fine job of keeping the school engaged in teamwork, with 3 full, face-to-face team meetings at school in just 5 months (September to January). The OP (based at school, employed by same agency as IHT) was a full participant in service planning and delivery, working on a parallel track with IHT to resolve trauma and issues at school while IHT worked with the family. This strong collaboration has facilitated the continuing of family sessions, as needed, as part of the OP work after IHT closed.</p> <p>Teamwork has sustained to date. Prescriber is consulted regularly about medication trials and compliance issues (when Youth is with Father). The new school provides weekly progress reports to IHT to support teamwork. IHT and OP have collaborated with Mother on a plan to reduce their sessions with Youth and family at least temporarily as IHBS services ramp up and then to re-evaluate the service mix if and when ICC starts. Mother's friend (respite provider) has become increasingly involved as a support in giving medication to Youth in the morning and getting him off to school.</p>	<p><b>ICC</b> No examples gathered from most recent review round.</p> <p><b>IHT</b> As service progressed there was no documented or reported effort at including any stakeholders other than the IHT staff. IHT did not attend IEP meetings or make contact with school about Youth's functioning. IHT seemed not to know about the TM or the work of the ongoing OP therapist. Even when these were revealed to him, they were not involved in planning or service delivery.</p> <p>IHT has not engaged a team in the ongoing effort to plan and deliver services. They could have included school personnel, the youth's outpatient therapist, and the caregiver's natural support(s). The current IHT said he has not included the school, because he doesn't see the need. His only contact with the OPT was by email to coordinate her MPR interview. The IHT coincidentally met the caregiver's sister when she was at the home during a session, but she was not included in the session.</p>
Care Coordination	<p><b>ICC</b> It was clear that the ICC had regular check-ins with team members to ensure that all were on the same page. She kept track of team member's meetings with the family and made a point to check in with them if they didn't contact her to check in following sessions with the family. While the ICC held primary responsibility for linking youth/family to services, she also co-coordinated some activities with the caregiver; when the ICC and the caregiver both communicated with an individual such as school personnel, the ICC checked in with the Caregiver to "compare notes" and discuss next steps.</p>	<p><b>ICC</b> The ICC has not been coordinating services with this youth's very large team of providers though he stated in his interview that coordination of care is his responsibility. The record does not show communication with any providers other than the IHT clinician. Therefore, the ICC explained in his interview that he does not know what the IHBS team, the TT&amp;S, or the individual therapist are working on. He believes the IHT clinician and TM are working on improving youth's communication of emotions, but is unsure of what else they are doing. Both the IHT clinician and caregiver felt that the TT&amp;S has done a great deal of coordination and identified both the ICC and the TT&amp;S as being the point person</p>

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	<p>The ICC has very successfully coordinated service planning and the delivery of services and supports as evidenced in documentation and interviews. The ICC collaborated with caregiver to assess efficacy of TM services and work toward replacement of TM due to lack of ICP follow-through. The ICC referred the youth/family to IHBS and DMH, both of which ultimately determined that the youth did not meet eligibility criteria or medical necessity. ICC actively advocates for youth and need for services and supports caregiver in following through with referrals and service delivery. FP works to empower the caregiver to recognize and use her own strengths/confidence in acting on her own and the youth's behalf.</p> <p><b>IHT</b></p> <p>Because the teamwork has been excellent, care coordination has fallen into place equally well. When Youth was experiencing such severe problems in the old school, IHT spoke with staff at school every day and visited occasionally. In the current temporary placement, IHT has visited the school from time to time to observe and have face-to-face updates; the social worker, IHT and family are all on the same page about not sending Youth back to the old school without much higher level of 1:1 support. All agree that further testing is needed to answer questions about Youth's learning delays and that a new neuro-psych evaluation is warranted to assess processing problems. School personnel report that it is very helpful to have information about the family context to understand out of school hours.</p> <p>Team members speak regularly to coordinate care among providers (including prescriber), school and home - at minimum every two weeks and more often when concerns arise. Evidence indicates that team is knowledgeable about recent medication changes, including side effects and issues around compliance. When Youth is experiencing difficulty at home, IHT puts MCI on alert.</p>	<p>for coordination. However, they also agreed that the caregiver seems to be the one responsible for updating all the providers of what is going on with the youth and with the other service providers.</p> <p>Care coordination requires that at least someone on the team knows if the child is taking medication or not. Everyone knew that he had missed his summer appointments with the prescriber, and some knew that the grandparents with whom the Youth apparently stayed often were opposed to medication. ICC's declaration that "his mother says he takes them" is insufficient care coordination. The ICC has missed an opportunity by not bringing together the medical specialists, behavioral health providers, and special education teams so that all stakeholders could look together at the complex picture of the Youth's medical and behavioral issues instead of operating in separate silos. This is an especially glaring omission given the agreement on all sides about how hard it is to untangle the various factors affecting the Youth's behavior. ICC reports that she delegates medical coordination to the social worker at the health center, but she reports that she is not aware of diagnostic work done at Children's Hospital. ICC attempted to include DCF but did not follow up with DCF supervisor when the worker was unresponsive to requests for information. More robust coordination with DCF is especially pressing given the ICC belief that DCF needs to close before DMH will get involved.</p> <p><b>IHT</b></p> <p>Care coordination is absent with this youth and family. The IHT is not coordinating service planning or delivery, so the family is not receiving the amount of care coordination his situation requires. The IHT is not facilitating communication among team members either.</p> <p>There was evidence of contact with team members. However, there was a lack of evidence that all team members (especially Psychiatrist) had key information needed to work with this youth/family. This suggests a potential lack of depth and breadth of discussions with team members that is necessary to support IHT and others in understanding and addressing youth/family needs in a congruent manner. There was evidence of a lack of common understanding across team members regarding who was the main point of contact on the team. Recent successive psychopharm appointments were not kept and it's unclear whether IHT was aware of this and explored or attempted to address barriers to appointment attendance. There was evidence of inconsistency among team members knowledge of whether DCF was open.</p>
Transition	<p><b>ICC</b></p> <p>Transition planning truly did begin from the start of services and ongoing planning was evident in the written record, both the ICP and progress notes, and through interviews. The Transition Readiness Chart was completed and it was identified that services would no longer be needed when the caregiver could be independent in arranging and accessing services. Transition was discussed at each CPT meeting and increased planning occurred when strong progress was seen over the summer. At this time the team identified which services would be needed to support the family after the end of ICC services. The caregiver had a strong voice expressing comfort with ending ICC and IHT services, but feeling that she continued to benefit from FP and TM services and the youth could be supported by an OPT. The team also agreed</p>	<p><b>ICC</b></p> <p>Planning for the reunification was left primarily to the Caregiver who spoke regularly with Mother, encouraged Mother to keep services for the Youth, and offered to send transitional objects along with the Youth. ICC expressed being very surprised at the sudden return home (despite months of increasing visits and discussion about when to move). The current services will likely remain in place, as DCF is requiring Mother to continue. There is no evidence of any discussion about rethinking when ICC will end or whether other services, such as IHT, might begin.</p> <p><b>IHT</b></p> <p>Transition planning was absent although there were significant transitions such as summer vacation, a new school, re-establishing</p>

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	<p>that services should stay in place while the youth transitioned back to school in order to ensure a good start and a date was chosen for the final meeting (the ICC accessed donated backpacks for school). The youth was involved in planning the final meeting. OPT services were identified prior to discharge and the ICC reached out to her to provide history, needs, and strengths. Right before closing the youth's mother reached out to her which unsettled the caregiver and caused her to reassess ending services. With reassurance from the team, the caregiver saw that she did have the ability to handle the situation and was comfortable with ending. The discharge summary was comprehensive, giving a clear description of services, the course of treatment, and clinical formulation. It will provide future providers with a vivid understanding of treatment during this time.</p> <p>Consensus is that the team is “always talking about transition” and that they are in early stages of transition at present. Discussion is embedded in reports of progress toward vision and in clear measures of progress. ICC and FP encourage Caregiver to see vision as continuing beyond services, and they have agreed on some key transition indicators. One outstanding concern is the accuracy of diagnosis. There is ongoing discussion of whether Youth is experiencing trauma reaction rather than incipient psychosis, and an evaluation is under way to help determine the best course of future treatment. Other transition indicators are: Youth is attending school every day, has no more suicidal ideation or destructive auditory hallucinations, and has made one or more healthy social connection. DCF has no current concerns but will remain open until the diagnostic evaluation is completed and MassHealth coverage is established elsewhere (now obtained via DCF). Caregiver, while reluctant to transition, reports that they have been scaling progress (1-10) all along, and she can see that the transition plan makes sense.</p> <p><b>IHT</b></p> <p>IHT team assisted the youth and family with the significant transitions at the start of services – move into an apartment, addition of new baby, and start of school. The IHT built measures for reducing aggression and increasing self-management and social skills into the treatment plan to indicate when goals were met. There were ongoing check-ins on progress toward goals. In order to exit, IHT planned well ahead in order to bring on an OP therapist in time for overlap and without interruption in the TM service. IHT also got DPH involved for future long-term support which will likely be needed for the Youth’s medical conditions. The team also attended to the strong attachments of the children to the IHT and TT&amp;S by managing expectations about their role and length of involvement.</p> <p>The treatment plan includes very clear measures of progress (# of tantrums, school reports etc.) which are reviewed with the family every week, with a formal review at 3-month intervals when they compare current and past indicators. Reviews include both Mother and Youth’s reports on progress. This has been discussed from the start, and there was no indication of concern or surprise in discussing exit with caregiver. While the TM’s departure was a significant loss to the Youth and team, the IHT team quickly obtained information on other possible TM programs, checked on availability of male TMs, reviewed options with Mother, and made referrals to her choices. The team is also working with the family and school to decide about Youth’s Special Ed services next year.</p>	<p>contact with Youth’s father, and the Youth turning 18. None of those life transitions seem to have been addressed according to the written record. The IHT said she discussed some of these topics with the family, but no planning or coordination occurred. Regarding IHT closing, the IHT reports plans to close in two or three weeks, but the family was not aware of this. There have not been any plans for aftercare or discussions about whom the family should call for support in between sessions rather than the numerous calls to the IHT during the week. A major concern around closure is the youth's possible June graduation from high school without set plans for after graduation. Since his counselor and psychiatrist are through the school, he will also lose those service providers at that time.</p> <p>Transition planning has been absent with this family. During IHT services, the youth's father had on again/off again visitation, and the caregiver got a new job but neither of those transitions were focused on in service delivery. During the change in IHT clinicians, there was a gap in IHT services for almost 3 months with no coverage or explanation given to the family. The upcoming summer vacation is a stressor for the caregiver who recently started working, but that has not been addressed either. The caregiver said that conversations about closing the case have not yet happened. The IHT clinician said when services began he told the caregiver they will determine when the services are no longer needed by checking on goals and talking about needs.</p>



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	<p>His current placement in the separate classroom was intended to be temporary, but a return to a regular classroom for the full day raises concerns.</p>	
<b>Responsiveness</b>	<p><b>ICC</b>            ICC services began immediately after referral. The ICC was assigned due to having a positive past working relationship with the family. Throughout the course of enrollment, the referrals were based on the needs of the youth and decided by the team. There were thoughtful discussions with the care planning team on the right service and the intensity for the family. The team tried TM services but when the service was not the right fit for youth the team decided to end the service. IHT services were also ended when family participation declined. The team decided to try IHBS instead of IHT and it was a much better fit. When the family was dissatisfied with outpatient therapy the ICC found an OPT that specialized in working with youth with intellectual disabilities. Caretaker acknowledges that ICC is quite responsive to the needs of the youth and family. ICC has accessed IHT/ARC, which caretaker voiced a preference for and which she finds exceptionally helpful. ICC has researched and referred youth to many social activities with peers, including basketball clinic, summer day camps, flag football and community basketball, while also pursuing funding sources for each when needed. ICC supported caretaker in pursuing an IEP based on youth's social/emotional needs and poor peer relationships. ICC supported caretaker in requesting neuropsychological testing of youth during CBAT stay. Caretaker is clear that ICC is available at any time to support her and offer direction when crises occur and is identified on the written Safety Plan.</p> <p><b>IHT</b>            IHT responded to the service in a timely manner, with the first appointment occurring on a Saturday to accommodate the family's schedule. Referral to TM was appropriate and well-timed. Medication has been explored several times with consideration of the family's beliefs and comfort.</p>	<p><b>ICC</b>            The family was on a waitlist for 8.5 months to receive ICC services. It is unclear if the agency checked in with them during that time.</p> <p><b>IHT</b>            The agency response rate to this referral was adverse to this youth's needs at that time. The family waited over eleven months for services to begin.</p>
<b>Service Accessibility</b>	<p><b>ICC</b>            Services are provided at convenient times and locations for the caregiver (e.g., if the caregiver has an appointment with her outpatient provider, ICC works with caregiver and outpatient therapist to have team meetings at outpatient therapist's office for convenience of caregiver and so outpatient therapist can participate in meetings). The meetings are all scheduled based on the caregiver and youth's needs.</p> <p>Services are provided at home, school, and doctor's office, as needed. Communication is in English for Youth and Spanish for Mother, including written documents. CPTs are conducted in both languages by ICC.</p> <p><b>IHT</b>            All the services are delivered in Spanish, which is the preferred language for this family. The IHBS therapist does not speak Spanish, but he is paired with a Behavior Monitor who does, and they work together as a team. The family keeps a binder, which the IHT team developed, will all key documents (assessments, CANS, treatment plans, and safety plans.) The IHBS schedule and behavior system was posted in the family's kitchen which they</p>	<p><b>ICC</b>            No examples gathered from most recent review round.</p> <p><b>IHT</b>            There was evidence of weekly IHT meetings occurring at a time that was not based on youth/family convenience.</p> <p>The preferred language of both the caregivers and the aunt is Spanish. However, the agency does not have any Spanish speaking staff, and the family agreed to the services in English. Therefore, all verbal and written communication is done in English and the grandfather and aunt assist with translating for the grandmother.</p>



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	<p>proudly shared during their interview. There was evidence that the team is very flexible with their scheduling, and makes every effort to accommodate the family when they are unable to keep an appointment. The length of appointment times appeared tied to need, rather than a standard of 1 hour.</p> <p>IHT has met on Saturdays in order to convene meetings with all family members (including extended family members) due to school and work schedules.</p>	
Cultural Awareness	<p><b>ICC</b></p> <p>Every provider (except prescriber) is a native Spanish speaker and from Puerto Rico with firsthand understanding of the culture, as was also the DCF worker, but cultural understanding was far deeper than language. ICC used her own religious upbringing and could articulate many values and practices, spoke with deep respect for Christian values, and fully understood how hard it is for Mother to reach out for mental health services when her church says the devil is the problem and only prayer can help. ICC sees huge strength in Mother's ability to make mental health and God co-exist. ICC also speaks with understanding of the typical role of an oldest daughter in a family and the responsibilities that go along with that. She has shared with Mother both her upbringing in the church and her own role as oldest daughter.</p> <p>ICC/FP are very aware and focused on issues related to his being a single father who feels he is discriminated against in that role by DCF and service providers- particularly initial IHT provider. ICC relates to caregiver as a single parent with a child with challenges. Both the ICC and FP have modified their approach, given his feelings of discrimination re: being a single father. They are both sensitive to his unique needs and learning process. Caretaker was initially guarded with providers; however, he has opened up and is receptive to interventions by IHT/FP.</p> <p><b>IHT</b></p> <p>Practice standards for cultural awareness were consistently met. There was evidence that provider was aware of culture nuances specific to this family including socioeconomic status; father's work ethic and rugged individualism; the value the family placed on spending time as a nuclear family and with extended family; and youth's fascination with and desire to be part of the military. There was also evidence that the provider considered ways that his culture was different and his need to keep his perceptions "in check." There was evidence that the provider had brief, relevant discussion about cultural differences when it came up naturally around the winter holidays.</p> <p>There are clear differences in race and ethnicity between the family and the provider. They have discussed differences and similarities at length and appear to have a good understanding of and respect for each other. They share some aspects of spirituality which has made mindfulness exercises especially meaningful as an intervention.</p>	<p><b>ICC</b></p> <p>Culture was almost entirely missing from the assessment, and Youth's culture barely mentioned at all. Greater exploration of culture might have yielded a more productive working relationship between ICC and Caregiver, especially as their cultures are so obviously different. Further exploration of the Youth's birth family culture, including Youth's experiences in foster care and past trauma, would also be warranted given that Youth will be returning to her culture of origin.</p> <p><b>IHT</b></p> <p>IHT has not explored culture in any depth. He is able to identify the family as Dominican and to describe them as being close and protective of one another. There was no evidence that he had explored their culture more deeply or discussed his own culture with them.</p>
	<p><b>ICC</b></p> <p>An extensive understanding of the family's culture and history is evident. Both the written record and interview reflect the ICC's understanding of what life was like prior to moving to the US, what circumstances have been like for them since they moved here, an understanding of the complicated family dynamics with extended family, the meaning and importance of religion, family members'</p>	<p><b>ICC</b></p> <p>The family's culture does not seem to have been incorporated into this family's work. The ICC does not know anything about where this family lived prior to their current apartment, missing important information about their homelessness and caregiver's upbringing. The ICC did not seem to be aware of the family's history of homelessness or the caregiver's own adoption either. The youth's</p>

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	<p>trauma history, the effects of cognitive differences within the family, and the joy felt by remaining connected to their culture. All team members have been made aware of the family's history and culture and work together to be sensitive to the difficult aspects and supportive and reinforcing of the positive aspects. When the mother expressed discomfort regarding calling the mobile crisis or the police, it became clear that there was a cultural taboo against reaching out for help. The ICC worked with the caregiver to educate her about the norms here and to help her feel more comfortable asking for help. At one point the youth complained that she did not want to take food from home because other students would make fun of her. A school meeting was held and options were provided.</p> <p>ICC and FP were both very helpful in addressing the language barriers and ensuring that Mother was included via translation in all discussions, even when an interpreter was not available for doctor's appointments and school meetings. Equally as important, they were sensitive to the way that Mother felt disrespected by the first psychiatrist (made to wait, seen for only a few minutes after long waits, concerns not addressed) and active in trying to find a better fit for her. ICC showed cultural acumen in respecting Mother's wishes not to involve her mother whose ideas of mental health are strongly opposed to therapy of any kind. Given the family culture of privacy and opposition to therapy, ICC's success in leading Mother to understand and embrace treatment for her daughter is a remarkable piece of work.</p> <p><b>IHT</b></p> <p>The clinician was aware of the family's story of trauma, the reasons for the move to Massachusetts, and the ways in which living with the grandparents was both a support and source of stress for this family. Further, the clinician had successfully communicated this context to the school which has helped this youth's transition from a small town elementary school that knew him very well to a large regional middle school. The clinician has incorporated this family's trauma into her understanding of this youth and his mother, as well as her parenting and relationship with her children.</p> <p>The primary cultural concern around differences in parenting and attitudes towards mental health are well understood and have been discussed at length over the course of treatment. At the time that referrals were made for medication and a neuropsychologist, the team actively and successfully engaged the father to address his concerns given that he does not support medicine or feel that therapy is useful. Many efforts have been made to work with the parents together in order to find common ground.</p>	<p>history of being a victim of bullying and the caregiver's history of being a victim of domestic violence seem to be minimized and somewhat disregarded by the team as well. The family's trauma when the father attacked them is often mentioned, but not incorporated into the work. The caregiver is anticipating an upcoming trauma anniversary to which the team is largely unaware.</p> <p><b>IHT</b></p> <p>There were significant cultural considerations for this family. The grandmother was not raised in the US and straddled two cultures while raising her grandson. Of particular note is the impact of her beliefs on discipline and mental health treatment. IHT had a preliminary understanding of the family's culture but there was no evidence that this was revisited in a strategic manner. The family had a complex history of trauma, loss, and victimization that was largely glossed over. The grandmother was raising her grandson and had no contact with her daughter; the youth now had no contact with his mother because of a fight she had with his uncle - an internal conflict that wasn't addressed (or planned to be addressed) besides acknowledgement by the TT&amp;S.</p> <p>The lack of depth and exploration around culture has led to limited knowledge of the family's culture being incorporated into the work. The youth and family's history of moves has not been explored, despite the youth's history of out of home placement with DCF. The Clinician has a superficial understanding of the youth's trauma history (i.e. fire, DCF removal, out of home placement), that would have benefited from more depth. The IHT Clinician denied cultural differences, and did not acknowledge that the caregiver and her husband are a bi-racial couple. There was also no evidence of the Clinician helping the rest of the team understand the youth's own culture.</p>