



FISCAL YEAR 2019
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">• 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.
Area 2: Service Planning	<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.

Area 3: Service Delivery	<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.
Area 4: Youth & Family Engagement	<ul style="list-style-type: none"> • The provider actively engages the youth and family in the ongoing service delivery process.
Area 5: Team Formation	<ul style="list-style-type: none"> • The provider identifies, outreaches, and engages formal providers, including prescriber (if applicable), in the initial service planning process. • The provider identifies, outreaches, and engages natural supports in the initial service planning process.
Area 6: Team Participation	<ul style="list-style-type: none"> • The provider actively engages a team including school personnel, other agencies, and natural supports in the ongoing effort to plan and deliver services.
Area 7: Care Coordination	<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.
Area 8: Transition	<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.
Domain 2: Community-Based	
Area 9: Responsiveness	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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.

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"> 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

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.

FY 19 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 2019, 61 ICC reviews were completed. For IHT, 25 provider sites out of 164 sites statewide (63 reviews in total) were sampled in FY 2019, with 62 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	119	97%	Gender	Male	78	63%
	Closed	4	3%		Female	43	35%
					Other	2	2%
Age of Youth	0-4 years	-	-	Race/Ethnicity	White	53	43%
	5-9 years	49	40%		Latino/Hispanic	32	26%
	10-13 years	35	28%		African-American/Black	15	12%
	14-17 years	29	24%		Biracial/Mixed	15	12%
	18-21 years	10	8%		Other	5	4%
>1 Behavioral Health Condition	Yes	85	69%	Interventions (Current)	Asian	3	2%
	No	38	31%		In-Home Therapy (IHT)	85	69%
Behavioral Health Conditions	ADD/ADHD	63	51%		Psychopharmacology	68	55%
	Anxiety Disorder	46	37%		Individual Counseling	67	54%
	Trauma/Stressor-related disorder	45	37%		Intensive Care Coordination (ICC)	61	50%
	Mood Disorder	34	28%		Therapeutic Training & Support	60	49%
	Anger/Impulse Control	26	21%		Therapeutic Mentoring	58	47%
	Disruptive Behavior Disorder	25	20%		FS&T (Family Partner)	53	43%
	Autism/Autism Spectrum Disorder	17	14%		Recreation activities	20	16%
	Learning Disorder	11	9%		In- Home Behavioral Services (IHBS)	13	11%
	Communication Disorder	8	7%		Group Counseling	4	3%
	Other	3	2%		Family Counseling	2	2%
	Intellectual Disability	3	2%		Other	2	2%
	Thought disorder	1	1%		Mobile Crisis Intervention	1	1%
					Peer Mentor	1	1%
Service System Use (Current)	Special Education	86	70%	DCF Involved (Past Year)*	No	73	82%
	DCF	34	28%		Yes	16	18%
	DMH	9	7%	*Excludes those with current DCF involvement			
	DDS	6	5%				
	Child Requiring Assistance (CRA)	3	2%				
	Probation	2	2%				
	Other	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
Practice Overall	1.7	4.5	3.4	0.63
-ICC	1.7	4.5	3.3	0.65
-IHT	2.1	4.4	3.4	0.63
Domain 1: Family Driven & Youth Guided	1.4	4.8	3.3	0.73
-ICC	1.4	4.8	3.3	0.72
-IHT	1.8	4.6	3.3	0.74
Domain 2: Community-Based	1.5	4.5	3.5	0.55
-ICC	1.5	4.5	3.5	0.64
-IHT	2.5	4.5	3.6	0.46
Domain 3: Culturally Competent	2.0	5.0	3.3	0.78
-ICC	2.0	5.0	3.3	0.78
-IHT	2.0	5.0	3.4	0.78

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
Assessment	3.1	(1) 1%	(27) 22%	(60) 49%	(32) 26%	(3) 2%
-ICC	3.1	(1) 2%	(13) 21%	(30) 49%	(15) 25%	(2) 3%
-IHT	3.1	-	(14) 23%	(30) 48%	(17) 27%	(1) 2%
Service Planning	3.2	(1) 1%	(24) 20%	(48) 39%	(44) 36%	(6) 5%
-ICC	3.3	-	(10) 16%	(24) 39%	(24) 39%	(3) 5%
-IHT	3.2	(1) 2%	(14) 23%	(24) 39%	(20) 32%	(3) 5%
Service Delivery	3.5	(1) 1%	(18) 15%	(36) 29%	(54) 44%	(14) 11%
-ICC	3.3	(1) 2%	(11) 18%	(19) 31%	(27) 44%	(3) 5%
-IHT	3.7	-	(7) 11%	(17) 27%	(27) 44%	(11) 18%
Youth & Family Engagement	3.7	-	(11) 9%	(35) 28%	(60) 49%	(17) 14%
-ICC	3.6	-	(7) 11%	(15) 25%	(34) 56%	(5) 8%
-IHT	3.7	-	(4) 6%	(20) 32%	(26) 42%	(12) 19%

Area	Mean	Frequencies (n) %*				
		Adverse Practice 1	Poor Practice 2	Fair Practice 3	Good Practice 4	Exemplary/ Best Practice 5
Team Formation	3.3	(6) 5%	(14) 11%	(50) 41%	(48) 39%	(5) 4%
-ICC	3.3	(1) 2%	(9) 15%	(26) 43%	(23) 38%	(2) 3%
-IHT	3.3	(5) 8%	(5) 8%	(24) 39%	(25) 40%	(3) 5%
Team Participation	3.3	(1) 1%	(18) 15%	(46) 37%	(54) 44%	(4) 3%
-ICC	3.4	-	(7) 11%	(24) 39%	(29) 48%	(1) 2%
-IHT	3.3	(1) 2%	(11) 18%	(22) 35%	(25) 40%	(3) 5%
Care Coordination	3.3	(7) 6%	(16) 13%	(41) 33%	(47) 38%	(12) 10%
-ICC	3.4	(3) 5%	(3) 5%	(23) 38%	(28) 46%	(4) 7%
-IHT	3.2	(4) 6%	(13) 21%	(18) 29%	(19) 31%	(8) 13%
Transition	3.2	(8) 7%	(26) 21%	(31) 25%	(48) 39%	(10) 8%
-ICC	3.2	(5) 8%	(14) 23%	(14) 23%	(21) 34%	(7) 11%
-IHT	3.2	(3) 5%	(12) 19%	(17) 27%	(27) 44%	(3) 5%

*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		3.2	(3) 2%	(15) 12%	(55) 45%	(49) 40%	(1) 1%
-ICC		3.2	(3) 5%	(9) 15%	(24) 39%	(25) 41%	-
-IHT		3.3	-	(6) 10%	(31) 50%	(24) 39%	(1) 2%
Service Accessibility		3.8	(1) 1%	(1) 1%	(21) 17%	(96) 78%	(4) 3%
-ICC		3.8	(1) 2%	-	(11) 18%	(46) 75%	(3) 5%
-IHT		3.8	-	(1) 2%	(10) 16%	(50) 81%	(1) 2%

*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	-	(15) 12%	(44) 36%	(55) 45%	(9) 7%	
-ICC	3.4	-	(9) 15%	(20) 33%	(30) 49%	(2) 3%	
-IHT	3.5	-	(6) 10%	(24) 39%	(25) 40%	(7) 11%	
Cultural Sensitivity & Responsiveness	3.2	-	(30) 24%	(45) 37%	(41) 33%	(7) 6%	
-ICC	3.1	-	(17) 28%	(23) 38%	(17) 28%	(4) 7%	
-IHT	3.3	-	(13) 21%	(22) 35%	(24) 39%	(3) 5%	

*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	1.0	4.5	3.1	0.69
-ICC	1.5	4.0	3.0	0.64
-IHT	1.0	4.5	3.2	0.74

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	(4) 3%	(23) 19%	(58) 47%	(35) 28%	(3) 2%
-ICC	2.9	3 (5%)	(12) 20%	(32) 52%	(14) 23%	-
-IHT	3.2	1 (2%)	(11) 18%	(26) 42%	(21) 34%	(3) 5%
Family Progress**	3.1	(1) 1%	(27) 22%	(56) 46%	(36) 29%	(2) 2%
-ICC***	3.1	-	(15) 25%	(26) 43%	(19) 31%	-
-IHT	3.1	(1) 2%	(12) 19%	(30) 48%	(17) 27%	(2) 3%

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

** 1% (1) "Not Applicable" score.

*** 2% (1) "Not Applicable" score.

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) %
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.				Yes	(8) 13%
				No	(54) 87%
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.				Yes	(9) 15%
				No	(53) 85%
3. Youth is receiving the amount and quality of care coordination his/her situation requires.					
Disagree Very Much (n) % (3) 5%	Disagree (n) % (9) 15%	Neither (n) % (10) 16%	Agree (n) % (28) 45%	Agree Very Much (n) % (12) 19%	
4. Has the youth previously been enrolled in ICC?				Yes	(13) 21%
				No	(49) 79%
5 a.) According to the CAREGIVER, has the IHT team ever discussed the option of ICC with the youth/family?				Yes	(31) 50%
				No	(18) 29%
				NA*	(13) 21%
5 b.) According to the IHT Clinician, has the team ever discussed the option of ICC with the youth/family?				Yes	(47) 76%
				No	(15) 24%
6 a.) Youth and family need the IHT provider to coordinate/ collaborate with school personnel.				Yes	(53) 85%
				No	(9) 15%
6 b.) If yes, the IHT is in regular contact with school personnel involved with the youth and family.**					
Disagree Very Much (n) % (2) 4%	Disagree (n) % (8) 15%	Neither (n) % (5) 9%	Agree (n) % (16) 30%	Agree Very Much (n) % (22) 42%	
7 a.) Youth and family need the IHT provider to coordinate/ collaborate with other service providers (e.g. TM, OP, psychiatry, etc.)				Yes	(45) 73%
				No	(17) 27%
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) 9%	Disagree (n) % (4) 9%	Neither (n) % (5) 11%	Agree (n) % (14) 31%	Agree Very Much (n) % (18) 40%	
8 a.) Youth and family need the IHT provider to coordinate/collaborate with state agencies (e.g. DCF, DYS, DDS, etc.)				Yes	(19) 31%
				No	(43) 69%
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) % (1) 5%	Disagree (n) % (2) 11%	Neither (n) % (2) 11%	Agree (n) % (8) 42%	Agree Very Much (n) % (6) 32%	

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

Strong Practice	Practice Needing Improvement
Assessment	
<p>IHT: Both the initial comprehensive assessment and the process for evolving the assessment over time are excellent. An initial assessment done at the first session provides sufficient detail to give a clear first impression of the Youth and family. For the comprehensive assessment, the IHT continued to talk with the Caregivers and also immediately gathered information from Youth's OP (referral source), the sister's OP, and DCF (legal guardian). In the written document, all domains were fully covered with cogent, detailed narrative. The section on family history required extra effort to communicate with DCF, where the family had experienced 3 different social workers in the prior year. The IHT took extra care to understand the family's experience with the prior IHT service from a different agency; family had terminated that course of treatment with some strong negative assessment of the value. Strengths and needs are well defined. The interpretive summary is clear and well informed, with neither surprises nor omissions. The IHT has a sophisticated hypothesis about the impact of Youth's trauma, the push-pull of her terror of letting down her guard and her desire to attach to this family, and the effects on her behavior and emotions of having only her younger sister as a constant in her life. Deepening of understanding is well documented on CANS updates done every 3 months, or more as needed to record changes. IHT has also collected, over time, all of the academic evaluations done by the school as well as the DCF assessment and the neuropsych evaluation, which the Caregivers requested.</p> <p>ICC: The ICC and FP team were able to draw on past experience with this youth and family as a basis for assessment of family history, past challenges for both parents, and past behavioral health struggles for Youth. In discussion with Father and Youth, they added understanding of the current situation, Youth's increasing behavioral health needs emerging over the past 3 years, as well as strengths and natural supports. The SNCD provided additional detail, and the CANS (done twice in 6 months) supported the assessment with ratings and narrative. ICC gathered and appended relevant documents, including Youth's current IEP, the hospital discharge summary, and psychological evaluations from 2012, 2015, and 2018. She consulted with both DCF and the middle school (where Youth was suspended after cutting incident) about their concerns. The highlight of the assessment process was the outstanding work that the ICC did to clarify Youth's diagnosis. After several years of services, a confusion of diagnoses had accrued to the Youth. The ICC consulted at length (including face to face meetings) with Youth's individual therapist and psychiatrist to clarify Youth's issues, rule out past suggestions, and agree on a clear working diagnosis to inform medication and treatment.</p>	<p>IHT: Information for the initial assessment was gathered primarily from the mother and the youth. IHT did meet with Youth's referring outpatient therapist to gather information, but the outcome of which was unclear. There appears to have been no effort made to get discharge information from previous MCI involvement or hospital admissions/discharges, nor from Youth's school (important since she had at that point dropped out of her honors high school). Most sections of the assessment simply referred to the CANS, but the CANS itself contained sparse information other than the scores. Despite Youth's previous hospital admissions, little to no information was included about what precipitated these events, or even when they actually occurred. Notably lacking was any information about Youth's family in either the initial or ongoing assessment. Family strengths were not identified, nor were any family concerns. It was unclear what parent's marital status is, or even whether father lives with the family or when/how he left the family home. Cultural differences within the family were not mentioned or explored in any way in the assessment although it was evident that these had later been occasionally addressed during family sessions.</p> <p>ICC: The assessments included some youth information, but would have benefited from more depth to have a clear understanding of the youth. The assessments did not contain family information, leaving no understanding of family information or history. The ICC said the Caregiver would not share about her past; however, none of those questions was re-visited as services and relationships progressed, showing no evidence of assessment as an ongoing process. Throughout the comprehensive assessment, the ICC answered many questions with "CANS assessment completed," but that information was not provided in the one CANS that was done which had only vague narratives. Most of the information contained in the comprehensive assessment seemed to have been gathered in the ICC's initial phone call with the Caregiver, and was documented in that progress note. Strengths were stated in the assessment for both the youth and Caregiver. Natural supports were not identified in the assessments, even though the progress notes sometimes referenced individuals in the family's life. The assessment would have been enhanced with a greater variety of sources (i.e. school, former provider, evaluations), and a well-informed clinical formulation. The clinical formulation section of the comprehensive assessment restated the referral information with a recommendation for OPT and TM rather than providing a formulation.</p>

Strong Practice	Practice Needing Improvement
Service Planning	
<p>IHT: Service planning has been outstanding in this intervention. Following from the concerns about school behavior, the IHT team met right away with the family to hear their perspective and then with school personnel to understand their concerns. During these initial meetings, the team identified potential interventions, shared what worked (and what didn't) at home and school, and together decided on a behavioral approach that strengthened limit-setting at home to reinforce structure at school. Collaboration on service planning has continued throughout the intervention with specific behavior management tactics implemented in tandem across the two environments. As work progressed, the team also consulted with Youth's basketball coach to include his perspective (Youth is generally attentive and cooperative there). The IHT team created two service plans, one for home and one for school, with similar warning signs for behavioral difficulties but responses tailored to the environment. The plans were developed with first input from the Youth, supplemented by parent and teacher contributions. The home plan is written in Spanish for the parents. Just after the school year began, when Youth had a major outburst at school, the IHT team went to the school with Mother (primary caregiver) and supported her in calling MCI and understanding when emergency services are warranted and how to handle the process.</p> <p>ICC: The family has driven the process of prioritizing their needs and setting goals for change. Both Father and Youth are actively involved in all Care Plan Team meetings, with Youth taking an especially central role in brainstorming and choosing options. Every meeting participant makes suggestions, and the resulting plan shows evidence of creative thinking without limiting the options to only adding behavioral health services. The plan also includes clear, measurable objectives for each goal, which assist in discussing progress at each meeting. Although needs have not significantly changed, there was a period of uncertainty about supervision for Youth when Father returned to work (Youth was not allowed in housing complex without adult supervision due to fire-setting incident). One whole CPT was devoted to developing a coverage plan. The safety plan made at start of services and reviewed at every CPT includes responses to three different risk situations - fire setting, emotional dysregulation, and school refusal (an issue over the summer when mother made attendance at summer school optional) - with suggestions for recognizing and handling each. One disappointment in service planning is that mother (an approximately 50/50 Caregiver) has only been marginally involved in planning. The ICC is keenly aware of this gap and has shown persistence in seeking out mother's input, inviting her to meetings, offering meetings at her house, keeping her up to date on plans for Youth, and simultaneously respecting Father's sensitive relationship with his ex-wife and his preference to remain the primary Caregiver.</p>	<p>IHT: While it would appear on the surface that there was work in this area, it was essentially absent as it was not done so with attention to this particular youth and family. Goals were developed by the IHT and then reviewed with the Caregiver, who signed off on the plan. Caregiver was not involved in developing the goals, nor did she receive a copy of the plan. Goals do logically follow from the needs identified in the assessment/CANS, but service planning could have been strengthened by addressing Youth's extensive trauma history and anxiety about Caregiver's well-being. Service planning could also have been strengthened by the development of a more meaningful safety plan. Although Youth does not present with significant safety concerns, the plan, which was again developed by the IHT and presented to the Caregiver, appears to be largely boilerplate, referring to youth alternately as "client" or "him," and contains advice such as "Client's mother will talk to client in an effective way" without any suggestion about what might actually be effective. There are also suggestions about sending client to her "own room" to relax, without considering that Mother and Youth are sharing one room in a shelter.</p> <p>ICC: The youth is included and invited, but has not necessarily engaged in the process. The service plan goals represent the family voice, but do not follow from the needs identified in the assessments. The vision was clinical jargon; not in language that was generated by the family. Goals have remained the same during the entire course of care (15 mos) and have not been responsive to emerging needs, or to drive the service delivery. Other needs that could have been addressed were the family's financial difficulties, lack of food, housing eviction/crisis. The record contained two safety plans with the goal being, "[Youth] is displaying safe behaviors in the home and is not using social media." The safety planning process could be more effective if plans were responsive to incidents that occurred, particularly in the community, which is not covered in the plans.</p>
Service Delivery	
<p>IHT: The choice of SMART as a process for developing emotional regulation and sensory integration was not only good planning but has been executed with skill, flexibility, and consistency. IHT has allowed Youth to lead sessions at her own pace, choosing play activities and sensory objects that she finds most useful. IHT has consistently used the format of check-in, play, and cool down to</p>	<p>IHT: The interventions provided to the youth early on in service delivery seemed more appropriate, but do not seem to match their needs at this time. The therapeutic work being done is a bit unclear at this time, since what is in the progress notes does not match what was reported during interviews. It is also unclear who is present at sessions and where they take place. The IHT Clinician</p>

Strong Practice	Practice Needing Improvement
<p>provide structure to sessions. When a strategy hasn't worked well, she has responded to Caregivers' concerns or her own sense of the problem by adapting the approach. For example, IHT initially had family sessions with the family all together, but the sisters' interactions with each other could too easily devolve into dysregulated emotion. The IHT then separated the play stage of each session with TT&S taking the sister and one parent (alternating weeks) while IHT worked with Youth and the other parent. After each session, IHT processes what worked and what didn't with the Caregivers. She also provides a summary to the two outpatient therapists and other providers involved (TM, Pathways therapist) so that sessions of each provider can build on each other. All agree that the amount (2x weekly of IHT) of service matches the need. IHT has come up with an exemplary use of Youth's strengths as part of this intervention. Youth loves to sing, and IHT has discovered that she can make up songs about very difficult subjects that she cannot talk about, so Youth is now able to express her emotions in song. Another outstanding piece of service delivery was the work that IHT did directly with birth mother to prepare her for the visit with her daughters. IHT collected questions from the sisters that they might ask, helped the Caregivers to understand the questions, and then helped birth mother to prepare answers to possible questions. One particularly sensitive subject was the death of birth father who had overdosed and died at least a year earlier, which children did not know. IHT helped birth mother plan for how to break this news to the girls as well as the fact that they would not be coming back to live with her.</p> <p>ICC: ICC focused from the start on the major presenting problems around Youth's behavior at school and the resulting 51A for neglect filed by the school. Complicating factors were: school filed with DCF without notifying the family or attempting to resolve issues directly with the family; and, family lost their home during the school year and were not sure where they would be living. Nevertheless, ICC got right to work, in collaboration with DCF, to improve communication with the school, support the parents in learning to advocate for the services Youth needs, plan for the summer, ease the transition to the new school (as soon as family secured housing), and access a limited and focused number of behavioral health services that could help Youth deal with frustration and express himself more effectively. They have worked together as a team to help Youth deal with some of his very rigid behavior (fear of germs, extreme limits on what he would eat), and the role of each service was clear to all interviewees. An especially effective plan is in place for starting work with an OP therapist who specializes in ASD.</p>	<p>reports the Caregiver is not available enough so she has been doing sibling sessions. The Caregiver said the sibling sessions are happening because the IHT Clinician does not have availability in her schedule that matches that of the Caregiver, so she takes the girls out when she is at work. She said the youth will sometimes go alone with her now, but was initially scared to, so both girls would go. This area would benefit from individualization of services, and creativity to continue to provide the intensity of services needed. It would have also been helpful to help the Caregiver understand the service she is receiving, as well as other services offered by the agency to improve the current confusion between IHT and home or community-based OPT.</p> <p>ICC: The interventions provided to the youth and family did not meet their needs or strengths. Actionable strengths were not included in service delivery either. The family would have benefited from greater intensity of services, as the FP did not meet with the Caregiver regularly sometimes with large gaps of up to one month in between face-to-face appointments. Service delivery could be improved with support around the youth's school advocacy, camp struggles, and youth's conflicts with Caregiver's boyfriend. For example, the Caregiver repeatedly stated that she was stressed with youth's transition back to school. Rather than addressing it or using the teaming process to support her, the ICC's notes documented that she would tell the Caregiver to speak to the FP about it, even after the Caregiver said she did not want to work with that particular FP. Service providers have not assisted the family in understanding the provider agency or the wraparound model.</p>
Youth and Family Engagement	
<p>IHT: IHT has done a remarkable job of building trust with these Caregivers who had been angered and disappointed by their first IHT experience and by two different ICC providers that they found to be unhelpful. Their trust is evident in their willingness to try whatever strategies this IHT suggests and their consistency in never missing a session. Caregivers have stated that they feel they "can say anything and get a good response" in describing the level of engagement in planning and adjusting services. Caregivers altered their work schedules to ensure that they can meet for both Caregiver sessions and family sessions. The girls appear to look forward to family sessions, too, and participate eagerly. Part of</p>	<p>IHT: According to some interviews and documentation, engagement with the youth has been satisfactory in recent months. However, there is also evidence that the youth starts every family session with behavior bordering on tantrums and significant resistance to participation. There is evidence that the Caregiver has concerns about the timing of family sessions (too soon after the youth returns from school) but that these may not have been brought to the IHT's attention. The Caregiver has struggled to be consistent with appointments, especially at the beginning, and with following through on assigned parenting suggestions. The father has not been included at all (one brief</p>

Strong Practice	Practice Needing Improvement
<p>IHT's success has been that she is very sensitive to each parent's reactions and to the different styles that they have for processing the challenges they face. She makes sure that she addresses both parenting styles (emotional and analytical) in all her psycho-education.</p> <p>ICC: The family, especially Youth, are clearly at the center of their treatment, and Youth asserted with no hesitation that she is in charge of her care. Nothing is added to the Care Plan without their full agreement. ICC has made efforts to include all family members, including brother, father, and maternal grandparents (next door), in various ways. Mother and Youth almost never miss any meeting with any provider. As one provider stated: "It's easy to say that this is a family you can't do Wrap with, but this is Wraparound with total fidelity" to family voice and choice. This is especially notable given Youth's communication difficulties, sanction-seeking behavior, lack of social skills, and tendency to perseverate about questions of race to the exclusion of other topics.</p>	<p>contact in passing). Yet, his daily presence in the home before school and in evenings, and his apparent success in helping with household routines, suggests that including him in family sessions (when possible due to his work schedule) could be useful. The paternal grandmother is also a daily presence, taking care of household chores, and might be a resource to support structure; she has joined family sessions from time to time but does not speak English (and no interpreter was provided) so her participation level is unclear.</p> <p>ICC: The Caregiver's engagement in the service delivery was poor, and she doesn't seem invested or to truly understand the wraparound services. This area could have been enhanced with some creative efforts to improve her engagement. There was also no clear efforts to engage the youth or bring the youth's voice into the service delivery. Additionally, this lack of engagement does not seem to be a noticeable or an identified concern of the ICC or FP, and may possibly be interpreted as a lack of desire or effort.</p>
Team Formation	
<p>IHT: Team formation has been both challenging and, given the number of obstacles, exemplary. In addition to attending all of the Care Plan Meetings convened by ICC, IHT made persistent efforts to connect with all providers (ICC, FP, OP) from the start as well as the probation officer involved via the CRA and, later on, the DCF worker in the short time the case was open with DCF. When the work was interrupted by hospitalizations and the CBAT placement, the team went to the milieus for service planning and discharge meetings. They went to Youth's school, when she was still enrolled, to invite participation in supporting her continued education, and when the school offered the dropout prevention plan at community college, the IHT team included staff there as members of the virtual team of support for the Youth. Both the IHT and TT&S have attended appointments with prescribers to bring them into the provider team. This was especially challenging due to several changes in prescriber with various hospital stays and by Youth's non-compliance with medication. Finally, the team has made consistent efforts to engage the whole family in teamwork around Youth's needs. In addition to family sessions with Caregiver and Youth, they meet regularly with maternal grandmother and from time to time with the only other family members (aunt and cousin) with any current connections to Youth. Youth's boyfriend, with whom she spends most of her time, has been considered throughout as a possible part of Youth's team. This suggestion has apparently been met with opposition from both Caregiver and maternal grandmother and, more recently, from Youth herself. Nevertheless, the attention to natural supports has been outstanding.</p> <p>ICC: All providers were invited and engaged right away, with the first CPT fully attended by all. New providers are similarly added to the team as soon as they start. Efforts to engage the prescriber by phone and email were unsuccessful, so the 2nd ICC began going to sessions with Youth to consult with prescriber. Others are engaged as needed. For example, the Jail Diversion clinician in the area was engaged on the team for several months after the police became involved due to the youth's stalking behavior.</p>	<p>IHT: The IHT Clinician identified the pediatrician, DCF worker, and the school at the time of intake by having releases signed for them. However, there was no documentation of outreach to engage any of them in the initial service planning process. There was no documentation of contact with DCF, and IHT Clinician did not recall any, though she was aware that DCF was the referral source. There was no documented outreach to the pediatrician except to ask him to be part of the MPR process, which resulted in a call from the doctor's assistant who said doctor is leaving the practice. The school was contacted three months after services began, which was one month after school started. Natural supports were handled similarly by being identified during the Clinician's interview, but not having any discussions about outreaching or engaging them. This area would have benefited from the formation of the team so that formal providers and natural supports could work together in the initial service planning process.</p> <p>ICC: There was no evidence of the ICC identifying, outreaching, or inviting providers in the initial service planning process. This area could have been strengthened with engagement efforts with the IHT Clinicians, prescriber, school, camp, after-school program or pediatrician. After hearing about what a Care Plan Team meeting is, the Caregiver said she is still waiting for youth's team to come together for one of those meetings. Exploration of the inclusion of natural supports was unclear but also appears to be absent. The Caregiver said she was not asked, and the ICC said the Caregiver refused to allow any natural supports to be included. The FP said that they did not explore natural supports after the Caregiver informed them that her mother wouldn't be able to be included in services because she works, as do all her other natural supports.</p>

Strong Practice	Practice Needing Improvement
Team Participation	
<p>IHT: IHT has formed a full-fledged team of all the formal supports working with the family, with the exception of a slow start with the school (due to Caregiver reluctance to share personal information with school personnel) and no natural supports (also by Caregiver preference). What is exceptional about the teamwork is the full participation by every team member for the duration of their involvement: both outpatient therapists throughout, the school counselor, and the new TM. By holding face-to-face meetings every month that have clear value in coordination among all parties, including Caregivers, the IHT has ensured ongoing commitment. This intervention has been described as "a dream collaboration."</p> <p>ICC: The ICC had an exemplary approach to actively engaging the team of providers and natural supports in the service planning and delivery. Once a provider was identified, she would reach out by telephone to introduce herself and immediately invited that person to the next care plan meeting. Those meetings were held regularly and on a monthly basis. They sometimes included the school (SPED director and counselor), who attended in person if the meeting was held at the school, or by phone if the meeting was held elsewhere. The youth's TM and IHBS are currently being included, as was the IHT when they were open. The sister's IHT team sometimes comes to the Care Plan Meetings also. Though the natural supports are not always available to attend, the ICC has met several of them, and the youth's paternal aunt is actively included whenever possible. There was a time that the Caregiver was concerned about an incident that occurred with the youth's TM, and the ICC not only organized a telephone conference call to address the matter, but she included the Caregiver and the aunt on that call with the TM. If any of the providers cannot attend a meeting, the ICC regularly communicates with them, before and after the meetings. This ensures that she has their update ahead of time, and that she can inform them afterwards of plans made at the meeting. The ICC had several communications with the clinician at the youth's pediatrician's office also, to keep them in the loop and on the same page, and informed of the team. When the Caregiver has had her own outpatient therapist, the ICC has also outreached them in attempts to include them on the team.</p>	<p>IHT: IHT never contacted the school despite ongoing concerns about Youth's behavior at school. There was no effort to engage school personnel, so there was no school involvement in planning or delivering services. The same is true for the prescriber and the Outpatient therapist. The OP therapist did not hear from, or even know that IHT was in place, for many months.</p> <p>ICC: The first ICC referenced team meetings that were held early on but it was unclear who attended these meetings, and what the purpose of the meeting was. She began documenting care plan meetings a couple months after the service began, and they continued from there inconsistently with gaps ranging from one month to four months between meetings. The team members in attendance varied, sometimes including DCF, IHBS, IHT, and TM. The school was not included in the care plan meetings even though the providers attended school meetings; and there was no discussion to include the school at some point. The youth's prescriber is currently the PCP, and the ICCs served as the liaison providing the team with the PCP's information. The family's natural supports have not been included in team meetings and there were differing responses about whether or not this was explored.</p>
Care Coordination	
<p>IHT: From the very start, collaboration with the school was central to the intervention. In addition to initiating regular communication with school personnel from the start, the IHT team pulled together 2 full-scale, face-to-face team meetings with both parents, both IHT team members, the classroom teacher, school counselor, paraprofessional aide, and principal to ensure that services were proceeding as expected and to monitor progress, make changes as needed, and ensure full review of any concerns. When IHT or TT&S communicate with school during their weekly sessions with Youth at school, they consistently report all information to Caregiver. They follow up similarly when only one Caregiver is able to meet for a home visit. IHT reports as soon as possible to the other parent about what happened in the session. Every interviewee was able to clearly describe goals, interventions, and progress across the team.</p>	<p>IHT: IHT worked in the last month to find and pass along to Caregiver some information about adult services through DDS that might help Youth when he turns 18. Otherwise, Caregiver is the conduit for all information with school and prescriber. This was described as more of an accident than a plan. A major concern in coordination is the complete lack of it with the OP therapist. Evidence suggests that they are both working on similar goals with Youth, but they have never shared insights, compared approaches, or in any way coordinated their work. Neither provider interviewed could describe what the other is doing. In addition, there is a counselor at school who is described as working on similar issues but who has not been consulted at all. Similarly, natural supports are not all given access to what is happening. Father is not engaged, or even informed, despite his part-time caregiving role. Youth's grandfather is not engaged despite living in the same house with the family.</p>

Strong Practice	Practice Needing Improvement
<p>ICC: ICC has a sophisticated grasp of care coordination. She has brought on new services with face-to-face meetings with the new provider, existing providers, and Father to share status of the work. She maintains a weekly scheduled call with IHT (from a different agency) and meets face-to-face weekly with OP (same agency as ICC). In addition to the consultation with OP and the prescriber to sort out Youth's diagnosis, ICC has met with the prescriber to clarify medication needs with the result that medications were reduced from 6 prescriptions to two, which are monitored regularly. With the new school year, Father has access to daily online reports of Youth's achievements and behavior, which he then shares with the ICC. Additional evidence of excellent coordination is that during the review, everyone on the team could describe the most up to date situation, the purpose of each service, the efforts to engage mother, and the ways to know when services might end.</p>	<p>ICC: ICC sees himself and Caregiver as responsible for coordination of care. The ICC is not facilitating ongoing, effective communication among team members outside of the ICP meetings; however, there is evidence other team members are coordinating care on their own. For example, TM talks with Caregiver weekly, as well as with the school staff. Cohesion of interventions by all providers seems lacking and natural supports are not included in planning or intervention. ICC did not share substantive information with the team. For example, DCF did not appear to know the reason for the current IHT referral. There is poor communication between the ICC and Caregiver. ICC indicates that care coordination is "just right" while it is evident that Caregiver does not see the value of the ICC and would prefer to end services.</p>
Transition	
<p>IHT: The preparation to exit began with the explanation of IHT services at the start and then ramped up to an ongoing discussion of progress and next steps, as the initial goal had been achieved. The IHT team has relied throughout the intervention on clear measures of progress at school (numbers of incidents, positive peer interactions, etc.) in addition to self-report by both Caregiver and Youth about behavior at home. Measures have also been verified by team observation at minimum 2x per week. IHT and the family have a plan to step down to weekly individual outpatient therapy to take place at school and a Therapeutic Mentor to continue modeling positive social interactions, with OP as hub.</p> <p>ICC: Transition from the first school (where Youth had been mainstreamed without success) to the new school with appropriate Special Ed services was the primary focus of the work at the start. The ICC and Family Partner team did an excellent job of building their understanding of the Youth's needs, consulting with DCF, sharing their understanding with the schools, and advocating in the new school district for the full range of Special Education services that the Youth needs to support his academic, emotional, and medical needs. They were very sensitive to the predicament of the parents who felt that they and their son were treated unfairly by the first school but who also had no idea of their rights or ways to advocate. The many staff changes during this brief intervention, whether caused by the family's move or by staff turnover, were handled smoothly, with an especially seamless transition of ICC. The new ICC picked up exactly where the first ICC left off and, with some overlap to be introduced to the team, carried on with the planned CPTs and care coordination. Transition out of ICC has also been well planned for and coordinated. Indicators for transition included: better understanding of the Youth's conditions shared with the whole team, demonstrated confidence by the Caregivers in advocating for themselves, on-going behavioral health services for Youth established, and success in the new school's more supportive environment sustained for at least a month. The whole intervention is planned to last for about 6 months.</p>	<p>IHT: There appears to have been no consideration of the transitions in Youth's life that happened immediately prior to IHT service opening - move to a new school, move into a shelter, and functional loss of a parent. Although one of Youth's goals (decrease in anxiety) was stated in a measurable way, progress towards that goal does not appear to have been tracked or evaluated. There appears to be no timeline for when services will end, nor has there been any discussion with Caregiver about when that might occur. IHT thought services might end after Mother's court appearances ended, although that was completely unrelated to any of the stated goals.</p> <p>ICC: Youth started at a new school just as both ICC and IHT services ended. There is no documentation that ICC facilitated youth's transition to the new school. ICC referred youth to OPT as part of after care plan, with the understanding that the OPT would refer the youth for psychiatric/medication assessment. Caregiver states that there was "no discussion" about ICC closing but she was informed that they had to close to "avoid an audit because all goals were met." ICC indicated in interview that planning for transition began four months ago; however, documentation did not support this process. The youth would also age out of his afterschool program but there was no discussion/planning on the part of the team for alternate programming. As part of closing, ICC has referred Caregiver to parenting classes which begin next month; however, it is not clear that Caregiver can be successful in participating in the classes. Youth and Caregiver moved to Florida several years ago and then returned the next year. There is no documentation relative to the move away or the move back and their relative impact on the youth and family. Transition could be improved by ICC taking a more active role in anticipating transitions and supporting the team in facilitating successful transitions for youth and his family.</p>

Strong Practice	Practice Needing Improvement
Responsiveness	
<p>IHT: IHT contacted the family immediately upon referral and, within a week, had their first meeting with the family and a face-to-face meeting with the school two days later. Their step-down plan includes OP and TM. Both referrals are in process with the agencies that can best provide the school-based OP and several TM choices (not just self-referral) to help speed up a potential match. IHT is monitoring progress on both. Because scheduling is challenging with the parents' work hours, the team is specifically seeking an OP who will go to the school and has already secured the school's cooperation in providing space for them to meet.</p> <p>ICC: Initial face-to-face meeting took place three days after referral. Referral made for TM as soon as Youth agreed to this - currently anticipating a three-week wait for Spanish speaking TM. ICC and FP have been very persistent in ensuring response from Housing Dept. and legal advocates during family's housing crisis.</p>	<p>IHT: The family waited approximately four months for IHT services to start. The Caregiver said she frequently checked in on the status of her referral, because she was desperate and frustrated with the youth's decompensation while waiting. According to the agency, the longer wait may have been indicative of the family only having evening availability. This area could have also been improved with the provider making appropriate service referrals for the youth and family. For example, conversations were had about a PHP, but it wasn't until MCI became involved that a referral was made. Other referrals that weren't met included to help the Caregiver find an OPT for herself, and assistance with a referral for a neuro-psychological evaluation that had been discussed for four months.</p> <p>ICC: The Mother signed intake paperwork two months after making a referral. An ICC was assigned at that time, but found Youth ineligible for service. This decision was apparently reversed, and an assessment was signed another month later by the same ICC. The ICC did not make referrals for any additional services, and is reported to have met only sporadically with Mother. It was essentially ten months from the time the Mother requested services until the second ICC assigned to this family began to make referrals for other services as requested. Throughout that time the Youth's behavior continued to deteriorate.</p>
Service Accessibility	
<p>IHT: The team has demonstrated very good flexibility with their appointments. They tend to each meet separately with the youth/family and have, at times, met with him at his school, at his group home, and at this home. A conscious decision was made to each meet separately so as to maximize the support provided to this youth and family. Appointments have been scheduled and re-scheduled according to his needs. When he joined a basketball league, the schedule was changed to accommodate this. The TT&S and TM are both bilingual in Spanish and English, and work with the youth in both English and Spanish.</p> <p>ICC: Every provider for this family is Spanish speaking, and all documents have been provided in English and Spanish. Services have been primarily provided in the home despite the previous home location being so unsafe that the agency has required that providers visit in pairs. Current home appears equally unsafe with notable police presence outside the building. Meetings have been held at Outpatient clinic to facilitate OPT's involvement, at school to engage Guidance Counselor, and will be held at Youth's new school in order to allow teachers to attend. Providers accompanied family to various courts for lengthy hearings, and to hospital for MCI intervention. ICC and FP's willingness to meet family wherever and whenever necessary to provide support and service has been exemplary.</p>	<p>IHT: It was not evident that the team fully explored the stepmother's verbal and written language needs; there was no exploration of the use of an interpreter nor was it clear that they took steps to ensure she could read/understand the various documents. This may have impacted her ability to fully participate.</p> <p>ICC: Caregiver expressed that she would like the whole family to meet together and the only available time was 5 PM. ICC reported that she only works until 5:00pm, so Caregiver acquiesced and accepted an alternate time. The resulting appointment time does not meet the caregiver's needs. ICC meets with family every other week, as a standard frequency, not based on the family's needs. Services are provided in English, although Caregiver states that she finds it easier to express herself with an interpreter. ICC indicated that she suggested an interpreter and Caregiver declined. All documentation is provided in English. This area could be improved by increasing awareness of Caregiver's feelings and wishes relative to time of appointments to include all family members, rather than each family member receiving individual services.</p>
Cultural Awareness	
<p>IHT: IHT has an excellent grasp of the family culture - both the cultural elements derived from their Hispanic background and the individual characteristics of the family's unique culture. For example, she can describe the Caregiver's efforts to keep her children close, her values of family looking out for one another, their religious beliefs, their relationship to poverty and the relentless efforts to break free of financial strain, and the struggle</p>	<p>IHT: IHT understands the Caregiver's reluctance to discuss emotions as perhaps being generational, but there has otherwise been almost no identification or discussion of this family's culture. There appears to be no awareness of a culture of adoption, although the Caregiver adopted four children in her earlier years, including the youth's mother, long before she adopted the youth and her sister. Likewise, there has been no consideration of the</p>

Strong Practice	Practice Needing Improvement
<p>to diverge from the unhealthy past influences on parenting. The Caregiver and IHT have discussed both of their cultures and how they are similar and different. IHT is especially astute in recognizing that she needs to guard against seeing things as "normal" (such as excessive bossing and yelling at children) just because she is used to them from her own upbringing.</p> <p>ICC: The team appears to have done an excellent job exploring the rich array of culturally driven beliefs about mental health, appropriate youth behavior, and appropriate parenting. The three key Caregivers all have differing beliefs and this appears to have contributed to difficulties responding effectively to the youth's needs. The team recognized early on that the stepfather's participation would be important, and transferred the care to a Spanish speaking ICC who could better engage him.</p>	<p>culture of grandparents raising their grandchildren even though TT&S is aware that their agency runs a support group for custodial grandparents. IHT and TT&S appear to believe that it would be inappropriate for them to share personal information about their own cultures in order to discuss similarities and differences with the family.</p> <p>ICC: Notable by its almost complete absence is any reference to or consideration of this family's culture. The only reference is that the family is Catholic, but there is no exploration of whether this is important to them, or if they have a church, which might be a source of support or community engagement (a goal for Youth). ICC had no idea what family's cultural heritage might be (maybe Irish? maybe Italian?) only that they spoke with a Boston accent. There is no exploration of extended family, despite noting that maternal uncle lived in the home when services were opened. Family's values are not identified in any way.</p>
Cultural Sensitivity and Responsiveness	
<p>IHT: IHT has explored and understands the family's beliefs, traditions and identity from the Dominican Republic. She has explored this with the family as a way to understand youth's fears. The Father has expressed that, as a kid, he was a lot like the youth in that he, too, had a lot of anxiety. IHT and family share special foods. IHT made sweet cookies with youth, brother, and cousin for Christmas Eve. IHT explored parenting differences with the Caregivers (mother and father) and Maternal Grandfather and came to mutual agreement- e.g. father manages AM routing while mother is working and mother manages evening routine while father is working, with consistency and new understanding. Caregiver feels IHT is respectful of their culture and makes suggestions that do not conflict with their culture.</p> <p>ICC: The ICC and Family Partner developed a very clear understanding of this family's culture as white, "working poor" people with a hardscrabble upbringing. For example, they were aware of the way that the school engaged DCF for "neglect" without addressing issues with the parents or respecting the efforts that the parents had made for years to sort out Youth's difficulties. ICC also had a good sense of how the Youth's encopresis, the family's homelessness, and parents' limited education and resources (in a relatively affluent area) could feed into prejudice about the family and the "blaming and shaming" attitude of the first school. They used their understanding to sow compassion with DCF and in the new school setting.</p>	<p>IHT: It is evident that the Caregiver has a complex history, which affects the youth. While some of the factual history is known to the IHT, it appears that it hasn't been explored deeply and synthesized into an understanding of how it influences her and the youth's cognitive perception of the world. Some areas worthy of further exploration include the circumstances around the time the youth spent in kinship placement, what the youth understands about that time, the Caregiver's perception of herself as a parent given that she does not have custody of two of her children, and the relationship between the Caregiver and her father, who is a minister.</p> <p>ICC: There appears to be an almost complete lack of awareness or use of this family's culture in the ICC's (and other providers') work with them. Despite Father's rich and varied cultural background, which he is very willing to discuss, this has not been explored. Neither racial/cultural differences within the family, nor intergenerational issues have been discussed. Nor has any racial or cultural similarities/differences between ICC and the family been discussed. ICC has not promoted such discussion or consideration among team members. Despite Father's initial and ongoing concerns about Youth's possible gang involvement, and the documented incident of Youth beating up another girl while the fight was recorded by "friends," there has been no consideration or discussion about the prevalence of Cape Verdean gangs in the community. This seems even more notable given the recent acts of violence in their neighborhood which impacted the family directly.</p>