System of Care Practice Review Regional Report of Findings: Metro/Boston

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TAC
TECHNICAL ASSISTANCE COLLABORATIVE

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In June 2013 the state implemented the System of Care Practice Review (SOCPR) process as part of its ongoing effort to evaluate the quality of care delivered to youth under 21 receiving MassHealth children's behavioral health care services. This review represented the first time the SOCPR has been used in Massachusetts and as such it served as a training round for the 12 Massachusetts-based reviewers and as a pilot of the sampling, scheduling, and consent procedures.

The SOCPR, which was developed by the University of South Florida (USF), uses a multiple case study methodology to learn how important Systems of Care (SOC) values and principles are operationalized at the practice level, where youth and families have direct contact with service providers. Trained reviewers use the SOCPR protocol to review a youth's treatment record and to guide interviews with providers, caregivers, the youth, and natural support persons. Reviewers then rate their impressions of the youth's care according to four domain areas that map closely to the core values of a SOC as articulated by Stroul, Blau, and Friedman.[1]

TABLE 1: SOCPR DOMAINS AND SUB-DOMAINS

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

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

Metro/Boston Review Summary

The care of 36 randomly selected youth who received services from eight (8) randomly selected In-Home Therapy (IHT) providers[2] serving the Metro/Boston region was reviewed using the SOCPR. Youth reviewed during this round ranged in age from 3 years to 20 years with an

[1] Stroul, B.A., Blau, G., & Friedman, R.M. (n.d). Updating the System of Care Concept and Philosophy. Washington, D.C.: National Technical Assistance Center for Children's Mental Health.
[2] In total nine provider sites were selected for review representing eight unique IHT providers.

overall mean age of 12.58 years. Almost 64% of the youth were male. Of the sample, 47% was Latino/Hispanic and 19% was White, with African American/Black and Multi-racial both at 17%. Seventy-eight percent of the children and youth in the sample spoke English as their primary language, and Spanish was identified as being the primary language in 19% of families. Typical length of treatment was 5-12 months (in 55% of the families). Almost 39% of the youth had Special Education involvement, followed closely by DCF (over 33%).

Results

SOCPR scores can range from a low of 1 to a high of 7. Scores from 1 to 3 represent lower implementation of a SOC approach, and scores from 5 to 7 represent enhanced implementation of SOC principles. A score of 4 indicates a neutral rating — lack of support for or against implementation was present. For the Boston/Metro Area, SOCPR mean scores ranged from 5.27 to 5.95 with an overall mean score of 5.52. One case (3%) fell into the range from 3 to 4, representing lower SOC implementation, while 35 (97%) of cases fell into the range from 4 to 7 representing higher SOC implementation; seven or 20% fell in the range from 4 to 5, eighteen, or 50% in the 5 to 6 range, and ten, or 28% in the range from 6 to 7. Twenty-eight cases or 78% fell into the top two levels.

The domain of Community-Based was the highest scoring domain followed by Impact, Child-Centered Family-Focused, and finally Culturally Competent. The scores indicate that in the Boston/Metro region, IHT provider agencies included in the sample performed best at including the Community-Based system of care value in service planning and provision.

TABLE 2: SOCPR DOMAIN SCORES

	Min	Max	Mean	Standard Deviation	95% Confidence Interval Lower Limit	Upper Limit
Overall	3.40	6.35	5.52	0.76	5.27	5.78
Domain 1: Child-Centered Family-Focused	2.50	6.75	5.37	1.05	5.02	5.73
Domain 2: Community-Based	4.60	6.90	5.95	0.65	5.73	6.17
Domain 3: Culturally Competent	2.80	6.60	5.27	0.93	4.95	5.58
Domain 4: Impact	3.00	7.00	5.51	0.90	5.20	5.81

Identified Strengths and Opportunities for Improvement

Overall, the findings from this review show that IHT providers in the Metro/Boston region are demonstrating a system of care approach to service planning and delivery. Areas of particular strength for providers in this region included:

- Services are being offered at convenient times and in convenient locations for families.

- Appropriate language is being used to communicate with youth and families – both written and verbally.

- Services are provided in environments that are the least restrictive and most comfortable for the youth and family.

- Families are actively participating in services.

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

- The types and mix of services for each family should be child-centered and family-focused. Services and supports should be adapted to meet the identified needs of the youth and family instead of expecting families to conform to preexisting service configurations.

- Improve service planning and provision by making sure that both formal providers and informal supports are communicating with each other. Make sure the process for connecting children and families with additional resources is seamless.

- Strengths of the youth and family should be considered when developing treatment planning goals and designing appropriate interventions.

- Assist families in identifying informal supports (both people and services) in the early stages of service planning development. This will help them establish a solid support network for understanding and navigating the system.

Introduction

Overview

This report presents findings from the System of Care Practice Reviews (SOCPR) that occurred in the Metro/Boston region during June of 2013. Developed by the University of South Florida (USF), the SOCPR utilizes a multiple case study methodology to learn how important Systems of Care (SOC) values and principles are operationalized at the practice level, where youth and families have direct contact with service providers. Using the SOCPR protocol, trained reviewers conduct structured interviews with key informants including the parent/caregiver of a randomly selected youth, the youth (if 12 or older), service providers, and other helpers familiar with the care the youth and family are receiving. A review of a youth's record is also performed which provides an additional source of information about the service planning and delivery process. During the June 2013 review cycle, the care of 36 randomly selected youth who received services from eight (8) In-Home Therapy (IHT) providers[3] serving the Metro/Boston region was reviewed using the SOCPR.

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

TABLE 3: CBHI VALUES AND SOCPR DOMAINS

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

The June 2013 review represented the first time the SOCPR has been used by the state to gather qualitative information about the service planning and delivery process. Therefore it served as a training review round and a pilot of the procedures for obtaining consent and scheduling informant interviews. Four additional review waves are planned so that adherence to SOC principles by IHT and Intensive Care Coordination (ICC) providers in each region of the state will be reviewed over the course of one year.

[3] In total nine provider sites were selected for review representing eight unique IHT providers.

TABLE 4: REVIEW SCHEDULE BY STATE REGION

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

History of Qualitative Case Reviews in Massachusetts

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

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

Methodology

Reviewer Training

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

arrive at a consensus score for each review. Reviewers also participated in a group debriefing at the end of the review week.

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

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

Provider Selection

For the June SOCPR review, it was determined that high-volume IHT providers (defined as those with reported capacity to serve 85 or more youth) serving the Metro/Boston region would be the focus of the reviews and that a total of nine providers (four youth per provider site) would be randomly selected to participate in this pilot review round. Data from the January 2013 Massachusetts Behavioral Health Access (MABHA) report was used to create a sampling frame which included the 12 Metro/Boston IHT provider sites with reported capacity to serve 85 or more youth. [4] According to the January 2013 MABHA report there were 27 IHT providers with 31 sites in the Metro/Boston region. Three of the 12 provider sites were in the Metro area, with the remaining nine in Boston proper.[5] A random sample of the Boston providers was conducted to arrive at the final six providers for the June 5th and 6th reviews. All three providers in the Metro area that were included in the sampling frame were selected for the June 24th and 25th reviews. At the time the sample was conducted, the nine selected provider sites reported serving a total of 1,017 youth or 47% of the youth participating in IHT in the Metro/Boston region.

Youth Selection

Once the providers were identified, MassHealth requested that their six contracted Managed Care Entities (MCEs) prepare a report to include all youth with an open authorization for IHT at each of the selected provider agencies. TAC then combined the lists from each of the MCEs to prepare a sampling frame that would be used to randomly select youth from each provider. TAC randomly selected 25 youth per provider, purposely oversampling in case some youth/families declined to participate. This list of 25 youth was then sent to the program director with a request to verify the enrollment of the youth and supply additional information necessary to proceed with the consent and scheduling process (e.g. name of IHT clinician, primary language of the family, age of youth, etc.). TAC also asked the IHT provider to indicate whether the youth was concurrently enrolled in ICC, as this was an exclusion criterion for the June SOCPR review round.[6] Program directors returned their verified lists to TAC who then randomly selected four youth per site for the providers to approach to obtain consent (see description of consent

[4] The 12 provider sites represented 11 unique providers. One provider had two sites selected.
[5] Following the provider selection one provider moved their IHT location to the Metro area.
[6] In subsequent rounds youth with ICC will be included.

process below). If a family declined, providers were asked to contact TAC so another youth from the verified list of youth could be selected to participate. This process continued until the target of four youth from each of the selected organizations was reached for a total of 36 youth, four per provider site.

To reach the goal of 36 interviews for the Boston review round, a total of 57 families were asked to participate in the SOCPR, with 21 families or 36% declining. The most common reasons cited by families for not participating were in the category of "significant life stressors" such as housing instability, financial strain, physical health problems, mental health or substance use crises, and divorce that families believed would be compounded if they participated in the SOCPR. Other reasons cited by families for not participating included not being in town or unavailable on the review dates, job conflicts, and not wanting to have "outsiders" in their home.

Consent Process

In April 2013, TAC hosted a webinar for the randomly selected providers to educate them about the consent and scheduling processes. A copy of the presentation is located in Appendix A. Following the webinar, IHT clinicians for the randomly selected youth approached the youth (if 18 or older) or the parent/caregiver to ask if they would be willing to participate in the SOCPR process. Parents and youth over 18 were informed that their participation in the SOCPR process was voluntary and would not impact their service delivery if they chose not to participate. They were also informed that they would receive a gift card to Target upon completion of their interview. If the youth or parent agreed, they were asked to sign a consent form and the necessary release of information forms. IHT clinicians also explained the SOCPR process to those youth between the ages of 12-17 whose parents had agreed for them to be interviewed and obtained their written assent to participate.

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

Scheduling PProcess

IHT providers were asked to schedule interviews with the following key informants: 1) the parent/caregiver; 2) the youth if 12 or older; 3) the IHT clinician; and 4) an informal helper. Providers were expected to schedule a minimum of three interviews for each youth. If the youth was under 12 and no informal helper could be identified, the provider was asked to work with the youth/family to select an alternate person who was familiar with the care delivery and planning process to participate in an interview. A review of the youth's record at the provider agency preceded the interviews. It is important to note that for an SOCPR administration to be considered valid a minimum of three data points (the record review and two interviews) are necessary.

SOCPR Description

The SOCPR collects and analyzes information regarding the process of service delivery to document the service experiences of children and their families, and then provides feedback and recommendations for improvement to the system. The process yields thorough, in-depth descriptions that reveal and explain the complex service environment experienced by children and their

families. Feedback is provided through specific recommendations that can be incorporated into staff training, supervision, and coaching, and may also be aggregated across cases at the regional or system level to identify strengths and areas in need of improvement within the system of care. In this manner, the SOCPR provides a measure of how well the overall system is meeting the needs of children and their families relative to system of care values and principles.

The reliability of the SOCPR has been evaluated, and high inter-rater reliability has been reported in its use.[7] The validity of the protocol is supported through triangulating information obtained from various informants and document reviews. The SOCPR was found to distinguish between a system of care site and a traditional services site. Moreover, Hernandez et al. found in their study that the SOCPR identified system of care sites as being more child-centered and family-focused, community-based, and culturally competent than services in a matched comparison site offering traditional mental health services.[8] System of care sites were more likely than traditional service systems to consider the social strengths of both youth and families and to include informal sources of support such as extended family and friends in the planning and delivery of services. In addition, Stephens, Holden, and Hernandez [9] found that the SOCPR ratings were associated with child-level outcome measures. In their comparison study, Stephens and colleagues discovered that youth who received services in systems that functioned in a manner consistent with system of care values and principles compared with traditional services had significant reductions in symptomatology and impairment one year after entry into services, whereas youth in organizations that did not use system of care values demonstrated less positive change. The study also found that as system of care-based practice increased, children's impairments decreased.

SOCPR Method

The SOCPR uses a case study methodology informed by caregivers, youth, formal providers, informal supports, and extant documents related to service planning and provision. The SOCPR relies on data gathered from interviews with multiple informants, as well as through case files and record reviews. Document reviews precede interviews and provide an understanding of the family's service history, including the presence and variety of services from sectors outside of mental health care systems. These reviews also provide the chronological context of service delivery and help to orient the reviewer to the child and family's strengths, needs, and involvement with services. The unit of analysis is the family, with each family representing a test of the extent to which the system of care is implementing its services in accordance with system of care values and principles. The family consists of the youth involved in the system of care, the primary caregiver (e.g., parent, foster parent, relative), the primary formal service provider (e.g., behavioral health care manager, therapist), and if present, a primary informal helper (e.g., extended family member, neighbor, friend).

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

[8] Ibid.

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

The interviews are based on a set of questions intended to obtain the child and family's perceptions of the services they have received. Questions related to accessibility, convenience, relevance, satisfaction, cultural competence, and perceived effectiveness are included. These questions are open-ended and designed to elicit both descriptive and explanatory information that might not be found through the record review. The questions provide the reviewer with the opportunity to obtain information about the everyday service experiences of the youth and family and thereby gain a glimpse of the life experience of a youth and family in the context of the services they have received.

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

SOCPR Domains

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

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

Domain 2, Community-Based, is defined as having services provided within or close to the child's home community in the least restrictive and most appropriate setting possible, and coordinated and delivered through linkages between a variety of providers and service sectors. This domain is composed of 4 sub-domains: a) Early Intervention, b) Access to Services, c) Minimal Restrictiveness, and d) Integration and Coordination.

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

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

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

improvement. Ultimately, results provide the basis for feedback, thus allowing a system's stakeholders to maintain fidelity to system of care values and principles.

IHT Supplemental Questions

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

Organization of the SOCPR

The SOCPR is organized into four major sections.

Section 1:

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

Section 2:

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

Section 3:

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

Section 4:

Reviewers use this section to summarize and integrate the information collected in the other three sections of the SOCPR. The Summative Questions call for the reviewer to provide a rating for a statement associated with SOC core values at the level of direct practice. Reviewers rate each Summative Question on a scale from 1 (disagree very much) to 7 (agree very much) (see Table 5). Scores from 1 to 3 represent lower implementation of a SOC approach, and scores from 5 to 7 represent enhanced implementation of SOC principles. A score of 4 indicates a neutral rating — lack of support for or against implementation of SOC principles was present.

TABLE 5: SUMMATIVE QUESTION SCALE

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

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

Quantitative Data Analysis

Responses to the Summative Questions (see Section 4 of the SOCPR as described above) were averaged to provide a score for the overall results and each of the domain areas. As part of the quantitative analysis, frequency distributions for each individual question were conducted. The frequency distributions provided both a frequency count and a percentage of individual reviewer responses for each question in the SOCPR.

Data were integrated and ratings determined for each question (embedded within a sub-domain of one of the four main domains), with higher scores indicating that a family's experiences were more consistent with SOC principles. All of the interview questions in the SOCPR were pre-coded at the time the protocol was developed. This allowed for questions to be sorted by interview (e.g., primary caregiver, child, formal provider) and by domain (e.g., Child-Centered and Family-Focused, Cultural Competence).

Qualitative Data Analysis

Qualitative analysis of the narrative portion of Summative Questions followed standard coding procedures designed to develop a formal system for organizing the data and documenting links between identified concepts (e.g. codes, themes, etc.) and the experiences of youth, family members, providers and informal supports described in the data.[10,11] The first step in the

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

process is for research team members to review the data without coding, allowing them to immerse themselves in the data to allow for comprehension of the "big picture," so to speak, promoting understanding of the scope and context of the site under study. Once data has been reviewed and prepared for coding (i.e. saved as Word documents), the narrative comments are coded.

After coding of narrative comments is complete it is reviewed by another reviewer to determine consensus with regard to themes identified through initial coding. Where questions arose with regard to identified themes or coding, research team members discussed and reconciled differences to reach consensus. Following coding, narratives for all Summative Questions were compiled and sorted to assess the degree to which SOC principles were implemented in each SOCPR domain area (n=36). The frequency of Summative Question responses were examined and analyzed for emerging patterns/trends. In order to be considered a trend, at least of half of the review responses had to provide similar information for a given sub-domain area. Trends in each sub-domain were then reviewed together to provide an overall assessment for the larger domain area. Using these findings, this report section also highlights particular successes and challenges with regard to implementation of SOC principles for each of the SOCPR domain areas.

The quantitative ratings for each item were considered in conjunction with the respective narrative to determine a general assessment for each domain. The compiled narratives for all Summative Questions were coded and sorted to assess the degree to which SOC principles were implemented in each SOCPR domain area. The frequency of Summative Question responses were examined and analyzed for emerging patterns/trends. In order to be considered a trend, at least of half of the review responses had to provide similar information for a given sub-domain area. Trends in each sub-domain are then reviewed together to provide an overall assessment for the larger domain area. To verify congruency between ratings and explanatory responses, findings from each are compared. Finally, the results are contrasted against the SOC core values, resulting in a conclusion to the extent to which the system of care is guiding service delivery.

Results

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

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

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

The SOCPR results and findings obtained from the June 2013 review cycle must be interpreted with caution. This data is preliminary and is based on initial training provided by the University of South Florida.

Demographics

Thirty-six families participated in the Boston/Metro SOCPR review. A summary of the demographic characteristics of these families are presented in the figures below.

FIGURE 1: GENDER

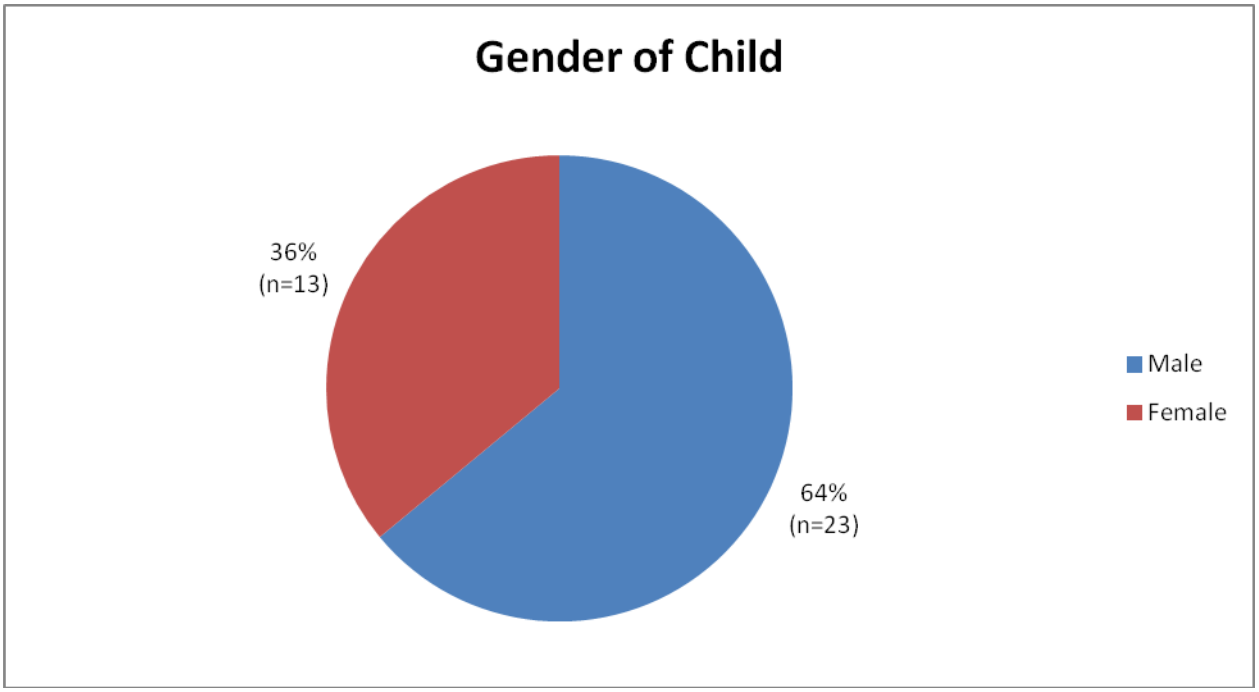


FIGURE 2: RACE

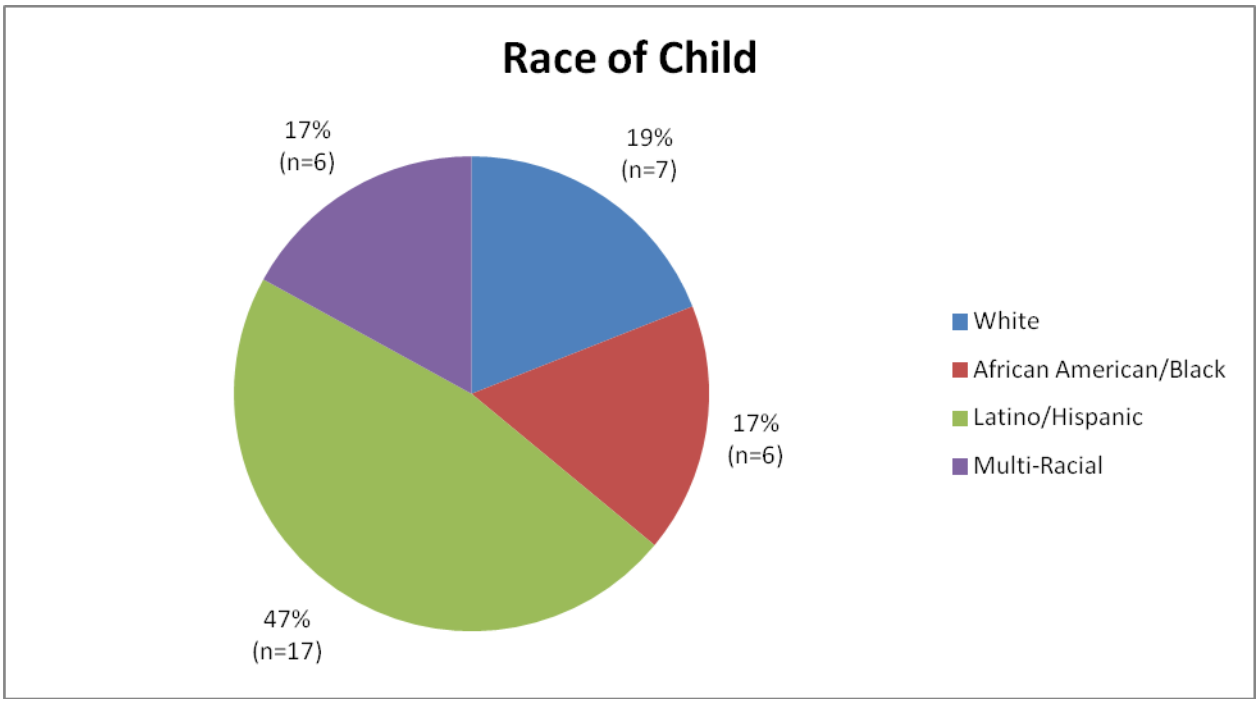


FIGURE 3: AGE

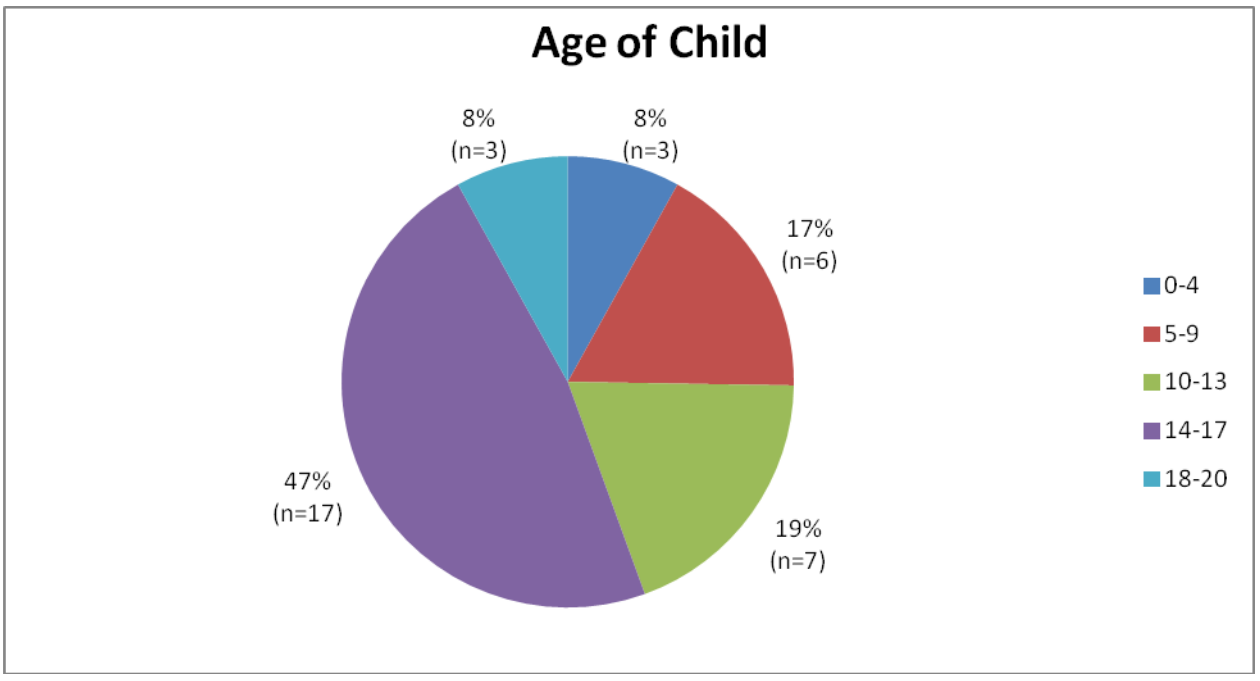


FIGURE 4: PRIMARY LANGUAGE

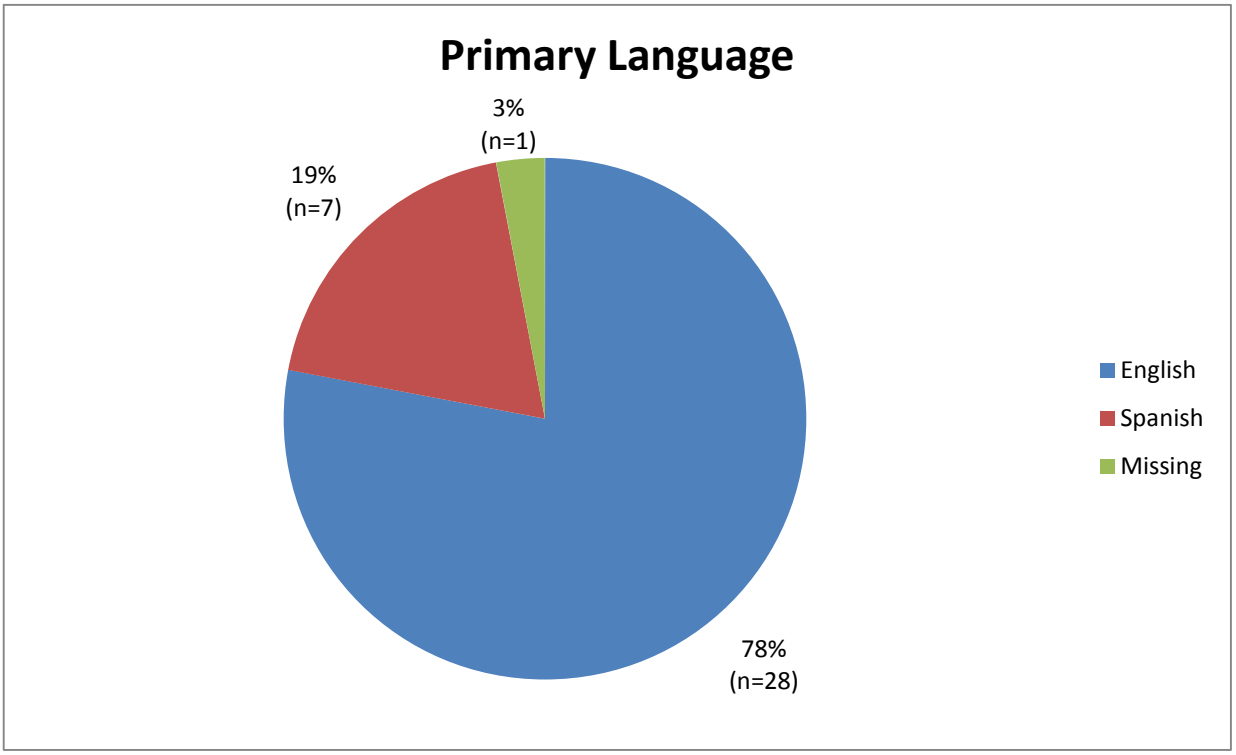
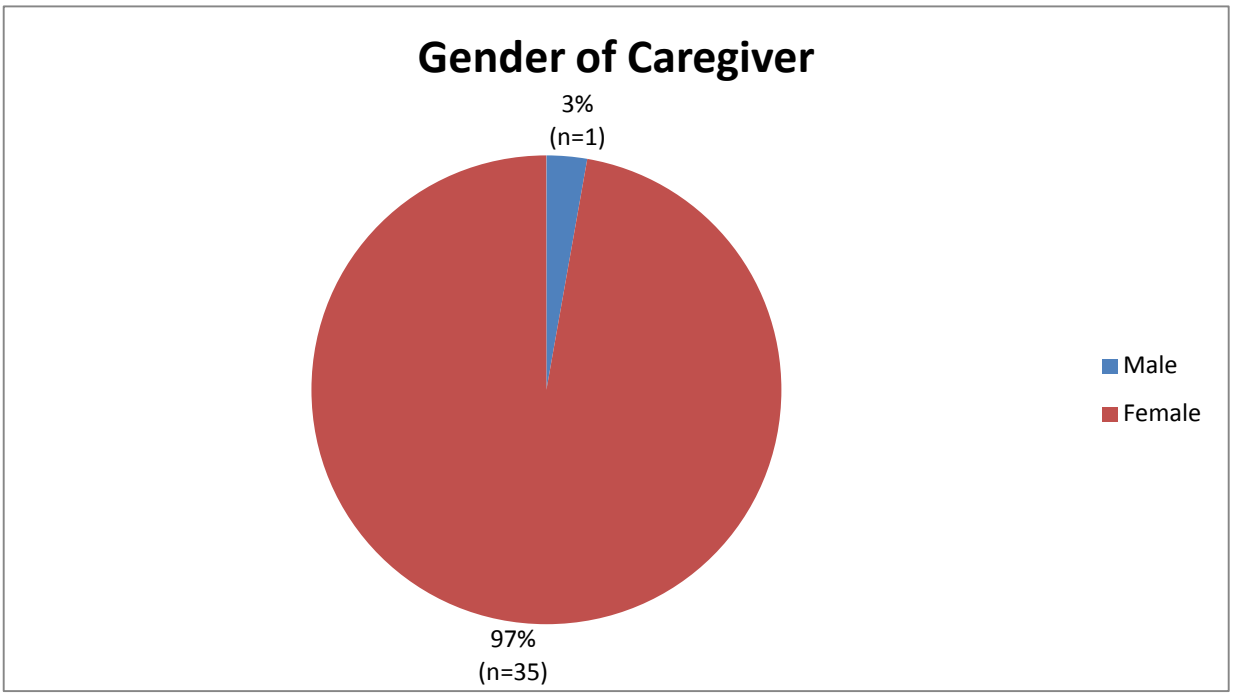
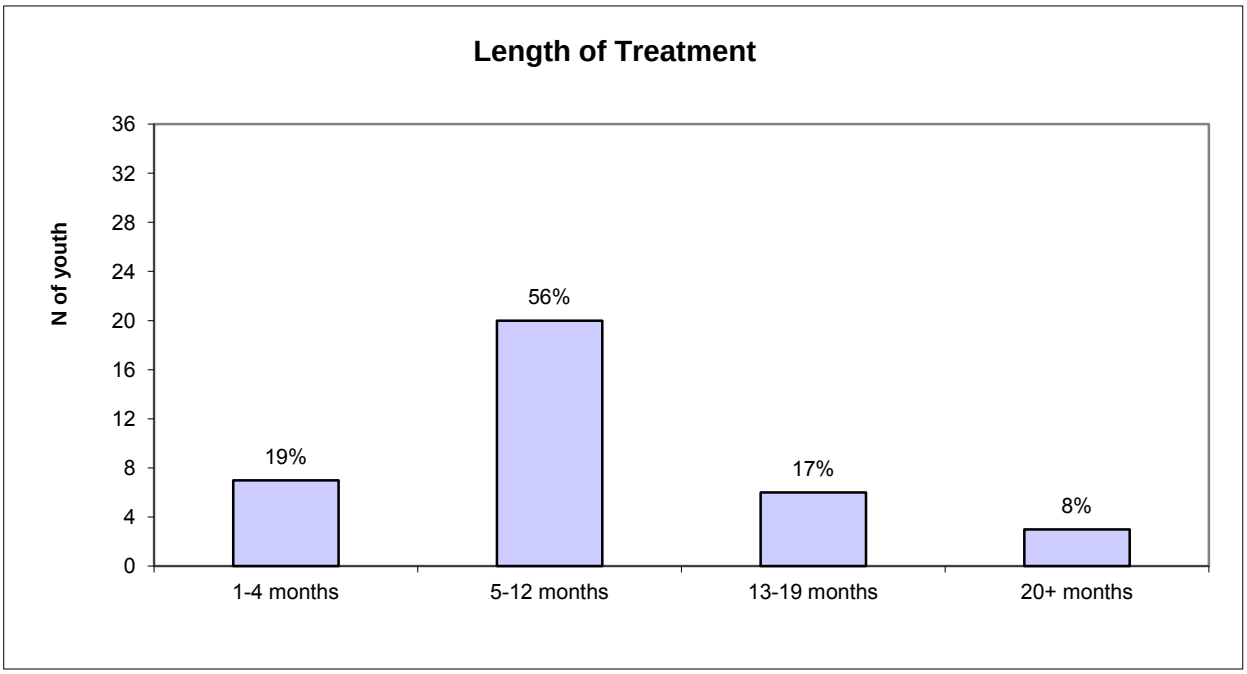


FIGURE 5: GENDER OF CAREGIVER



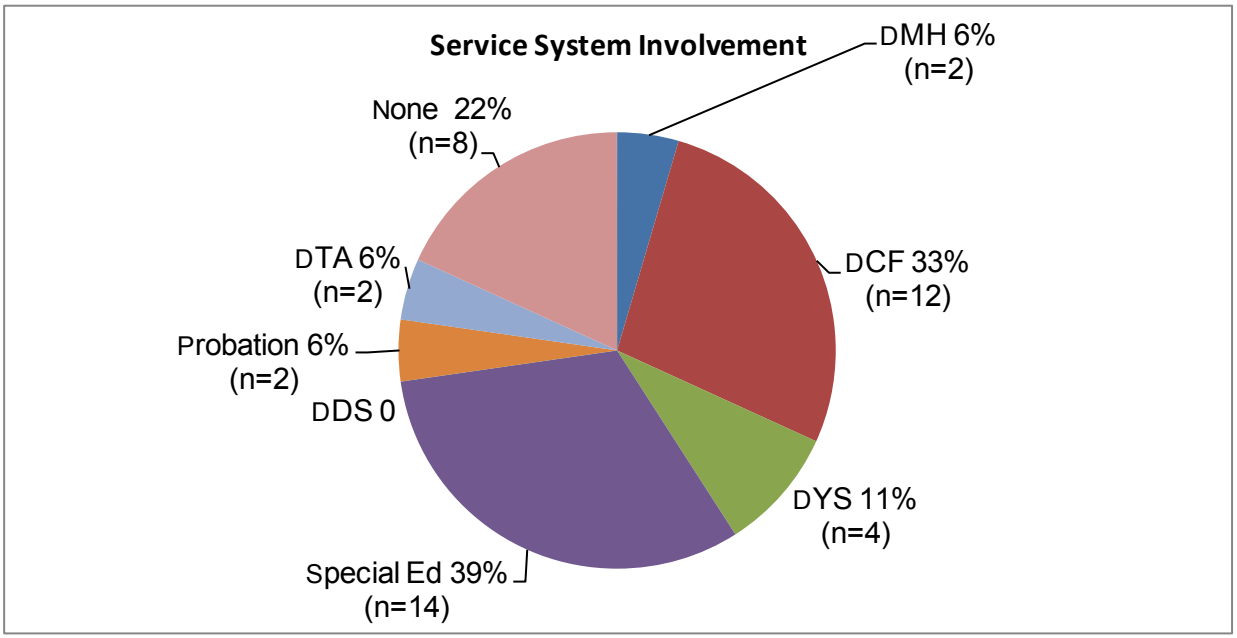
As shown above, children and youth ranged in age from 3 years to 20 years. The overall mean child age for the 36 families was 12.58 years. Almost 64% of the youth were male. Of the sample, 47% was Latino/Hispanic and 19% was White, with African American/Black and Multi- as their primary language, and Spanish was identified as being the primary language in 19% of families. The primary caregiver interviewed was overwhelmingly female occurring in 97% of the families.

FIGURE 6: LENGTH OF TREATMENT



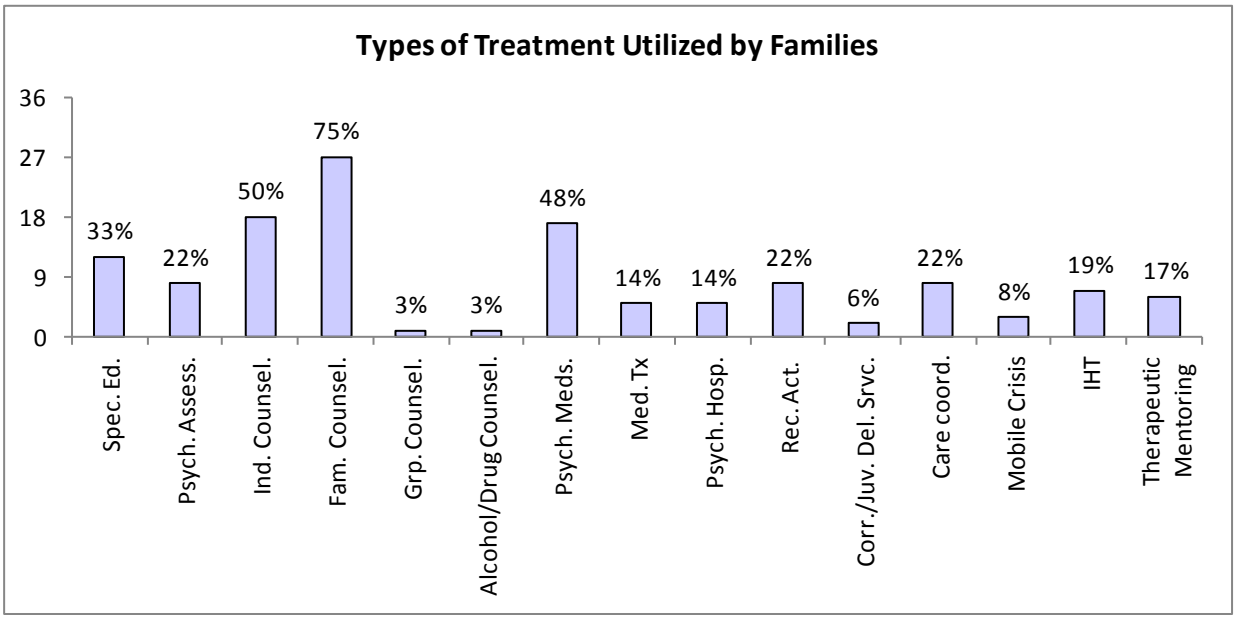
At the time of the review the majority of youth, 56%, had been receiving IHT services between 5-12 months. Nineteen percent of the families had been in IHT 1-4 months while almost 17% had been in treatment for 13-19 months. Eight percent (n =3) families had been in treatment for 20 or more months. It should be noted here that the majority of youth (n = 30) were in active IHT treatment at the time of the review (i.e. they had not yet been discharged). Therefore for most youth the data above reflect only the amount of time the youth had been in treatment at the time of the review. For the six youth who were no longer enrolled in IHT at the time of the review, one had received IHT services between 13-19 months and the other five had participated in IHT between 5-12 months.

FIGURE 7: SERVICE SYSTEM INVOLVEMENT



Seven different child-serving systems and a "None" category were used to capture service system involvement as part of the services profiles of children and youth who were chosen as part of the sample. The SOCPR protocols documented that almost 39% of the youth received special education services, followed closely by DCF (over 33%). No youth received services from DDS. The "None" category accounted for 22% of responses. As it is possible for a youth/family to be involved with more than one service system, the total number of instances of involvement represented in Figure 7 is greater than 36.

FIGURE 8: TREATMENT INTERVENTIONS



The types of treatment children and youth in the sample used were calculated. Fifteen named types of treatment as well as an "Other" category were used to identify service provision. The most utilized service was Family Counseling (75%) followed closely by Individual Counseling (50%) and Psychiatric Medications (almost 48%). Group Counseling and Alcohol and Drug Counseling were the least utilized treatments (3% each). The types of treatment comprising the "Other" category appear in Appendix D. The treatment categories used in the SOCPR protocol for reviewers to select from did not correspond directly to the types of treatment available in Massachusetts, making the data displayed in Figure 8 difficult to interpret. For example, many reviewers selected the "Family Counseling" category to represent that the youth was participating in IHT, while others wrote in IHT to create a unique category. The demographic section of the SOCPR has been modified for future review rounds to help mitigate this problem going forward.

SOCPR Mean Domain Scores

Mean scores were computed for the overall SOCPR score, as well as for each of the four SOCPR domains (Child-Centered Family-Focused, Community-Based, Culturally Competent, and Impact). Each summative question was also examined individually. In general, the mean score for each item of interest was an important statistic to be examined. In addition, the minimum and maximum scores, as well as the standard deviation for each item of interest, were examined. Using these four statistics, an understanding of the range of scores, the average score, as well as an indication of the variability from family to family, could be examined. This section will report on the overall findings, and then report on specific items of interest which demonstrate extreme scores.

Table 6 shows the overall score as well as those for each SOCPR domain for the entire sample of 36 families. SOCPR scores range from a low of 1 to a high of 7. Scores from 1 to 3 represent lower implementation of a SOC approach, and scores from 5 to 7 represent enhanced implementation of SOC principles. A score of 4 indicates a neutral rating — lack of support for or against implementation was present.

For the Boston/Metro Area, SOCPR mean scores ranged from 5.27 to 5.95 with an overall mean score of 5.52. One case (3%) fell into the range from 3 to 4, representing lower SOC implementation, while 35 (97%) of cases fell into the range from 4 to 7 representing higher SOC implementation, seven or 20% fell in the range from 4 to 5, eighteen, or 50% in the 5 to 6 range, and ten, or 28% in the range from 6 to 7. Twenty-eight cases or 78% fell into the top two levels.

The domain of Community-Based was the highest scoring domain followed by Impact, Child-Centered Family-Focused, and finally Culturally Competent. The scores indicate that in the Boston/Metro region, IHT provider agencies included in the sample performed best at including the Community-Based system of care value in service planning and provision.

TABLE 6: BOSTON/METRO REGION SOCPR DOMAIN SCORES

	Min	Max	Mean	Standard Deviation	95% Confidence Interval Lower Limit	Upper Limit
Overall	3.40	6.35	5.52	0.76	5.27	5.78
Domain 1: Child-Centered Family-Focused	2.50	6.75	5.37	1.05	5.02	5.73
Domain 2: Community-Based	4.60	6.90	5.95	0.65	5.73	6.17
Domain 3: Culturally Competent	2.80	6.60	5.27	0.93	4.95	5.58
Domain 4: Impact	3.00	7.00	5.51	0.90	5.20	5.81

Histograms were drawn to illustrate the range of SOCPR scores for the overall case and the four SOCPR domains. These figures are presented below. The data are not normally distributed, but are negatively skewed. This is a result of the ceiling effect because the scores fell in the high end of the scale.

FIGURE 9: OVERALL MEAN SCORES

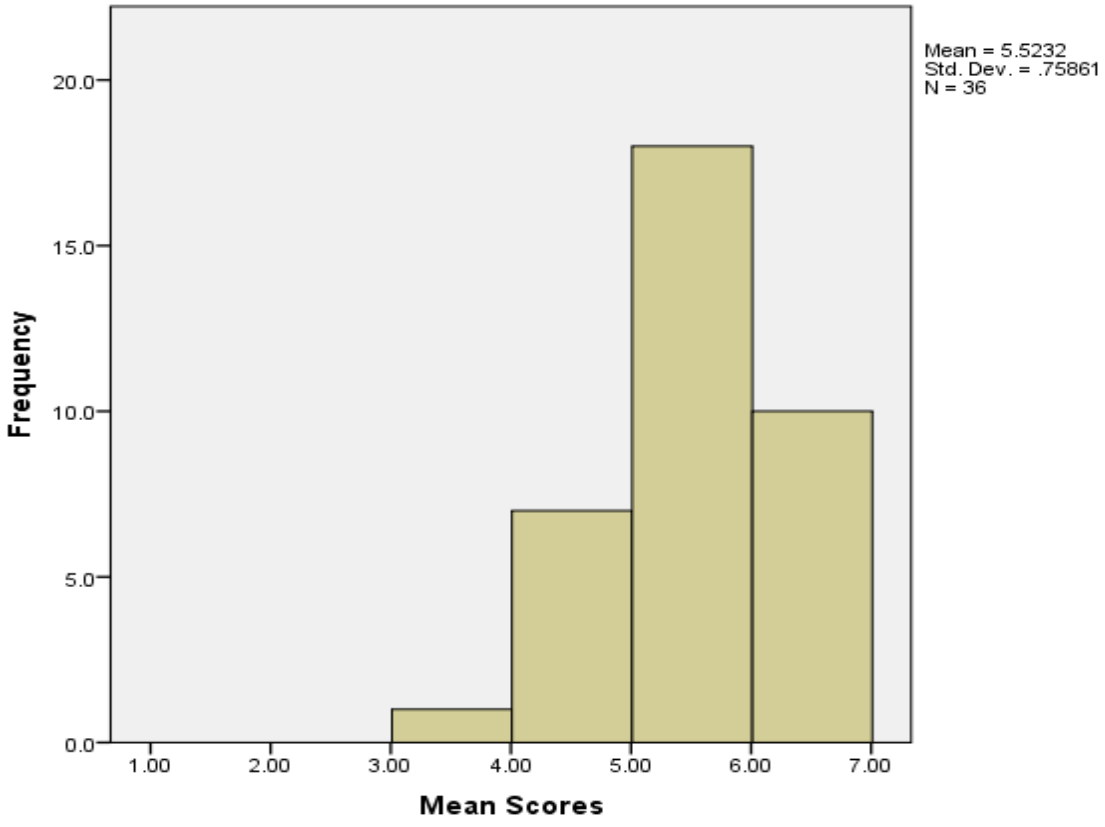


FIGURE 10: CHILD-CENTERED AND FAMILY-FOCUSED MEAN SCORES

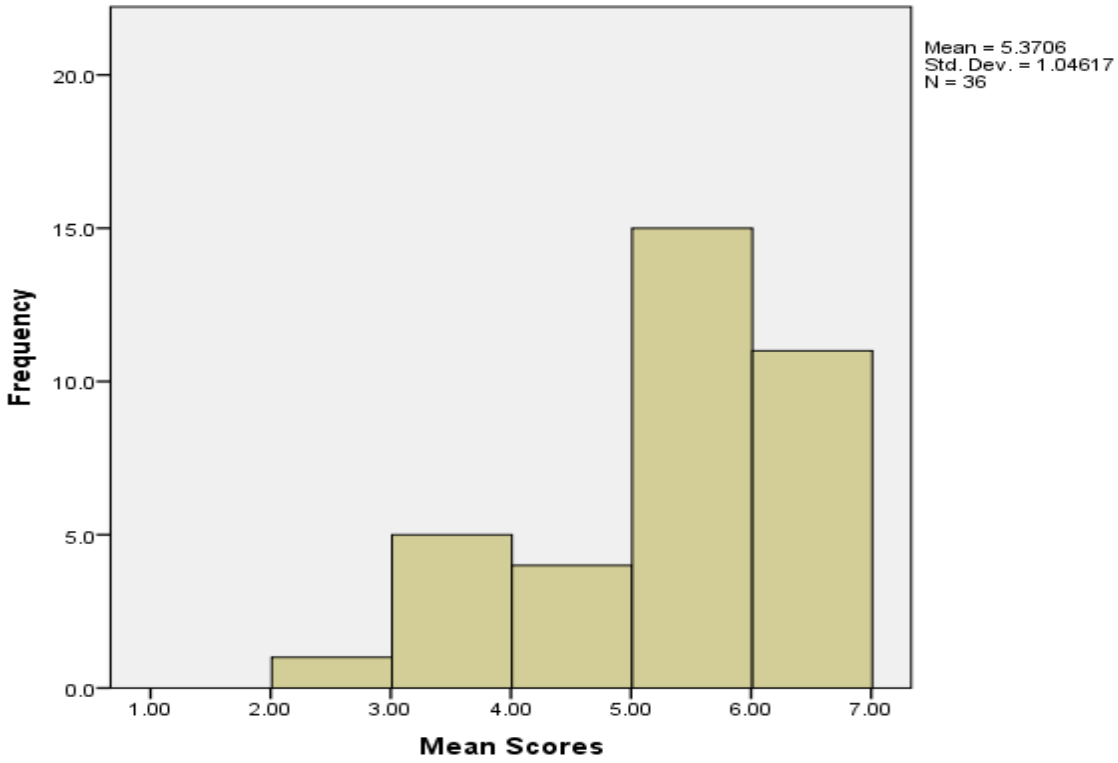


FIGURE 11: COMMUNITY-BASED MEAN SCORES

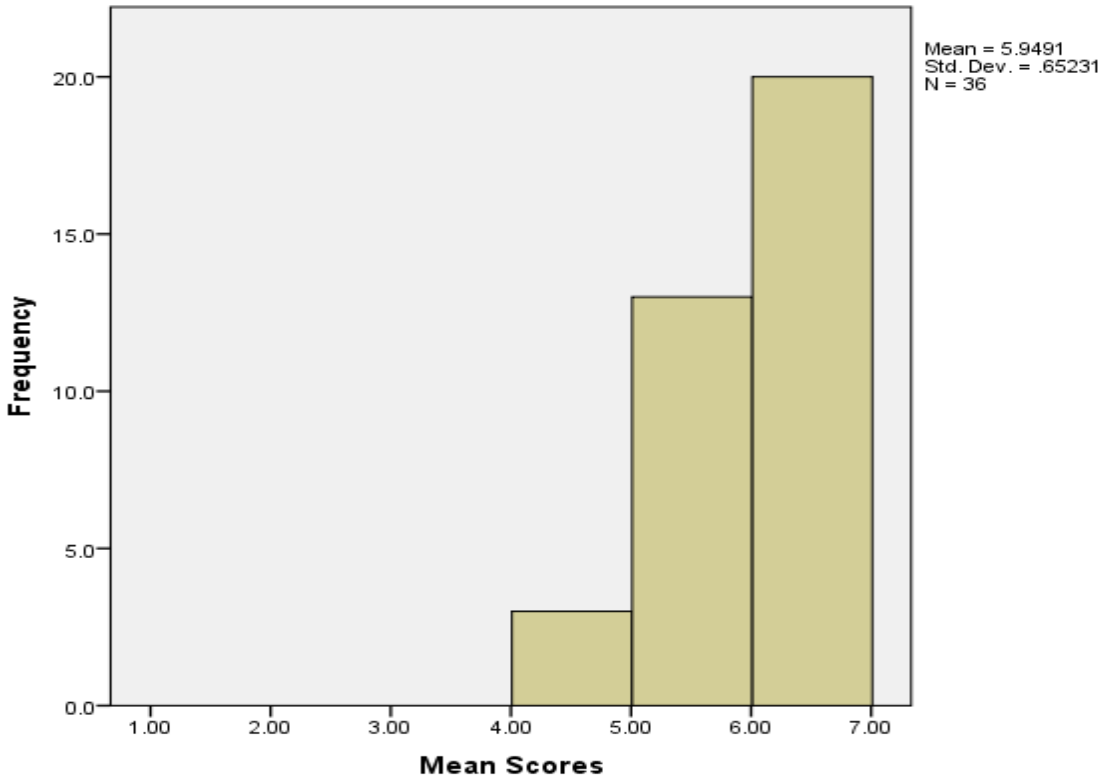


FIGURE 12: CULTURALLY COMPETENT MEAN SCORES

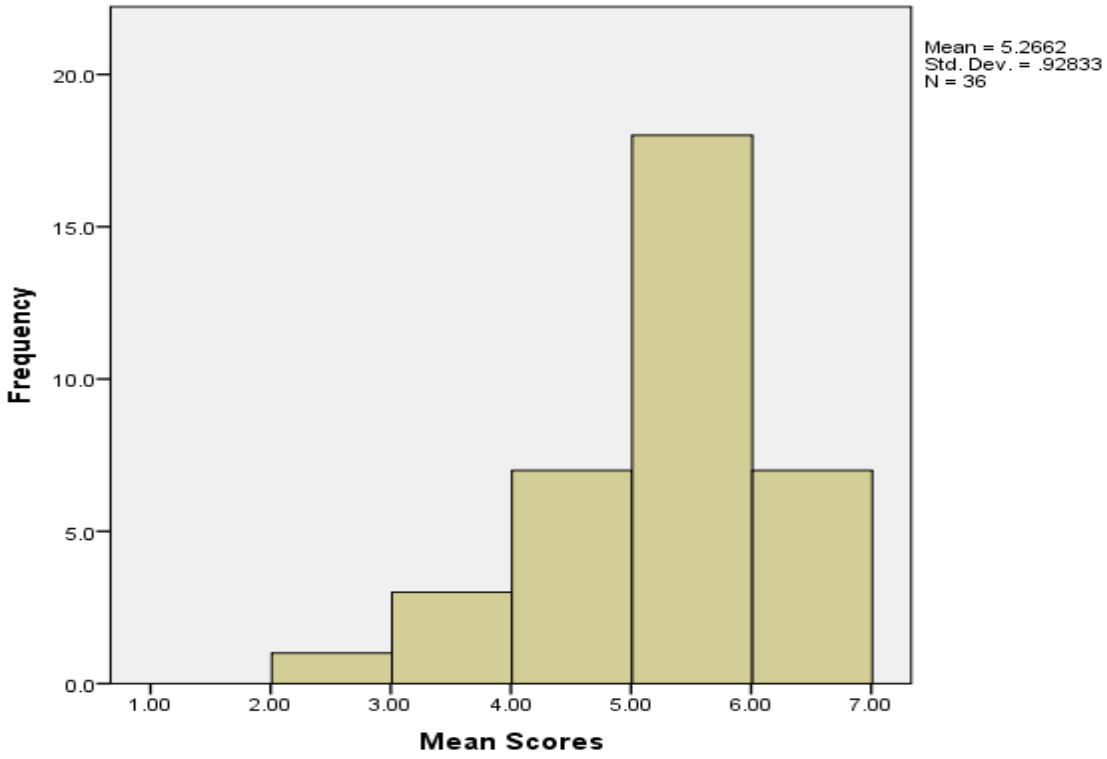
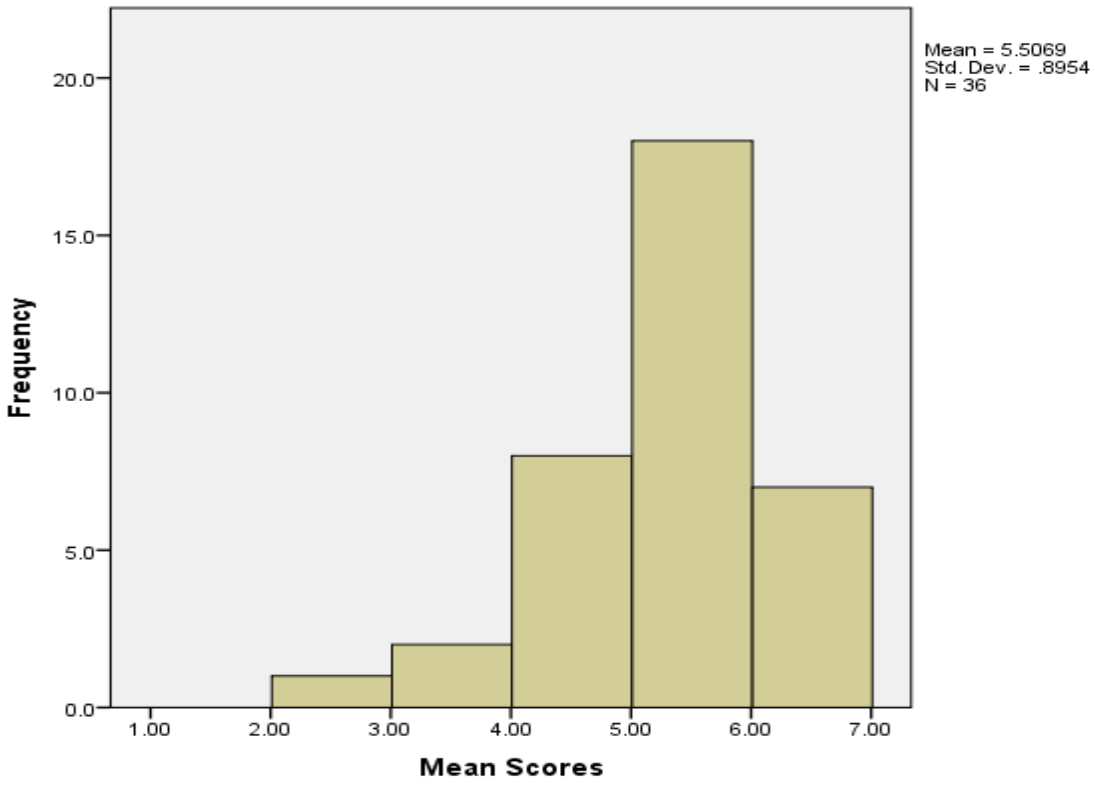


FIGURE 13: IMPACT MEAN SCORES



SOCPR Individual Question Scores

The following data are the mean scores, frequency counts, and percentages of responses for each individual question of the SOCPR based on a sample of 36 families for the Boston/Metro region. Data are presented by the sub-domains and areas within each domain.

Domain 1: Child-Centered and Family-Focused

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

The Child-Centered and Family-Focused domain had a mean score of 5.37, which reflects good implementation of this SOC principle. In general, analysis of descriptive comments provided by SOCPR raters suggests that Metro/Boston IHT providers are delivering services that are child-centered and family-focused.

Sub-domain 1a: Individualized

The *Individualized* sub-domain includes four general areas. The first area focuses on the assessment of the youth and family. Almost 90% of reviewers agreed that a thorough assessment was conducted across life domains. One reviewer commented that, “It was clear that both the therapist and TT&S staff knew this family extremely well and had a good understanding of family dynamics between youth, his caregiver, and his grandparents.” In addition, 83% of reviewers agreed that the needs and strengths of the youth and family were identified in the assessment. One review commented that the IHT team had helped the youth and family identify, “strengths they did not know they had and did not know how to access.”

However a review of the notes written by the reviewers indicated that some assessments were incomplete suggesting that certain areas were not covered in the assessment. Areas noted by reviewers as missing in some cases included: substance use, legal, education, spiritual, medical, and social/recreational. Some reviewers expressed concerns about the overall quality of the assessments. One reviewer noted, “Assessment not comprehensive, areas missing, no integration of information concerns across broad range not addressed.” Another reviewer expressed concern about the assessment commenting that, “Assessment of the overall situation of the family is weak, and has led to a plan which appears unsustainable.” In some cases reviewers noted that while the family reported they felt the assessment was thorough, the reviewer believed that critical areas had been missed.

The second area of focus within the *Individualized* sub-domain is the service plan. In almost 78% of cases (n = 28) reviewers indicated that the service plan was integrated across providers. One reviewer wrote that, “…most all providers were on the same page regarding services.” This item did stand out however has having one of the lower average scores at 4.69. A review of the

qualitative information provided by reviewers offer some insight into this area. Several reviewers suggested that the plan focused only on what was being worked on in IHT and did not include other service provider's goals or activities. One reviewer mentioned that the, "Service plan doesn't reflect the goals/interventions or strategies of other providers." Another reviewer noted that the, "Service plan [was] weak, lacked any integration." Integration of the plan with the school was cited by more than one reviewer as a concern.

Approximately 83% of reviewers agreed that the service plan goals reflected the needs of the youth and family. Comments from reviewers reflective of this included:

- [There was] direct correspondence between needs and goals;
- Goals reflect needs as identified in assessment;
- Needs identified by school, family, addressed in goals. Goals added as service progressed; and
- By all reports, goals are exactly what is needed at this time.

A few reviewers indicated that the goals in the plan did not always address a primary concern or left major areas unaddressed. For example, one reviewer commented that, "Needs were listed, goals reflected main need, [but] nothing about school truancy which is a main issue." Others noted that while the plan accurately captured needs of the youth, critical family issues were not included.

Fifty percent of reviewers found that service plan goals incorporated the strengths of the youth and family. This was an area however that received the lowest average score of all SOCPR items. Many reviewers indicated that while strengths may have been found in the treatment plan or noted in the assessment they were not incorporated into the plan. One reviewer noted that the, "…plan is primarily focused on symptoms." Although SOCPR items do not necessarily address the development of goal statements, per se, this finding highlights the need for providers to more clearly articulate goal statements that reflect youth and family needs and strengths fully and clearly, and to develop strengths-based goals that can encourage active youth and family participation in service planning.

While the item above specifically asked if service plan goals incorporated the strengths of the family, a separate question asked if there was evidence that the provider had "informally" acknowledged and incorporated strengths into the service planning and delivery process. The majority of reviewers (95%) agreed that providers did. As described by one reviewer, "[Strengths] Not explicitly [identified] in goals, but exhibits in practice."

The third area focuses on whether the types of services and supports provided to the youth and family reflect their needs and strengths. Almost 81% of reviewers agreed that they did. Reviewer comments in this area included:

- Absolutely getting the right kind of services. IHT has also helped the family get clothing when needed as well;

- Throughout interviews with both providers it was reported that types of services needed reflect their needs and strengths; and
- Caregiver feels [she is] getting kind of help needed right now and wouldn't change anything.

Other reviewers did mention that the services provided to the family omitted important areas or did not fully address the youth and families needs. A reviewer wrote that, "Services appropriate to some needs regarding family relationships and individual symptom management but leave out many." Another wrote that there was, "Little evidence that the special needs of the youth/ mother were met through the services provided."

The final area within the *Individualized* sub-domain is related to the intensity of the services and supports provided to the youth. The data indicate that in almost 90% of cases reviewers indicated that the intensity of services and supports were reflective of the needs and strengths of the youth and families. Several caregivers reported that the intensity of service delivery was "just right". Another noted that the family felt "in charge" of the intensity of services provided. There were a few comments suggesting that service delivery could have been more intensive. One reviewer wrote that the, "Intensity does not address range of needs, insufficient care coordination, not addressing school issues."

TABLE 7: SUB-DOMAIN 1A INDIVIDUALIZED

SUBDOMAIN: 1a: Individualized	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Area: Assessment/Inventory								
1. A thorough assessment or inventory was conducted across life domains.	5.53	0	2 (5.6)	2 (5.6)	0	7 (19.4)	21 (58.3)	4 (11.1)
2. The needs of the child and family have been identified and prioritized across a full range of life domains.	5.39	0	2 (5.6)	4 (11.1)	0	9 (25.0)	16 (44.4)	5 (13.9)
3. The strengths of the child and family have been identified.	5.33	0	2 (5.6)	4 (11.1)	0	9 (25.0)	16 (44.4)	5 (13.9)
Area: Service Planning								
4. There is a primary service plan that is integrated across providers and agencies.	4.69	2 (5.6)	6 (16.7)	0	0	13 (36.1)	15 (41.7)	0
5. The service plan goals reflect needs of the child and family.	5.19	0	5 (13.9)	1 (2.8)	0	13 (36.1)	10 (27.8)	7 (19.4)
6. The service plan goals incorporate the strengths of the child and family.	4.00	2 (5.6)	6 (16.7)	10 (27.8)	0	8 (22.2)	10 (27.8)	0
7. The service planning and delivery informally acknowledges/considers the	5.61	1 (2.8)	1 (2.8)	0	0	11 (30.6)	17 (47.2)	6 (16.7)

SUBDOMAIN: 1a: Individualized	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
strengths of the child and family.								
Area: Types of Services/Supports								
8. The types of services/supports provided to the child and family reflect their needs and strengths.	5.06	1 (2.8)	4 (11.1)	2 (5.6)	0	11 (30.6)	14 (38.9)	4 (11.1)
Area: Intensity of Services/Supports								
9. The intensity of the services/supports provided to the child and family reflects their needs and strengths.	5.50	0	2 (5.6)	2 (5.6)	0	11 (30.6)	14 (38.9)	7 (19.4)

Sub-domain 1b: Full Participation

Data indicated that youth and families are full participants in the service planning process (almost 89%), and they influenced any updates to the initial plan (over 84%). Reviewers indicated that not only did families actively participate in the planning process (97%), but they also understood the content of their plans (over 94%). With respect to the planning process one caregiver summed up her experience by stating, “We review every three months. Sometimes she'll [the IHT worker] makes suggestions. I sometimes agree, sometimes not. If we don't like the plan, we can change it.” While most reviewer comments suggested that the parent/caregiver and/or youth are actively involved in the planning process and feel “heard” with respect to their concerns, a few expressed a more passive role. One parent commented, "I don’t feel I am influencing, I am [an] aside. I don’t want to get involved more. I am not comfortable influencing more. I respect that they know what to do." Analysis of reviewer comments found that youth, in particular, are participating actively in services and/or service planning meetings, though several youth expressed ambivalence about participating in services and their service plan. There were a few reviewers who noted one member of the family might have participated actively while another did not (i.e. parent participated actively, but youth did not). Other reviewers noted that while service planning meetings were documented early on in the service delivery process, updates to the plan were not adequately documented.

Almost 78% of reviewers agreed that formal providers and informal helpers participate in service planning. Reviewer comments however suggest uneven participation in service planning on the part of providers and caregivers who are working toward reaching common goals. Some IHT providers were more successful than others in including formal providers and/or natural supports in the planning process. While some providers appeared to actively engage and include others in the planning process others did not. Some family members were also reluctant

to involve others, particularly natural supports in the planning process. Comments in this area included:

- No formal providers involved in service planning; no informal supports involved at all;
- [IHT] consults with other clinicians weekly. Have tried to contact PCP with no response;
- Informal providers although actively involved in child and grandmother's lives providing support, they do not participate in planning, however grandmother prefers they not be involved;
- Caregiver reports best friend and sister-in-law are aware of treatment plan and influenced goals though not formally part of meeting;
- Outpatient not involved, school heavily involved; and
- No documentation that hospital or school social worker were involved in IHT service planning.

Greater inclusion of both formal providers and natural supports in the planning process may represent an opportunity for growth and improvement.

TABLE 8: SUB-DOMAIN 1B FULL PARTICIPATION

SUBDOMAIN 1b: Full Participation	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
10. The child and family actively participated in the service planning process (initial plan and updates)	5.53	2 (5.6)	0	2 (5.6)	0	8 (22.2)	17 (47.2)	7 (19.4)
11. The child and family influence the service planning process (initial plan and updates)	5.42	0	2 (5.6)	4 (11.1)	0	7 (19.4)	17 (47.2)	6 (16.7)
12. The child and family understand the content of the service plan.	5.92	1 (2.8)	0	1 (2.8)	0	7 (19.4)	15 (41.7)	12 (33.3)
13. The child and family actively participate in service.	6.14	0	0	1 (2.8)	0	4 (11.1)	19 (52.8)	12 (33.3)
14. The formal providers and informal helpers participate in service planning (initial plan and updates)	4.83	1 (2.8)	3 (8.3)	4 (11.1)	0	16 (44.4)	9 (25.0)	3 (8.3)

Sub-domain 1c: Care Coordination

In the *Care Coordination* sub-domain, almost 90% of reviewers reported that one individual appeared to be responsible for coordinating youth and family services and was doing so successfully. Several reviewers noted they saw evidence in the youth's record that the IHT clinician had been coordinating with other service providers. One caregiver described that the IHT clinician, "…goes to school meetings, helped out when we couldn't get a prescription filled." A reviewer for that same youth noted that the coordination was, "very good" and that the

documentation showed regular calls to the primary care clinician, contact with prescriber, school staff and mentor. For a youth that stepped-down to IHT from ICC, the IHT clinician acknowledged that she had a good foundation to start from and was working with the parent to continue to communicate among all parties involved. Another caregiver described that the IHT clinician and the Therapeutic Training and Support (TT&S) worker shared responsibility for coordinating the youth's care and reported feeling that she is "very much" satisfied with care coordination. She went on to say, "They are two amazing people, before they came into my life it was worse."

There were some comments from reviewers suggesting that coordination could have been better, particularly with the school. An IHT clinician reported that the only time she spoke with the therapeutic mentor assigned to work with the family was, "at staff meeting." A caregiver mentioned that, "I don't think there's any teamwork." One reviewer found there was, "Lots of confusion over who, if anyone, is coordinating planning and service delivery." This reviewer went on to mention that," IHT and TM work together, outpatient therapist works with school. Both IHT and outpatient therapist [are] working on community resources. No one person [is] in charge."

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

- [Caregiver] has good working relationships with other providers and changes the plan as needs arise;
- Plans changed many times in response to fluctuating symptoms and changing wishes of youth. IHT continues to plan for future with young adult.
- Although not fully indicated in documentation, interview reports indicate services are very responsive; and
- A third goal was added when planning for case closure began.

There was some disagreement among reviewers in this area however. In eight of the 36 cases reviewed, reviewers disagreed that services were responsive to the changing needs of the youth and family. One provider commented that the treatment plan, "would probably not be updated before the 90 days". A few reviewers noted they found no evidence in the youth's record that treatment goals had changed or that plans had been updated despite changes in the family's situation or youth's symptoms.

TABLE 9: SUB-DOMAIN 1C CARE COORDINATION

SUBDOMAIN 1c: Care coordination	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
15. There is one person who successfully coordinates the planning and delivery of services	5.50	0	1 (2.8)	3 (8.3)	0	11 (30.6)	15 (41.7)	6 (16.7)

SUBDOMAIN 1c: Care coordination	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
and supports.								
16. Service plan and services are responsive to the emerging and changing needs of the child and family.	5.17	2 (5.6)	2 (5.6)	3 (8.3)	0	9 (25.0)	14 (38.9)	6 (16.7)

Domain 2: Community-Based

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

As indicated earlier, of the four SOCPR domains, the *Community-Based* domain had the highest mean score (M = 5.95). Scores in the sub-domain of *Access to Services* were the highest scoring areas (mid to high 6 range).The sub-domain of *Minimal Restrictiveness* also scored in the high 6 range. These scores indicated that services were accessible to children and families and that their needs were met on their terms. When services and supports were provided to youth, they were provided in the primary language of the family, although providing written documentation in a family's primary language could be improved. These areas represent strengths for the Metro/Boston IHT providers.

Sub-domain 2a: Early Intervention

In the sub-domain of *Early Intervention*, almost 92% of reviewers indicated that the IHT provider quickly assessed and clarified the youth and family's initial concerns and 84% agreed that once the needs were clarified services and supports were initiated. Where reviewers indicated a challenge in this sub-domain, they noted that while IHT services started right away, other services, such as medical and psychological services, for instance, took a longer time to start. Others noted that if "the system" had intervened earlier the youth and family might have benefitted. For example a caregiver and a formal provider both indicated that, "earlier help would have made an impact." While IHT received a, "big thumbs up" for starting services, a youth reported that, "If I had services sooner my grades would have been better." A reviewer suggested that for the youth he reviewed the youth and family could have used services "6 months earlier" but that needs were not identified until the youth ran away from home twice. The reviewer went on to state that the, "IHT agency [was] very responsive once they received [the] referral. Prior to that family was flying under the radar." This finding seems to suggest that while IHT services began quickly, earlier identification and referral to services would have benefitted many of these youth and families.

Some of the discrepancy related to this domain may be the result of reviewer training issues and/or an ambiguity about time parameters within the protocol. Additional guidance for reviewers on rating this item will be sought from USF.

TABLE 10: SUB-DOMAIN 2A EARLY INTERVENTION

SUBDOMAIN 2a: Early Intervention	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
17. As soon as the child and family began experiencing problems, the system clarified the child and family's needs.	5.47	1 (2.8)	0	2 (5.6)	0	10 (27.8)	21 (58.3)	2 (5.6)
18. As soon as the child and family entered the service system, the system responded by offering the appropriate combination of services and supports.	5.36	0	2 (5.6)	4 (11.1)	0	7 (19.4)	19 (52.8)	4 (11.1)

Sub-domain 2b: Access to Services

Three general areas comprise the *Access to Services* sub-domain: whether services were provided at *convenient times*, *locations*, and in the *appropriate language*. Reviewers agreed that services were provided to youth and families in convenient locations (100%) and at times (100%) that families indicated worked for them. One reviewer commented that the caregiver "drove timing of scheduled appointments" and that helpers were able to "work around her [the parent's"] schedule." Another mentioned that the "client and family schedule is always a priority."

All reviewers agreed that verbal communication about services and supports were provided to youth and family in their primary language. Most reviewers agreed that families were provided written communication (97%) in their primary language although one reviewer disagreed. Families that did not speak English received services from bilingual providers; however some reviewers did note the records did not always reflect whether documentation was available to families in their preferred language.

TABLE 11: SUB-DOMAIN 2B ACCESS TO SERVICES

SUBDOMAIN 2b: Access to Services	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Area: Convenient Times								
19. Services are scheduled at convenient times for the child and family.	6.67	0	0	0	0	1 (2.8)	10 (27.8)	25 (69.4)
Area: Convenient Location								
20. Services are provided within or close to the home community.	6.83	0	0	0	0	0	6 (16.7)	30 (83.3)

SUBDOMAIN 2b: Access to Services	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
21. Supports are provided to increase access to service location.*	5.29	0	1 (2.8)	0	0	1 (2.8)	5 (13.9)	7 (19.4)
Area: Appropriate Language								
22. Service providers verbally communicate in the primary language of the child/family.	6.78	0	0	0	0	1 (2.8)	6 (16.7)	29 (80.6)
23. Written documentation regarding services/service planning is in the primary language of child/family.	6.44	1 (2.8)	0	0	0	4 (11.1)	6 (16.7)	25 (69.4)

*NA:=29; Respondents did not need to answer question 21 if they responded "Agree Very Much" (+3) to question 20.

Sub-domain 2c: Minimal Restrictiveness

Reviewers indicated that services were provided in an environment that families found comfortable (100%) and that was appropriate 97% of the time. In two instances where reviewers provided additional information within the narrative accompanying the rating for *Minimal Restrictiveness* items, reviewers noted that a primary caregiver or a youth did not feel comfortable receiving services in a school-based setting. These scores indicated that services were accessible to children and families and that their needs were met on their terms. These areas represented strengths for the Metro/Boston providers.

TABLE 12: SUB-DOMAIN 2C MINIMAL RESTRICTIVENESS

SUBDOMAIN 2c: Minimal Restrictiveness	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
24. Services are provided in a comfortable environment.	6.72	0	0	0	0	0	10 (27.8)	26 (72.2)
25. Services are provided in the least restrictive and most appropriate environment.	6.56	0	1 (2.8)	0	0	2 (5.6)	7 (19.4)	26 (72.2)

Sub-domain 2d: Integration and Coordination

The *Integration and Coordination* sub-domain data showed that the majority (78%) agreed there was on-going two way communication among and between all team members. In general, reviewers noted that clinical documentation and key interviews reflected communication between service system representatives or providers and family members. Comments reflective of this included:

- IHT maintains communication with other providers, including DCF, school, mentor and PCP.
- Yes, in spite of weak school services, IHT and TM both in communication with school, including principal.
- One parent noted, "We were all on the same page. I would give a 10 if I could."
- Clearly there is ongoing 2-way communication between behavioral health providers, caregiver and youth as evidenced by progress notes and service plan documents.
- Caregiver reports all providers and supports are working together via email, text, most face to face meetings, she is very much satisfied.

Challenges with communication were reported in several instances however, with schools and primary care clinicians identified as being particularly difficult to correspond with.

The data showed that 81% of reviewers agreed that there was a smooth and seamless process for linking the youth and family with additional services when necessary. This question however was one where the mean score fell slightly below five. Several reviewers identified challenges with helping families connect with local community service or resources. Locating and gaining access to housing services and supports were noted by more than one reviewer as a difficulty. Gaining access to appropriate school supports and services in a timely way were also mentioned as a challenge.

TABLE 13: SUB-DOMAIN 2D INTEGRATION AND COORDINATION

SUBDOMAIN 2d: Integration and Coordination	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
26. There is ongoing two-way communication among and between all team members, including formal service providers, informal helpers (if desired by the family), and family members including the child.	5.17	1 (2.8)	3 (8.3)	4 (11.1)	0	7 (19.4)	15 (41.7)	6 (16.7)
27. There is a smooth and seamless process to link the child and family with additional services if necessary.	4.97	0	5 (13.9)	2 (5.6)	0	13 (36.1)	14 (38.9)	2 (5.6)

Domain 3: Culturally Competent

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

Competent Services are: *Awareness*, *Sensitivity and Responsiveness*, *Agency Culture*, and *Informal Supports.*

Analysis of descriptive comments related to cultural competence identified a key challenge to ensuring that services to youth and families are culturally competent. The main challenge identified in this domain appeared to reflect difficulty on the part of providers with documenting and/or articulating their understanding of how a family's culture shapes decision-making. Another issue identified in this domain was the lack of accompanying explanation for ratings in 14 cases. As noted earlier, ratings without narrative are difficult to substantiate and analyze fully.

Sub-domain 3a: Awareness

The mean scores for the sub-domain of *Awareness* fell into the mid to high 5 range. Over 90% of reviewers indicated that providers recognized youth within the context of their culture and their community, while 89% stated that providers understood that a family's culture influenced their decision making process. Eighty-six percent of reviewers indicated that providers understood their own values and principles and how that might influence how they worked with youth and families. In addition, 89% of reviewers stated that providers were aware that there may be subtle cultural characteristics present between themselves and the families with whom they worked.

Reviewers assessing for *Awareness* noted that providers generally seemed to understand the culture and community of the youth and family, although some did note that this understanding was not often documented within the record. Reviewers did note that, during interviews, providers were able to articulate their understanding of the youth and families that they served within the context of the neighborhoods or communities in which they live. Reviewers also generally reported that providers were aware of "family culture", although many did not provide evidence of how providers understood a family's culture to influence their overall decision-making. This finding could reflect a lack of documentation or articulation of how family culture affects family decision-making, but it can also be reflective of insufficient evidence provided by raters. Raters generally identified understanding on the part of providers with regard to their own respective cultures and the impact of a provider's culture on the delivery of services, and awareness as to the dynamics inherent in working with families whose culture differs from the provider's.

TABLE 14: SUB-DOMAIN 3A AWARENESS

SUBDOMAIN 3a: Awareness	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Area: Awareness of Child/Family Culture								
28. Service providers recognize that the child must be viewed within the context of their own culture group and their neighborhood and community	5.75	0	1 (2.8)	2 (5.6)	0	7 (19.4)	18 (50.0)	8 (22.2)
29. Service providers know about the family's concepts of health and family.	5.39	0	0	6 (16.7)	0	8 (22.2)	18 (50.0)	4 (11.1)
30. Service providers recognize that the family's culture, values, beliefs and lifestyle influence the family's decision-making process.	5.44	0	1 (2.8)	3 (8.3)	1 (2.8)	9 (25.0)	18 (50.0)	4 (11.1)
Area: Awareness of Providers' Culture								
31. Service providers are aware of their own culture, values, beliefs & lifestyles and how these influence the way they interact with the child and family.	5.53	0	0	4 (11.1)	1 (2.8)	8 (22.2)	18 (50.0)	5 (13.9)
Area: Awareness of Cultural Dynamics								
32. Service providers are aware of the dynamics inherent when working with families whose cultural values, beliefs & lifestyle may be different from or similar to their own.	5.64	0	0	4 (11.1)	0	5 (13.9)	23 (63.9)	4 (11.1)

Sub-domain 3b: Sensitivity and Responsiveness

Scores in the area of *Sensitivity and Responsiveness* showed that 92% of reviewers agreed that services were responsive to the values and beliefs of the youth and families. The data also indicated that providers were able to take their awareness of the cultural beliefs of the families they served and translate these into action steps (86%). However, reviewers commented that records did not appear to clearly document the way in which providers did so.

TABLE 15: SUB-DOMAIN 3B SENSITIVITY AND RESPONSIVENESS

SUBDOMAIN 3b: Sensitivity and Responsiveness	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
33. Service providers translate their awareness of the family's values, beliefs and lifestyle in action.	5.56	0	1 (2.8)	4 (11.1)	0	5 (13.9)	21 (58.3)	5 (13.9)
34. Services are responsive to the child and family's values, beliefs and lifestyle.	5.72	0	1 (2.8)	2 (5.6)	0	5 (13.9)	23 (63.9)	5 (13.9)

Sub-domain 3c: Agency Culture

The *Agency Culture* sub-domain data showed that 80% of reviewers agreed that the IHT provider recognized that a family's participation in service planning and in the decision making process is influenced by their knowledge/understanding of the expectations of the provider.

In assessing the *Agency Culture* sub-domain, reviewers generally reported finding evidence that providers are assisting families in understanding and navigating the service system(s) with which they have interaction. A number of reviewers noted that records included documents explaining agencies and their services, which were signed by the youth's caregiver.

TABLE 16: SUB-DOMAIN 3C AGENCY CULTURE

SUBDOMAIN 3c: Agency Culture	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
35. Service providers recognize that the family's participation in service planning & in the decision making process is impacted by their knowledge/understanding of the expectations of the agencies/programs/provider	5.25	1 (2.8)	0	6 (16.7)	0	6 (16.7)	21 (58.3)	2 (5.6)
36. Service providers assist the child and family in understanding/navigating the agencies they represent.	5.47	0	0	5 (13.9)	0	9 (25.0)	17 (47.2)	5 (13.9)

Sub-domain 3d: Informal Supports

One third of reviewers indicated that service planning and delivery did not include informal sources of support for the child and family. In some cases, reviewers noted that informal supports had been identified and recommended to families, but that family members had declined such offers.

TABLE 17: SUB-DOMAIN 3D INFORMAL SUPPORTS

SUBDOMAIN 3d: Informal Supports	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
37. Service planning and delivery intentionally includes informal sources of support for the child and family.	4.50	3 (8.3)	2 (5.6)	7 (19.4)	0	12 (33.3)	10 (27.8)	2 (5.6)

Domain 4: Impact

The *Impact* domain includes two sub-domains: *Improvement* and *Appropriateness of Services*, which are meant to determine whether services have had a positive impact on the youth and family and if so, whether these services met the child/youth and family's identified needs.

It is important to keep in mind that the majority of youth (n = 30) were still in active treatment at the time of the review. Therefore it would be expected that unresolved issues for many youth remain and that treatment goals may have not yet been realized.

Sub-domain 4a: Improvement

Within the *Impact* domain the *Improvement* sub-domain scored in the mid to high 5 range. Almost 97% of reviewers indicated that services and supports that were provided to both youth and families actually did help their circumstances, although one reviewer disagreed.

In most cases, reviewers noted that multiple team members identified improvement on the part of the youth and family. Reviewers noted improvements in areas such as decreased aggression, compliance with adult directions, better communication, improved grades and behavior at school. One youth described her experience by stating: "Less than six months ago I felt bad. Now I feel kind of happy." A parent summed up her experience by stating: "Sometimes I think where would my baby be without this help? In a bad school? Maybe in jail?" Another parent noted that IHT helped the family work better together and has, "….motivated her to get more accomplished in life." Another respondent was able to report that the youth was "better" but could not articulate what improvements had been made.

In some instances, reviewers noted that family members and providers were not always in complete agreement as to the degree of progress and improvement ("slight" versus "moderate" improvement, for instance) that had been made as a result of services. Other respondents reported that services had helped, "some" and there was evidence of minor progress in the youth's record. Again, as mentioned above the majority of youth (n = 30) were still in active treatment at the time of the review, thus it would be expected that unresolved issues remain and that treatment goals may have not yet been realized.

TABLE 18: SUB-DOMAIN 4A IMPROVEMENT

SUBDOMAIN 4a: Improvement		Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
38. The services/supports provided to the child and family has improved their situation.	CH	5.58	1 (2.8)	0	0	0	13 (36.1)	19 (52.8)	3 (8.3)
	FAM	5.75	1 (2.8)	0	0	0	12 (33.3)	17 (47.2)	6 (16.7)

CH=Child; FAM=Family

Sub-domain 4b: Appropriateness

Eighty-three percent (n = 30) of reviewers indicated that that the services and supports being provided to the *youth* were meeting their needs with slightly more agreeing (86%) that this was the case for the *family*.

One parent reported that the services the youth and family received were, "like the seed that started a big tree with beautiful fruit." Others noted that IHT had helped with coordinating services and supports, which is a critical function of IHT. Several respondents reported to reviewers that the counseling IHT provided had helped address communication issues in the family.

Some respondents indicated unmet needs remained. Two caregivers reported concern that IHT had not addressed, "financial" problems while another noted she would have liked to have seen more action related to connecting with "community activities". Another respondent indicated that IHT was appropriate but that issues related to transition to adulthood was an unmet need. Another reviewer noted that while the family reported satisfaction with the services a major unresolved issue related to school attendance remained unresolved.

TABLE 19: SUB-DOMAIN 4B APPROPRIATENESS

SUBDOMAIN 4B: Appropriateness		Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
39. The services/supports provided to the child and family has appropriately met their needs.	CH	5.31	1 (2.8)	1 (2.8)	3 (8.3)	1 (2.8)	10 (27.8)	15 (41.7)	5 (13.9)
	FAM	5.39	0	0	5 (13.9)	0	11 (30.6)	16 (44.4)	4 (11.1)

CH=Child; FAM=Family

Final Impressions Qualitative Analysis

Reviewers were also asked to complete a brief narrative at the end of each review of their "final impressions to provide additional context for their ratings." The final impression section of the SOCPR specifically asked reviewers to report on strengths observed, weaknesses/challenges, or issues not addressed in other areas of the SOCPR.

Final impressions with regard to strengths and challenges in service delivery were examined and coded separately, and then reviewed to determine correspondence between comments in each section. Although impressions recorded for each case were diverse in their articulation and often, specific to the individual case under review, these were coded into larger categories associated with SOC sub-domains. In order to be considered a trend, at least of half of the review responses had to provide similar information for a given sub-domain area. No one service delivery category was consistently identified by more than half of reviewers; however, there were a few that were identified by 30 to 40 percent of reviewers, especially with regard to service delivery successes. Service delivery categories associated with weakness will also be discussed below, despite the fact that they were identified by less than 30 percent of reviewers. So while the discussion of final impressions does not reflect clear trends in the data (i.e. less than half of reviewers mentioning the issue) it can provide practitioners with additional information that explains SOCPR findings.

Reviewers reported some key successes that they noted during the course of SOCPR reviews. About 40 percent of comments related to system of care implementation successes indicate that reviewers felt the IHT provider understood the family's culture and/or context and were therefore able to engage with them effectively, as well as to provide services that families felt produced a positive impact. For example one reviewer noted, "I found the biggest strength to be the formal providers' knowledge of the neighborhood this young man lives in. She knew resources to help, but she also knew the culture from having lived in a similar neighborhood. She also knew where to find the youth when he went missing and she actually would go find him." About 36 percent of reviewers specifically made note of youth and family strengths and resilience that they felt played a great part in generating positive impacts as a result of services. The majority of these responses did not provide comments about the services provided or the service providers, making it difficult to ascertain the degree to which reviewers felt that the service system did a thorough job of incorporating the youth and family as active participants. In two cases, reviewers reported feeling that parent or youth's efforts outweighed those of the lead provider with regard to advocacy for increased or more appropriate services. Three reviewers made comments indicating they felt there was consistent and clear communication between the provider and the family.

Some reviewers also noted key challenges or weaknesses in service delivery identified during the course of SOCPR reviews. Twenty-seven percent of comments in this section indicated that reviewers were not clear on whether the mix and intensity of services provided were appropriate. For instance, one comment questioned whether IHT was warranted for a family that had transportation with access to an outpatient provider within their neighborhood. Other reviewers questioned why youth or families had not received a particular service, therapeutic mentoring or individual therapy, despite clear indications from providers and/or family members that such services were welcome. Another 27 percent of comments indicated that reviewers felt that integration and coordination had not been clearly evident in the respective cases that they reviewed. Examples provided included a lack of communication and coordination with additional providers or service systems. One reviewer commented, "…there did not appear to be a team, just individuals working to help the family." Twenty-five percent of comments indicated that reviewers felt that the goals outlined in treatment plans did not adequately reflect youth and/or

family needs. Twenty-two percent of comments indicated that reviewers felt that case files did not provide adequate documentation to assure that services were delivered according to SOC values and principles. Examples of these concerns, included comments indicating that needs were not adequately documented, that case files did not provide evidence that they had been updated to reflect emerging needs and subsequent service plan changes, and that providers did not always make documents available in the preferred language of families. For example a reviewer commented about a transition age youth: "No assessment or updated plan since 2008, youth no longer in school, graduated a year ago and not reflected in plan or goals, no change in written goals in many years….no work done on helping youth transition into adulthood." Finally, another 22 percent of comments indicated that reviewers felt that the IHT providers were inconsistent in their interactions with youth and/or families over time, reflecting specific concerns about a lack of consistent communication with primary caregivers and a lack of real understanding about youth and/or family needs.

As noted above, the reviewer impressions outlined here do not reflect clear trends in the data, given the small number of comments made in any one specific area. It is hoped, however, that analysis of these impressions provides the system with an initial gauge of service delivery with regard to successes in SOC implementation and with potential challenges that can be addressed with individual provider agencies.

IHT Supplemental Questions Results

In addition to the standard set of questions contained in the SOCPR protocol, nine additional questions were added to the Massachusetts version of the SOCPR. Developed as part of the disengagement criteria for the lawsuit, the additional questions were created to assess if youth with IHT serving as their "clinical hub" are receiving all medically necessary remedial services including appropriate care coordination.[12]

Question 1 inquired about the need for or receipt of multiple services and the need for coordination of those services. More than half of the reviewers indicated the youth did not need a care planning team to coordinate services from the same or multiple providers (54.3%).

Question 2 asked about receiving services from multiple agencies and the need for coordination of services. Again, 66% of reviewers indicated they did not need assistance.

[12] The IHT supplemental questions were completed for 35 of the 36 youth in the sample. Just prior to the review round we learned one of the selected youth was currently enrolled in ICC, thus ICC served as the "clinical hub" for this youth therefore the questions contained in this section were not applicable for this youth. The reviewer for this youth did note however that he believed that IHT alone would have been sufficient to coordinate care for the youth and family.

TABLE 20: NEED FOR COORDINATION

	Response	n (%)
Q1. The youth needs or receives multiple services from the same or multiple providers. AND The youth needs are care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof.	No	19 (54.3)
Q2. The youth needs or receives services from, state agencies, special education, or a combination thereof. AND The youth needs a care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof.	No	23 (65.7)

Question 3 (Table 21) asked if the level of care coordination, in this case IHT, was appropriate. Almost 86% of the reviewers agreed that it was.

TABLE 21: APPROPRIATE LEVEL OF CARE COORDINATION

	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Q3. The youth/family is receiving the level of care coordination his/her situation requires.	1 (2.9)	3 (8.6)	1 (2.9)	0	5 (14.3)	17 (48.6)	8 (22.9)

For question 4 (Table 22), the majority of reviewers (88.6%) indicated that the youth had not been enrolled in ICC previously.

TABLE 22: PRIOR ICC ENROLLMENT

	Response	n (%)
Q4. Has the youth previously been enrolled in ICC?	No	31 (88.6)

Table 23 describes the reasons provided for why ICC ended for the four youth who had been previously enrolled. For those families who had been enrolled, ICC ended because it was put in place to help support the family through transition from residential care but were now receiving IHT, the family decided to end services, or the family had graduated from IHT.

TABLE 23: REASONS FOR ICC DISENROLLMENT

Q4a. If yes, briefly explain why the youth is no longer enrolled.
[Had ICC] briefly after leaving residential, then IHT took over.
Family decided to end.
ICC ended with successful graduation. IHT continues with coordination function.

Question 5 showed that more than half of reviewers (57.1%) indicated that the option of receiving ICC had not been discussed with the family by the IHT team.

TABLE 24: DISCUSSION OF ICC WITH YOUTH/FAMILY

	Response	n (%)
Q5. Has the IHT team ever discussed the option of ICC with the youth/family?	No	20 (57.1)

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

TABLE 25: REASONS FOR NOT DISCUSSING ICC WITH THE FAMILY

Q5a. If no, briefly explain why not.
After assessing, no need [for ICC].
Did not come up.
[IHT team] Didn't feel they needed -- "too many cooks".
Family did not trust in services when they began. Services have been added as the family was ready.
Had ICC during course of IHT.
Hospital had referred family to IHT & ICC simultaneously but family only wanted IHT.
IHT clinician considered; before discussing with family, she discussed with her supervisor and they decided at this time not needed, that TT&S more appropriate.
IHT felt not enough services to require coordination.
IHT sufficient to coordinate with school and probation. Caregiver does not want extended family involvement.
[IHT reported] it does not seem necessary at this point.
Mom reported no one asked her. The IHT reported it was not needed.
IHT provider suggested IHBS, but mother rejected.
[IHT reported} ICC not needed for this family.
Not needed- hardly any outside services.
Previously enrolled in ICC.
Services just right at time. IHT- no, not appropriate, not enough providers in this case, stabilizing family first.
The family has not needed too many services and what they have IHT coordinates.
Youth/family receiving minimal services and no state agency involvement.

If reviewers said yes, reasons included that ICC was discussed but services were still declined because families were overwhelmed by more services or they did not think services were needed; families did not meet criteria for ICC; and families were already receiving IHT; and that ICC adds work to IHT.

TABLE 26: FAMILY REASONS FOR DECLINING ICC

Q5b. If yes, briefly explain below the family's reason for declining ICC.
[IHT reports] Aunt declined because of health issues beginning of April; Aunt says no one has asked.
Declined due to IHT feeling they were not helpful in her experience.
Asked family if needed; youth had enough [services]; IHT could manage
ICC in place first.
ICC was linked with brother at first then youth was linked
[IHT reports] no reason for declining; Family [said] no.
IHT- referral made but mother refused too overwhelming; Mom- didn't rule out FP, [did] not want ICC "too much"
Mother declined. Did not want additional providers working with the family. Felt the reason for referring the family to ICC was not explained to her.
Not seriously explored.
Primary caregiver reported that they [IHT] - "Brought up, but didn't seem needed"
Youth reported - I wouldn't want more services; Mother- No, I thought about a hospital program though"
[Primary caregiver reported] Explained once, thought about it but need to think more about. [IHT reports] Problem with ICC sometimes add work to IHT.

Question 6 asked if the youth needed assistance from their formal provider in working with the schools. Overwhelmingly, reviewers agreed (82.9%) that the youth/family did need assistance in working with the school system.

TABLE 27: NEED FOR COORDINATION WITH SCHOOL

	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Q6. The youth needs providers to coordinate/ collaborate with school personnel.	5 (14.3)	0 (0)	0 (0)	1 (2.9)	5 (14.3)	9 (25.7)	15 (42.9)

Question 7 asked reviewers to indicate if the IHT team was in contact with all the service systems involved with the youth and family. Almost 83% agreed that the IHT team was connecting with the other service systems.

TABLE 28: CONTACT WITH PROVIDERS AND SERVICE SYSTEMS

	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Q7. The IHT is in regular contact with other providers, state agencies and school personnel involved with the youth and family.	1 (2.9)	4 (11.4)	1 (2.9)	0	7 (20.0)	12 (34.3)	10 (28.6)

For question 8 reviewers were asked to indicate if the multiple service systems involved with the youth participate in care planning. Sixty-three percent agreed that the service systems were involved in the planning for youth.

TABLE 29: PARTICIPATION IN PLANNING

	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
Q8. Providers, school personnel or other state agencies involved with the youth participate in care planning.	4 (11.4)	4 (11.4)	5 (14.3)	0	7 (20.0)	12 (34.3)	3 (8.6)

Question 9 asked for information about the other hub dependent services that youth were receiving at the time of the review. Responses indicated that one hub dependent service, Therapeutic Mentoring, was received by almost 25% of the families while the other two hubs were accessed by one family each.

TABLE 30: OTHER HUB DEPENDENT SERVICES

Q9. Indicate the other "hub dependent" services supported by IHT	Response	n (%)
Q9i. Therapeutic Mentoring	Yes	8 (22.9)
Q9ii. Family Support and Training	Yes	1 (2.9)
Q9iii. In-Home Behavioral Services	Yes	1 (2.9)

Discussion

Strengths of the Service System

Overall, the findings from this review reflect that the Metro/Boston IHT providers are delivering care in a manner consistent with system of care principles. Areas that stood out as strengths were:

- Services are being offered at convenient times and in convenient locations for families.
- Appropriate language is being used to communicate with youth and families – both written and verbally.
- Services are provided in environments that are the least restrictive and most comfortable for the youth and family.
- Families are actively participating in services.

As discussed earlier, the domain area of Community-Based is a particular strength for Metro/Boston IHT providers. Within that domain, the system performed particularly well in ensuring that services were delivered at the convenience of the family rather than the provider and in the family's language. This finding is positive as it suggests that the system is moving toward a more family-driven rather than provider-driven system of care. One reviewer noted that a caregiver reported she was, "in [the] driver's seat" when it came to making decisions about services. High scores on items in the sub-domain area of Full-Participation also reflect that Metro/Boston providers are working collaboratively with families and including them as partners in the planning process.

The sub-domain of Minimal Restrictiveness was also an area of strength with mean scores over 6 on both items comprising this sub-domain. In some ways this is unsurprising in that IHT is a service that is delivered in the community and in most instances in the family's home. In the debriefing that followed the June reviews, several reviewers remarked that IHT helped youth, "avoid the hospital" and IHT providers manage some "very complex" families in the community. Developing the home and community-based services array to help youth and families receive services in the least restrictive and most normative environment was one of the primary goals of the *Rosie D.* lawsuit, so this finding is positive.

It is also important to highlight that mean scores on the two sub-domains comprising the Impact domain, Improvement and Appropriateness were above five. For the Improvement sub-domain, 97% of reviewers agreed that the services and supports provided to the youth/family had improved their situation. One caregiver reported that she was," extremely grateful for the services and says one of the biggest impacts for her is that she feels more confident and able to deal with various challenges." For approximately 83% of the youth, reviewers reported that the services and supports provided to the youth/family appropriately met their needs. For five families, reviewers indicated that they did not agree that the services/supports were appropriately meeting the family's needs. This result corresponds closely to the result on the question in the IHT Supplemental section asking if the reviewer agreed that the youth/family was receiving the level of care coordination his/her situation required; 86% of reviewers agreed with this statement. During the debriefing session, while most reviewers agreed that IHT was providing appropriate care coordination, a few reviewers questioned if IHT was indeed the most appropriate service for the youth. A reviewer noted that for one youth the care coordination "could have occurred in outpatient" while several other reviewers felt as if the youth and family could have benefitted from a referral to ICC.

Opportunities for Improvement

Some areas stood out as opportunities to focus future training, supervision and quality improvement efforts. For example, while results showed that providers did well on identifying the strengths of the family, reviewers found they did not consistently incorporate these strengths into the plan for the youth. For approximately 50% of the youth/families reviewers did not agree that strengths were incorporated into the youth's plan. Identifying strengths is an important step but this should not be an end unto itself. Translating the identified strengths into meaningful goals and interventions is a more sophisticated skill that should be an area for training and supervision.

The general area of coordination and collaboration among providers, agencies, and informal supports also presents an opportunity for improvement for IHT providers. Mean scores fell below five on several items including:

- There is a primary service plan that is integrated across providers and agencies (M = 4.69);
- Formal providers and informal helpers participate in service planning (M = 4.83);
- There is a smooth and seamless process to link the child and family with additional services if necessary (M = 4.97); and
- Service planning and delivery intentionally includes informal sources of support for the child and family (M = 4.50).

Qualitative information provided by reviewers also highlights this as an area to improve IHT service delivery. As mentioned earlier approximately 27 percent of comments in the final impressions section of the SOCPR indicated that reviewers felt that integration and coordination had not been clearly evident in the respective cases they reviewed. A comment from a reviewer illustrative of this was that for one youth/family they reviewed the, "IHT defined role [as] very limited to therapy [with] no coordination." Another reviewer reported he observed that the IHT "…has no communication with outside providers, [and] no communication with informal helpers such as godmother who plays large role in his life."

While the results of this analysis are preliminary and should be considered in light of the small sample size, they do suggest that more work is needed to ensure that care for youth in IHT is coordinated across providers, agencies, and informal supports. There has of course been considerable work done in the area of provider and agency collaboration throughout the implementation of CBHI: state agency protocols were developed that detail how state agency personnel should interface with the CBHI services; Community Service Agencies (CSAs) are required to regularly convene local System of Care meetings to promote provider and agency collaboration at the local level; and numerous formal and informal trainings have occurred across the state since the implementation of CBHI to help educate provider and state agency staff persons about the services available for MassHealth enrolled youth with behavioral health challenges. While IHT providers should be working to outreach and engage formal providers and state agency staff in the planning process and helping educate them about the value of engaging in a collaborative planning process, these same individuals must be willing and active participants. They also need support from their organizations and the larger system to do so. The responsibility to participate in the planning process for a youth with behavioral health challenges must be a shared one.

Clearer expectations and guidance for IHT and other behavioral health service providers as well as state agency partners including school personnel regarding service planning participation in IHT could be one possible intervention. For example, while the state agency protocols clearly articulate expectations for state agency personnel as it relates to their participation in the

planning process for youth in ICC, the guidelines are not as clear as it relates to youth for where IHT is serving as the "clinical hub." Similarly for IHT providers, the performance specification is somewhat vague as it relates to the development of the plan stating only that the plan must be, "developed in consultation with other providers." While ICC providers have the benefit of a clearly articulated care coordination model in Wraparound, IHT providers do not have the same clarity regarding how to coordinate care and develop a plan that is coordinated across providers and agencies. Service guidelines for IHT that are currently under development may offer providers some assistance and useful strategies for how to better coordinate care.

Inclusion of natural supports is a challenge for providers across the country. While in ICC there is considerable focus on the identification and incorporation of natural supports in the planning process, the same is not true in IHT. Performance specifications for IHT state that providers are supposed to identify community resources and develop natural supports, yet discussion in the debriefing suggested that both IHT providers and families were often unaware of supports and services that a family could benefit from. Assistance related to housing was mentioned by several reviewers as a particular need for families who were in the process of being evicted or who were living in poor conditions. Providers reportedly had limited understanding of available housing related resources. While IHT providers cannot be expected to solve the wide-ranging and often complex needs of the families they serve, they should be familiar with the services and supports available in the family's community and help connect families with the appropriate resources. Better use of established sources of information on community resources, including the Massachusetts 2-1-1 system and attendance at local SOC meetings could help IHT staff persons make more effective use of local resources to help the youth and families they serve. IHT providers should be challenged to come up with their own creative solutions for how to raise awareness of their staff regarding the resources in their community.

One additional area that should be considered for improvement was related to the IHT Supplemental Questions. Specifically, results indicated that for 57% of the youth in the sample the IHT team had not discussed the option of ICC with the youth/family. One of the core values of the CBHI is family-driven care. Families need to have the appropriate information about the services that their child(ren) are eligible for in order to make informed decisions about the services and supports that may help their child and family. Results of this SOCPR review suggested that the majority of IHT providers did not discuss the option of ICC with the family indicating that they believed as if the family did not require it. While some of the youth might not have met the medical necessity criteria for ICC, others may have. For youth where an ICC referral may be appropriate, providers should be discussing the option with the family and making these decisions collaboratively.

Recommendations

Several recommendations emerged as a result of this review that should be considered as opportunities to improve and refine practice. These include:

- The types and mix of services for each family should be child-centered and family-focused. Services and supports should be adapted to meet the identified needs of the

youth and family instead of expecting families to conform to preexisting service configurations.

- Improve service planning and provision by making sure that both formal providers and informal supports are communicating with each other. Make sure the process for connecting children and families with additional resources is seamless.

- Strengths of the youth and family should be considered when developing treatment planning goals and designing appropriate interventions.

- Assist families in identifying informal supports (both people and services) in the early stages of service planning development. This will help them establish a solid support network for understanding and navigating the system.

Conclusion

Overall the results of the Metro/Boston SOCPR reviews suggested that IHT providers are delivering care in a way that adheres to important SOC and CBHI values with overall domain scores falling in the “enhanced implementation” range. The results also suggested several individual items such as incorporating strengths into planning and coordinating care across providers and agencies that present opportunities for improvement. These findings must be considered in light of the small sample size and the fact that this round served as a training round for the reviewers.

This review played another important role in that it served as a pilot test of the protocol itself and the processes and procedures used for sample selection, informed consent, and scheduling. This information learned about these processes helped inform several changes to the demographic information that will be collected in future rounds. Refinements to the scheduling and sampling procedures are also being made based on feedback from providers and reviewers to help reduce provider and reviewer data collection burden and improve the quality of the information collected.

In addition, this review helped to highlight areas where SOCPR reviewers may need additional training or coaching. Specifically reviewers need to use more descriptive comments thereby ensuring more accurate analysis of ratings. A lack of narrative comments accompanying ratings such as “Agree moderately or very much,” in particular, made it difficult to ascertain why a specific rating was given. It also made it difficult to assess for qualitative information related to patterns or trends in ratings. There were a total of 78 ratings (or 5 percent of responses) that did not include an accompanying narrative to support a particular rating. Additional guidance will be offered to reviewers in the future in order to minimize unsubstantiated ratings and produce more useful qualitative data.

Appendix A:

Consent and Scheduling Webinar

System of Care Practice Review (SOCPR) for CBHI

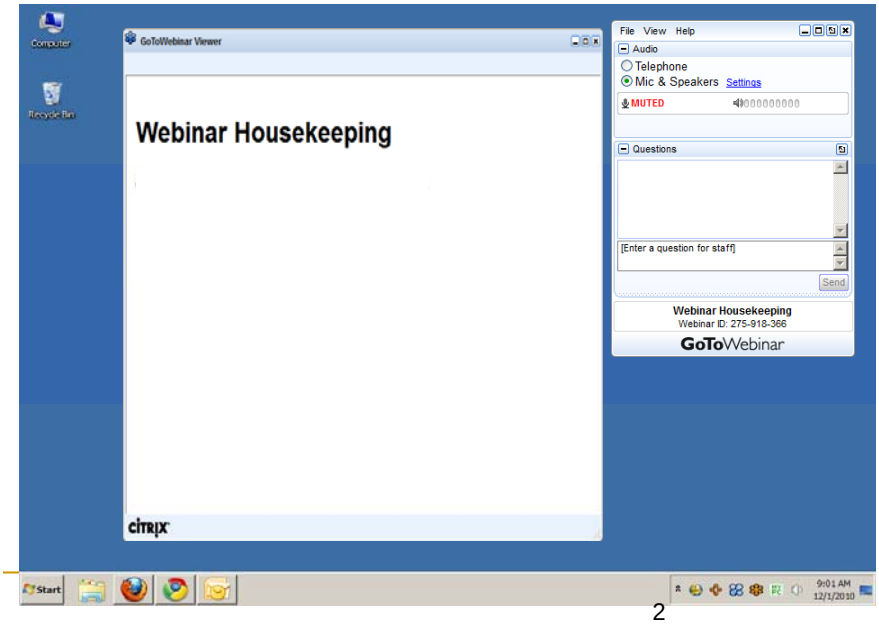
IHT Clinician Webinar on

Consent & Scheduling Procedures

Technical Assistance Collaborative

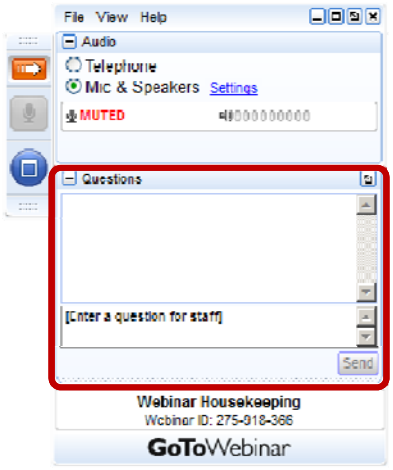
April 29, 2013

GoToWebinar: Attendee Interface



2

GoToWebinar Housekeeping: Time for Questions



Your Participation

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

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

3

Introduction

- Executive Office of Health & Human Services initiating new case review process to learn about care delivery in the MassHealth CBHI services
- Selected the System of Care Practice Review (SOCPR) protocol, developed by the University of South Florida (USF), to guide this process
- The SOCPR replaces the "Community Service Review (CSR)" conducted by the *Rosie D.* Court Monitor over past 2 years
- What is learned through the SOCPR will help us all to improve the quality of CBHI services

4

SOCPR Implementation

- Structured case review process
- Multiple reviewers being trained to conduct week-long reviews of cases, to be completed in 'waves' across the various regions of the state
- Structured interview protocol that includes record reviews & 60-90 minute interviews with: 1) the primary caregiver; 2) the youth, if he/she is 12 or older; 3) the IHT Clinician; and 4) an informal helper/natural support.**

  ***In the event a youth or natural support is not able to be interviewed, another respondent (e.g., Care Coordinator, outpatient therapist, psychiatrist, teacher) may be substituted*
- Technical Assistance Collaborative, Inc. (TAC) procured to assist in managing SOCPR implementation, easing some provider burden

5

June SOCPR Training/Pilot

- 9 Metro/Boston In-Home Therapy (IHT) Providers randomly selected to take part in June pilot:
  - Test run of procedures for family/case selection, obtaining family consent & case contact information
  - Reviewer training from USF on SOCPR protocol
  - Working with providers to schedule & conduct training case reviews using SOCPR protocol
- Following pilot, will work with USF to summarize data, create process for reporting findings & to obtain input from providers on the SOCPR experience
- Refine SOCPR process for full implementation across state beginning in the Fall

6

June Training/Pilot Schedule

Monday, June 3	Tuesday, June 4	Wednesday, June 5	Thursday, June 6	Friday June 7
Reviewer Training	**Reviewer Training/ Record Reviews**	**Case Reviews (2 per provider)**	**Case Reviews (2 per provider)**	**Reviewer Debriefing**
9:30 – 5:00 Reviewer Training w/USF	9:30 – 1:00 Reviewer Training w/USF	Interview w/ IHT clinician *	Interview w/ IHT clinician *	Debriefing for reviewers only (with USF)
	1:30 - 6:00pm Record Reviews* (4 per provider)	Interview w/ caregiver	Interview w/ caregiver	
		Interview w/ youth (if 12 or older)	Interview w/ youth (if 12 or older)	
		Interview w/ natural support	Interview w/ natural support	
June 3 -7 Participating Providers:				
	Providers should plan to arrange space for up to 8 reviewers to review records Tuesday PM, as well as private space for IHT Clinician Interviews on Wednesday & Thursday			

7

June Training/Pilot Schedule

Monday, June 24	Tuesday, June 25	Wednesday, June 26
Case Reviews (2 per provider)	**Case Reviews (2 per provider)**	**Reviewer Debriefing**
AM: Record Reviews*	AM: Record Reviews*	Debriefing for reviewers only (with USF)
Interview w/ IHT clinician *	Interview w/ IHT clinician *	
Interview w/ caregiver	Interview w/ caregiver	
Interview w/ youth (if 12 or older)	Interview w/ youth (if 12 or older)	
Interview w/ natural support	Interview w/ natural support	
June 24-26 Participating Providers:		
	Providers should plan to arrange space for up to 4 reviewers to review records Monday & Tuesday AM, as well as private space for IHT Clinician Interviews.	

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Procedures

- Names of youth (4 per provider) randomly selected for case reviews sent to each provider in secure e-mail
- IHT Clinicians of selected youth responsible to:
  - Describe the SOCPR process & obtain informed consent, authorization(s) to release information from the youth/family
  - **Notify TAC in 1-2 business days about the status of the consent**
  - Complete a form with basic info about the youth & contact information for key informants that may be interviewed
  - Return completed forms to TAC in self-addressed stamped envelope prior to record reviews/interviews taking place
  - Schedule interviews with youth/family & other key informants

9

Obtaining Informed Consent

Three types of consent/assent:

- **1) Primary Caregiver/Parental Consent:**
  - Completed regardless of youth's age
  - 2 copies in packet, hand them one & let them follow along as you read aloud
  - Ask them to sign the ***caregiver consent to participate*** section of both copies indicating they give their consent to participate
  - If the youth is ages 12-17, ask them to also sign the ***parental consent*** section.
  - You need to sign both copies as a witness/program or agency representative.
  - Let caregiver keep one fully signed copy, you keep the other & return to TAC

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Obtaining Informed Consent

- **2) Youth (18 or older) Consent:**
  - Completed only if youth is 18 or older
- **3) Youth (ages 12-17) Assent:**
  - Completed only if youth is 12-17 years old

For both types:

- 2 copies in packet, hand them one & let them follow along as you read aloud
- Ask them to sign both copies indicating they give their consent to participate, or in case of assent, that they understand process
- You also need to sign both copies as a witness/program or agency representative
- Let youth keep one fully signed copy, you keep the other & return to TAC

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Obtaining Informed Consent

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

Age of Youth	Must Have	Also Try to Get
Under 12	Caregiver Consent to Participate	**will not be interviewing youth under 12*
12-17	Caregiver Consent to Participate	-Parental Consent -Youth Assent
18 or older	Youth Consent to Participate	Caregiver Consent to Participate

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Case Info/Contact Form

- Once consent obtained, work with youth/family to complete
- Pre-fill Sections I, II and IV to extent possible
- Make sure info in Sections III and V contains **current contact info** (same for Youth 18 or older in Section I)
- IHT Clinician considered primary mental health provider for this round of the SOCPR case reviews
- Informal helper/natural support – ask who youth/family identifies as fulfilling this role
- Other provider/caregiver – could be a Care Coordinator, therapist, psychiatrist, teacher, etc. (may or may not be interviewed)

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Authorization to Release Info Form

- Complete one for each individual identified in Section V of Case Information/Contact Form
- Forms should be signed by the youth, if 18 or older, or the primary caregiver/parent
- When completing for yourself as the IHT Clinician, be sure to include your agency name – this will provide the necessary authorization to review the youth's case record

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Overall Agency Schedule

Review Teams Assigned: Teams X & Y

Tuesday, June 4 Record Reviews	Wednesday, June 5 Youth/Family Interviews		Thursday, June 6 Youth/Family Interviews	
	Review Team # X: Reviewer Names	**Review Team # Y:** Reviewer Names	***Review Team #X:*** Reviewer Names	**Review Team # Y:** Reviewer Names
	Youth #1: *[initials]* *IHT Clinician*	***Youth #2:*** *[initials]* *IHT Clinician*	***Youth #3:*** *[initials]* *IHT Clinician*	***Youth #4:*** *[initials]* *IHT Clinician*
Record Reviews *[Provider Name Address Phone]* ***1:30 – 6 pm*** *Each team will review 2 youths' records & will need about 2 hours per record (4 hours per team)*	*[To be filled in w/times, names, location/ address, contact info for each once scheduled:]* • *IHT Clinician (approx 1 hour)* • *Primary Caregiver (approx 2 hours)* • *Youth (approx 30-45 mins)* • *Natural Support/ Other (approx 1 hour)*	*[To be filled in w/times, names, location/ address, contact info for each once scheduled:]* • *IHT Clinician (approx 1 hour)* • *Primary Caregiver (approx 2 hours)* • *Youth (approx 30-45 mins)* • *Natural Support/ Other (approx 1 hour)*	*[To be filled in w/times, names, location/ address, contact info for each once scheduled:]* • *IHT Clinician (approx 1 hour)* • *Primary Caregiver (approx 2 hours)* • *Youth (approx 30-45 mins)* • *Natural Support/ Other (approx 1 hour)*	*[To be filled in w/times, names, location/ address, contact info for each once scheduled:]* • *IHT Clinician (approx 1 hour)* • *Primary Caregiver (approx 2 hours)* • *Youth (approx 30-45 mins)* • *Natural Support/ Other (approx 1 hour)*

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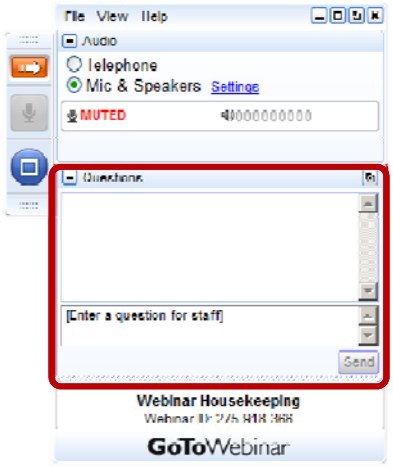
IHT Clinician Schedule Template

Tuesday, June 4 Record Reviews	Wednesday, June 5 Youth/Family Interviews	Thursday, June 6 Youth/Family Interviews
	Review Team # X: Reviewer Names	
	Youth #1: *[initials]*	***Youth #3:*** *[initials]*
Record Reviews ***1:30 – 6 pm*** *[Provider Name Address Phone]* *Team will review both youths' records & will need about 2 hours per record (4 hours total)* *Please ensure records are available for review.*	*[Fill in times, names, location/ address, contact info for each once scheduled:]* • *IHT Clinician (approx 1 hour)* • *Primary Caregiver (approx 2 hours)* • *Youth (approx 30-45 mins)* • *Natural Support/ Other (approx 1 hour)*	*[Fill in times, names, location/ address, contact info for each once scheduled:]* • *IHT Clinician (approx 1 hour)* • *Primary Caregiver (approx 2 hours)* • *Youth (approx 30-45 mins)* • *Natural Support/ Other (approx 1 hour)*

16

Questions??



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Appendix B:

Consent, Assent, and Release of Information Forms

System of Care Practice Review (SOCPR)

YOUTH 18 OR OLDER CONSENT TO PARTICIPATE

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

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

What the SOCPR Process Involves:

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

Confidentiality and Privacy:

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

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

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

Voluntary Participation and Withdrawal:

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

Questions

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

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

Consent

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

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

_____ _____

Youth Signature Date

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

_____ _____

Witness/ Program or Agency Representative Date

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

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

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

What the SOCPR Process Involves:

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

Confidentiality and Privacy:

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

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

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

Voluntary Participation and Withdrawal:

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

Questions

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

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

Caregiver Consent to Participate

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

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

_____ _____

Parent/ Guardian's Signature Date

Parental Consent for Child Ages 12-17

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

_____ _____

Parent/ Guardian's Signature Date

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

_____ _____

Witness/ Program or Agency Representative Date

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

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

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

What is the purpose of the SOCPR?

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

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

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

Do I have to take part in this process?

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

Who will see the information I give?

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

What if I have questions?

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

Assent to Participate

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

_____ _____
Child/Youth Name Date

_____ _____
Witness/Program or Agency Representative Date

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

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

Instructions for Completing:

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

SECTION I

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

_____ (_____/_____/_____) with the SOCPR Team.

Name of youth receiving CBHI services Date of Birth

SECTION II

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

_____

Street Address

_____

City/State/Zip Code Telephone Number

SECTION III

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

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

SECTION IV

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

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

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

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

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

SECTION V

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

_____ _____

Signature Date

Address: _____

Phone number: _____

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

Signature of the person filling out this form: _____

Printed name: _____

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

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

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

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION

Appendix C:

IHT Supplemental Questions

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

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

Question #	Question	Data source	Rating/Response
1	The youth needs or receive multiple services from the same or multiple providers **AND** The youth needs a care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof.	Document review (all pages) Parent/caregiver interview Formal support interview	☐ Yes ☐ No
2	The youth needs or receive services from, state agencies, special education, or a combination thereof. **AND** The youth needs a care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof.	Document review (all pages) Parent/caregiver interview Formal support interview	☐ Yes ☐ No
3	The youth is receiving the level of care coordination his/her situation requires.	Summative Questions Q. 16; p. 84 Q. 26; p. 94 Q. 27 p. 95 *For additional guidance in scoring please refer to the index questions associated with the above questions*	**Disagree** -3 ☐ Disagree very much; -2 ☐ Disagree moderately; -1 ☐ Disagree slightly; 0 ☐ Neutral; +1 ☐ Agree slightly; +2 ☐ Agree moderately; +3 ☐ Agree very much **Agree**
4	Has the youth previously been enrolled in ICC?	Document review Q. 8 & 9; p. 5 and p. 11	☐ Yes ☐ No *If yes, briefly explain below why the youth is no longer enrolled.*
5	Has the IHT team ever discussed the option of ICC with the youth/family?	**This question will need to be explicitly asked during the IHT provider interview**	☐ Yes *If yes, briefly explain below the family's reason for declining ICC.*

Ques-tion #	Question	Data source	Rating/Response
		as well as the family interview.	☐ No *If no, briefly explain below why not.*
6	The youth needs providers to coordinate/collaborate with school personnel?	Document review p. 4	**Disagree** -3 ☐ Disagree very much; -2 ☐ Disagree moderately; -1 ☐ Disagree slightly; 0 Neutral; +1 ☐ Agree slightly; +2 ☐ Agree moderately; +3 ☐ Agree very much **Agree**
7	The IHT is in regular contact with other providers, state agencies and school personnel involved with the youth and family.	Summative Questions Q. 26; p. 94 Q. 27 p. 95 *For additional guidance in scoring please refer to the index questions associated with the above questions*	**Disagree** -3 ☐ Disagree very much; -2 ☐ Disagree moderately; -1 ☐ Disagree slightly; 0 Neutral; +1 ☐ Agree slightly; +2 ☐ Agree moderately; +3 ☐ Agree very much **Agree**
8	Providers, school personnel or other state agencies involved with the youth participate in care planning.	Summative Questions Q. 26; p. 94 Q. 27 p. 95 *For additional guidance in scoring please refer to the index questions associated with the above questions*	**Disagree** -3 ☐ Disagree very much; -2 ☐ Disagree moderately; -1 ☐ Disagree slightly; 0 Neutral; +1 ☐ Agree slightly; +2 ☐ Agree moderately; +3 ☐ Agree very much **Agree**
9	Indicate the other "hub dependent" services supported by the IHT. (check all that apply)	N/A	☐ Therapeutic mentoring ☐ Family support and training ☐ In-home behavioral services ☐ None

Appendix D:

Other Types of Treatment

"Other" Category Types of Treatment
Baby University
Boston Municipal Court
Community Based Acute Treatment
Children's Hospital, BMC Violence Advocacy, City Counselor Yancy's Office, MSPCC
Community Resources, Homeless Shelter, Cambridge Pediatrics
DYAA/ MI
Education/Family Support
Intensive Family and Community Support
Partial Hospital
Psychiatrist Assessment
School Guidance
Special Education Support
Speech Therapy, Behavior Nursing Support in School