System of Care Practice Review Regional Report of Findings: Central

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Executive Summary

SOCPR overview

As part of its ongoing effort to evaluate the quality of care delivered to youth under 21 receiving MassHealth children's behavioral health services, the state selected the System of Care Practice Review (SOCPR) process. The SOCPR, which was developed by the University of South Florida (USF), uses a multiple case study methodology to learn how important System of Care (SOC) values and principles are operationalized at the practice level, where youth and families have direct contact with service providers. This report presents the results from the reviews of Intensive Care Coordination (ICC) and In-Home Therapy (IHT) providers that occurred in January 2014 for providers serving the Central region of the state.

Trained reviewers use the SOCPR protocol to review a youth's treatment record and to guide interviews with service providers, caregivers, and the youth. Reviewers then rate their impressions of the youth's care according to four domain areas that map closely to the core values of a SOC as articulated by Stroul, Blau, and Friedman.[1]

TABLE 1: SOCPR DOMAINS AND SUB-DOMAINS

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

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

Central region review summary

The care of 22 randomly selected youth who received services from ICC or IHT providers in the Central region was reviewed using the SOCPR. Youth between the ages of 5-9 (n = 7) and 10-13 (n = 7) represented 64% of the sample (32% each). Seventy-seven percent (77%) of the youth were male. In terms of race, the majority of youth reported as White, at 59% of the

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[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] Twenty-four (24) youth consented to participate. One family withdrew consent just prior to the review while the other review could not be completed due to scheduling conflicts.

sample. English was identified as the language spoken at home for 91% of the families (n = 20). At the time of the review, the largest number of youth (n = 9) had been receiving services between 7 to 9 months, with five of these youth enrolled in ICC and four youth enrolled in IHT. Eighteen or almost 82% were involved with a service system such as the Department of Mental Health (DMH), the Department of Developmental Services (DDS), or the Department of Children and Families (DCF). The SOCPR protocols documented that 11 of the youth were involved with DCF, followed by special education (n = 9). A smaller number received services from Probation (n = 2) as well as DMH and DDS (n = 1 each). The most frequently utilized service was IHT with 13 youth or 59% participating in this service, followed by ICC (n = 10 or 45%) and Individual Therapy (n = 8 or 36%). Sixty-eight percent of the youth reviewed had more than one reported behavioral health condition.

Results

SOCPR scores can range from a low of 1 to a high of 7. Scores from 1 to 3 represent lower implementation of a System of Care (SOC) approach. A score of 4 suggests a neutral rating, lack of support for or against a SOC approach to implementation. Scores in the 5 range represent good implementation of SOC principles, while those from 6 to 7 represent enhanced implementation of SOC principles. For the Central region, SOCPR mean domain scores ranged from 4.91 to 6.13. The overall mean score of the cases examined was 5.54.

The domain of Community-Based was the highest scoring domain, followed by Culturally Competent, Child-Centered and Family-Focused, and finally, Impact. The scores indicate that in the Central region, provider agencies included in the sample performed best at including the Community-Based SOC value in service planning and provision. This is due in large part to the fact that ICC and IHT are services that are delivered primarily in home and community-based settings and are expected to be offered at times that are convenient for youth and families.

TABLE 2: SOCPR DOMAIN SCORES

	Min	Max	Mean	Standard Deviation	95% CI	
					Lower Limit	Upper Limit
Overall	2.75	6.93	5.54	1.19	5.04	6.04
Domain 1: Child-Centered Family-Focused	2.38	6.94	5.31	1.37	4.74	5.88
Domain 2: Community-Based	3.64	7.00	6.13	0.86	5.77	6.49
Domain 3: Culturally Competent	1.90	6.90	5.55	1.39	4.97	6.13
Domain 4: Impact	1.50	7.00	4.91	1.89	4.12	5.70

As the histogram in Figure 1 shows, forty-one percent (9 of 22 cases) fell into the 6 range representing enhanced SOC implementation, and seven cases (32%) scored in the 5 range, reflecting good implementation. Three cases (13.5%) had means in the 4 range. Scoring the lowest were two cases (9%) with means in the 3 range and one (4.5%) with a mean in the 2 range, demonstrating poor implementation of SOC principles.

Mean = 5.54
SD = 1.1917
N = 22
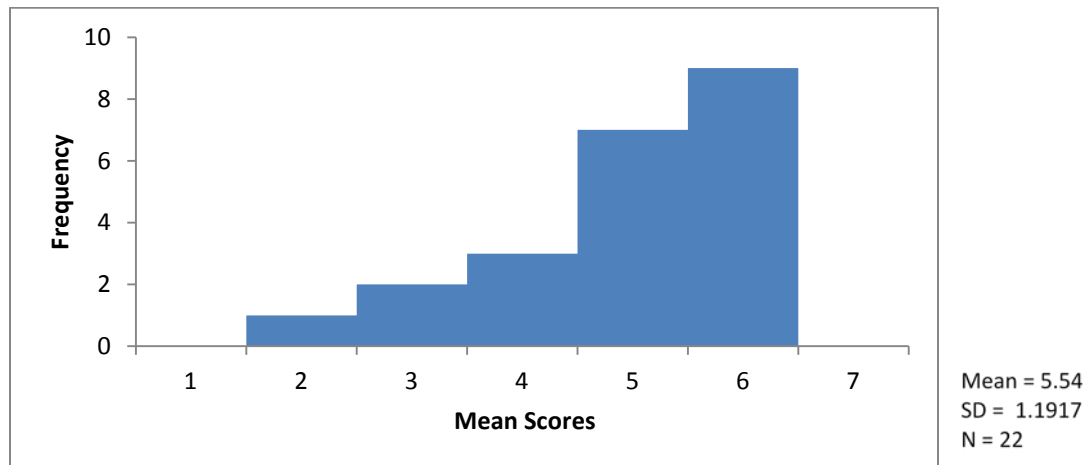
Identified strengths and opportunities for improvement

Overall, the findings from this review show that ICC and IHT providers in the Central region are generally demonstrating a system of care approach to service planning and delivery, performing best at including the Community-Based SOC value in service planning and provision. Areas of particular strength for providers in this region included:

- Services are accessible to children and families and are offered at convenient times, in convenient locations, and in the primary language of the family.
- Services are provided in comfortable environments that are the least restrictive and most appropriate.
- Service providers performed well at assisting children and families with understanding and navigating the agencies they represent.

Although ratings for the majority of youth reviewed fell in the enhanced (n = 9) or good (n = 7) range, findings indicated the greatest opportunities for growth in the following areas:

- Service plans should better incorporate child and family strengths into goals, and both service plans and the planning process should be better integrated across providers and agencies.
- Service planning should be inclusive of both formal and informal providers, with more intentional inclusion of informal and natural supports in both the service planning and delivery processes.
- A smoother and more seamless process is needed for connecting youth and families with additional services and supports.

Further, important differences between IHT and ICC cases reviewed in the Central Region revealed the need for improvements among IHT providers in particular related to conducting more thorough assessments, ensuring types of service and supports provided reflect needs and strengths, early intervention, and integration and care coordination.

About this report

This report, along with the information offered at the individual provider-specific debriefings that were convened by staff from MassHealth and EOHHS following the Central reviews, should be used to help inform quality improvement efforts and guide discussions with staff about the development of provider-specific strategies for building upon areas of strong performance and how to improve service delivery to youth and families. The areas identified for growth could serve as important topics for in-service trainings, be given greater attention and focus in individual and group staff supervision, and/or become areas that are regularly reviewed as part of a provider's quality assurance processes. Recommendations for specific system-level interventions will be made in the final year-end report when trends across regions can be summarized and based upon a larger number of reviews.

Introduction

Overview

This report presents findings from the System of Care Practice Reviews (SOCPR) that occurred in the Central region during January 2014. 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 January 2014 review cycle, the care of 22[3] randomly selected youth who received services from 12 provider sites[4] was reviewed using the SOCPR. Six of these 12 providers were randomly selected IHT providers. The remaining six represented the ICC providers that serve the Central region. Ten of the youth had ICC serving as their care coordination "hub" while 12 had IHT serving in that role.

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

The January 2014 review represented the third time the SOCPR has been used by the state to gather qualitative information about the service planning and delivery process in IHT and the second time it has been used with ICC providers. See Table 4 for a summary of review dates by region. It is expected that by the end of May 2014 adherence to SOC principles by providers in each region of the state will have been reviewed.

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[3] Twenty-four (24) youth consented to participate. One family withdrew consent just prior to the review while the other review could not be completed due to scheduling conflicts.

[4] The twelve provider sites represented ten unique providers.

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

History of qualitative case reviews in Massachusetts

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

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

Methodology

Reviewer training

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

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

An additional five Massachusetts-based reviewers were trained during this review cycle. The January training was conducted by the Technical Assistance Collaborative with each new reviewer partnered with an experienced Massachusetts-based SOCPR reviewer.

Provider selection

The January SOCPR reviewed the care of 24[5] youth from 12 provider sites in the Central region. All six ICC providers located in the Central region were selected to participate. According to a recent Monthly CSA Access Report, the Central region ICC providers were serving approximately 607 youth, ranging from a high of 201 youth to a low of 28, with an average capacity of 101.

Data from the June 2013 Massachusetts Behavioral Health Access (MABHA) report was used to randomly select six IHT providers serving the Central region.[6] According to the report there were 15 IHT providers with 27 sites in the Central region serving 1,246 youth, ranging from 200 to 15, with an average capacity of 46. By comparison, the six selected provider sites reported serving a total of 516 youth or 41% of the youth participating in IHT in the Central region. The capacity of the six selected sites ranged from a high of 200 youth to a low of 36 youth, with an average capacity of 86 youth.

Youth selection

Once the providers were identified, MassHealth requested that selected ICC providers prepare a report including the names of all currently enrolled youth and IHT providers prepare a report including only those youth who were enrolled in IHT without concurrent enrollment in ICC. MassHealth then sent the completed reports to TAC. TAC randomly selected 15 youth per provider, purposely oversampling in case some youth/families declined to participate. This list of 15 youth was then sent back to the program director with a request to supply additional information necessary to proceed with the consent and scheduling process (e.g. primary language of the family, age of youth, etc.). Program directors returned their completed lists to TAC who then randomly selected two youth per site for the providers to approach to obtain consent (see description of consent process below). If a family declined, providers were asked to contact TAC so another youth from the verified list of youth could be selected to participate.

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[5] Twenty-four (24) youth consented to participate. One family withdrew consent just prior to the review while the other review could not be completed due to scheduling conflicts. Therefore, the final number of families reviewed in this region was 22.

[6] The randomly selected IHT provider sites for the early January reviewers were limited to those serving the Worcester area due to training considerations. Four of the 12 IHT provider sites serving Worcester were randomly selected to participate along with the two CSAs serving Worcester. For the second review round in January, two IHT providers serving other areas of Central Massachusetts were randomly selected along with the remaining four CSAs serving the Central region.

This process continued until the target number of two youth from each of the selected organizations was reached for a total of 24 youth, two per provider site.

To reach the goal of 24 reviews[7] for the Central review round, a total of 49 families were asked to participate in the SOCPR. Of those families who either declined or were unable to participate approximately 54% were enrolled in ICC and 48% were enrolled in IHT. The most common reason why families declined to participate related to them feeling anxious about having "strangers" in their homes and being overwhelmed by the prospect of adding an additional task/responsibility to their already busy lives.[8]

TABLE 5: REASONS FOR NOT PARTICIPATING

Reason	N of families
Anxious/overwhelmed	12
Unavailable/out of town	5
Medical reasons	3
Unable to be contacted	3
Other	2
Total	**25**

Consent process

In November 2013, TAC hosted a webinar for the participating providers to educate them about the consent and scheduling processes. A copy of the presentation is located in Appendix A. Following the webinar, IHT clinicians or care coordinators for the participating 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. Providers 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 process

Providers scheduled interviews with the following key informants: 1) the parent/caregiver; 2) the youth if 12 or older; 3) the IHT clinician or care coordinator; and 4) a second formal provider who was familiar with the care provided to the youth (e.g. family partner, DCF worker, outpatient therapist, etc.). Providers scheduled a minimum of three interviews for each youth with a preference for four. If the youth was under 12 the provider worked with the youth/family to select

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[7] Twenty-four (24) youth consented to participate. One family withdrew consent just prior to the review while the other review could not be completed due to scheduling conflicts.

[8] It is important to keep in mind that providers were seeking consent for this January review during the holiday season which could have impacted the number of families who declined due to feeling overwhelmed.

an alternate provider who was familiar with the care delivery and planning process to participate in an interview. A review of the youth's record at the provider agency preceded the interviews. It is important to note that for an SOCPR administration to be considered valid a minimum of three data points (the record review and two interviews) are necessary.

SOCPR description

The SOCPR collects and analyzes information regarding the process of service delivery to document the service experiences of youth and their families, and then provides feedback and recommendations for improvement to the system. The process yields thorough, in-depth descriptions that reveal and explain the complex service environment experienced by youth and their families. Feedback consists of specific recommendations that can be incorporated into staff training, supervision, and coaching, and may also be aggregated across cases at the regional or system level to identify strengths and areas in need of improvement within the system of care. In this manner, the SOCPR provides a measure of how well the overall system is meeting the needs of youth and their families relative to system of care values and principles.

The reliability of the SOCPR has been evaluated, and high inter-rater reliability has been reported in its use.[9] 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.[10] 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[11] found that the SOCPR ratings were associated with child-level outcome measures. In their comparison study, Stephens and colleagues discovered that youth who received services in systems that functioned in a manner consistent with system of care values and principles compared with traditional services had significant reductions in symptomatology and impairment one year after entry into services, whereas youth in organizations that did not use system of care values demonstrated less positive change.

SOCPR method

The SOCPR uses a case study methodology informed by caregivers, youth, formal providers, and extant documents related to service planning and provision. The SOCPR relies on data gathered from interviews with multiple informants, as well as through a review of the youth's record. Document reviews precede interviews and provide the reviewer with important contextual

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[9]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

[10] Ibid.

[11] 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.

information about the youth and family's treatment history and current treatment and planning processes. The unit of analysis is the family, with each family representing a test of the extent to which the system of care is implementing its services in accordance with system of care values and principles.

The interviews are based on a set of questions intended to obtain the youth, caregiver, and service provider's perceptions of the service delivery process. Questions related to accessibility, convenience, relevance, satisfaction, cultural competence, and perceived effectiveness are included. These questions are open-ended and designed to elicit both descriptive and explanatory information that might not be found through the record review. The questions provide the reviewer with the opportunity to obtain information about the everyday service experiences of 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 four sub-domains: a) Early Intervention, b) Access to Services, c) Minimal Restrictiveness, and d) Integration and Coordination.

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

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

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

IHT supplemental questions

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

Organization of the SOCPR

The SOCPR is organized into four major sections.

Section 1:
This section includes demographic information and a snapshot of the child's current array of services.

Section 2:
Organizes the record review and comprises the Case History Summary and the Current Service/Treatment Plan; the Case History Summary facilitates reviewers recording key elements from the history. It also provides information about all of the service systems with which the child and family are involved (e.g., special education, mental health, juvenile justice, child welfare). It summarizes major life events, persons involved in the child's history and current life, outcomes of interventions, and the child's present status. Review of the treatment or care plan provides information about the types and intensity of the services received, integration and coordination, strengths identification, and family participation. The Document Review is completed prior to any interview so that the information gathered through the documents can inform and strengthen the interviews.

Section 3:
Consists of the interview questions organized by the type of informant (primary caregiver, youth, formal service provider); the interviews are designed to gather information about each of the four identified domains (Child-Centered and Family-Focused, Community-Based, Culturally Competent, and Impact). Questions for each of the four domains are divided into sub-domains that define the domain in further detail. Questions in each of the sub-domains are designed to indicate the extent to which core system of care values guide practice. Data are gathered through a combination of closed-ended and more open-ended questions. The open-ended questioning provides an opportunity for the reviewer to probe issues related to specific questions so that answers are as complete as possible. In addition, direct quotes from respondents are recorded whenever appropriate and possible.

Section 4:

Reviewers use this section to summarize and integrate the information collected in the other three sections of the SOCPR. The Summative Questions call for the reviewer to provide a rating for a statement associated with SOC core values at the level of direct practice. Reviewers rate each Summative Question on a scale from 1 (disagree very much) to 7 (agree very much) (see Table 6). SOCPR scores can range from a low of 1 to a high of 7. Scores from 1 to 3 represent lower implementation of a SOC approach. A score of 4 indicates a neutral rating, lack of support for or against implementation. Scores in the 5 range represent good implementation of SOC principles, while those from 6 to 7 represent enhanced implementation of SOC principles.

TABLE 6: 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

For the Central region review, Massachusetts elected to make a change to how reviewers organized their qualitative information in Section 4. As previously discussed, reviewers were asked to provide a narrative summary of strengths and challenges for groups of questions organized by area (e.g. assessment, intensity of services, service planning) or sub-domain (e.g. full participation, care coordination, early intervention, etc.) rather than for each individual question. This was done in order to help reviewers organize their thinking related to areas of interest and helped to align the qualitative data analysis more closely with quantitative data analysis. See Appendix D for how the Summative Questions were organized by area or sub-domain.

Quantitative data analysis

Mean scores were computed for the overall SOCPR score, as well as for each of the four SOCPR domains (Child-Centered and Family-Focused, Community-Based, Culturally Competent, and Impact). In addition, mean scores were computed for those sub-domains contained within the domains. Finally, each summative question was examined individually. In general, the mean score for each item of interest was an important statistic to be examined. In addition, the minimum and maximum scores, as well as the standard deviation for each item of interest, were examined.

Qualitative data analysis

As previously noted, this round of reviews required narrative summaries of practice strengths and challenges for groups of questions organized by area (e.g. assessment, intensity of services, service planning) or sub-domain (e.g. full participation, care coordination, early intervention, etc.) rather than for each individual question.

Evaluation team members first reviewed the data without coding, allowing them to immerse themselves in the data to allow for comprehension of the "big picture," promoting understanding of the scope and context of the region under review. Once data had been reviewed and

prepared for analysis (i.e. saved as Excel documents), the narrative comments were examined and coded for key themes.

Evaluation team members discussed and reconciled any differences regarding themes/trends to reach consensus. The quantitative ratings for each item were also considered in conjunction with corresponding narrative summary and any identified themes/trends to determine a general assessment for each domain.

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.

Results

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

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

Demographics

Twenty-two youth participated in the Central SOCPR review. Ten of the youth had ICC serving as their care coordination "hub" while 12 had IHT serving in that role.[12] A summary of the demographic characteristics of these youth are presented in the figures below.

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[12] The original sample included two additional youth who were enrolled in ICC but these reviews did not occur for the reasons stated earlier in this report.

Age of youth
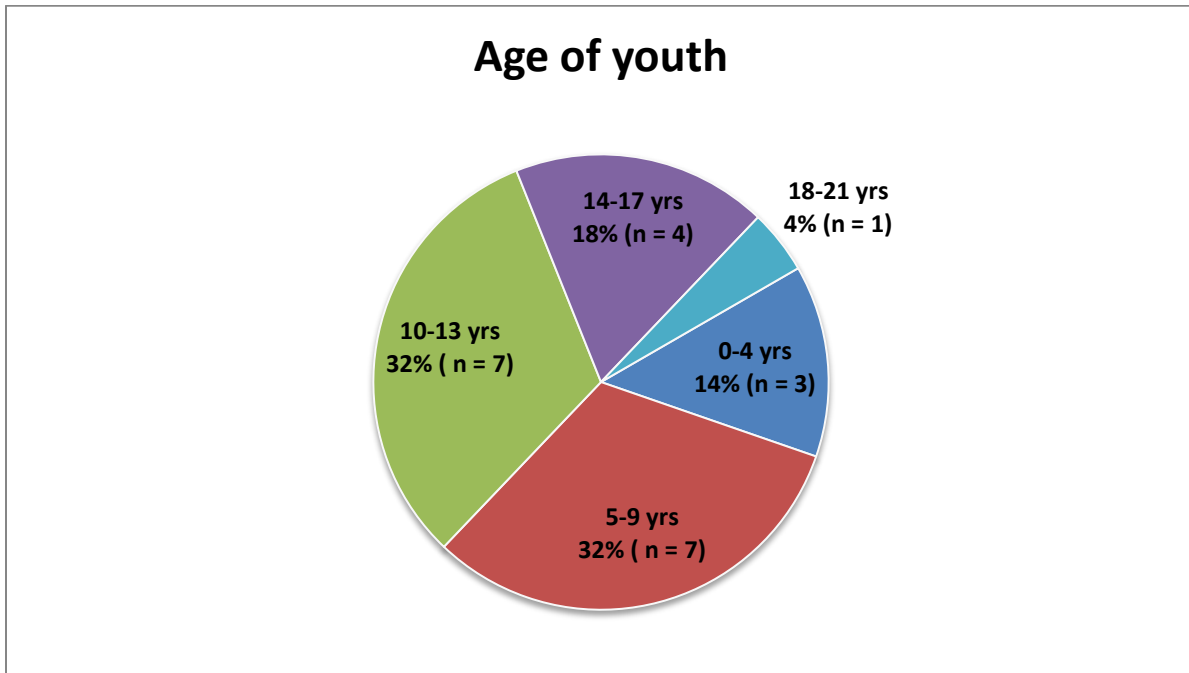
Gender

Race

Hispanic 27% (n = 6)

Bi-racial 14% (n = 3)

White 59% (n = 13)

Language spoken at home

American Sign Language 4.5% (n = 1)

Spanish 4.5% (n = 1)

English 91% (n = 20)
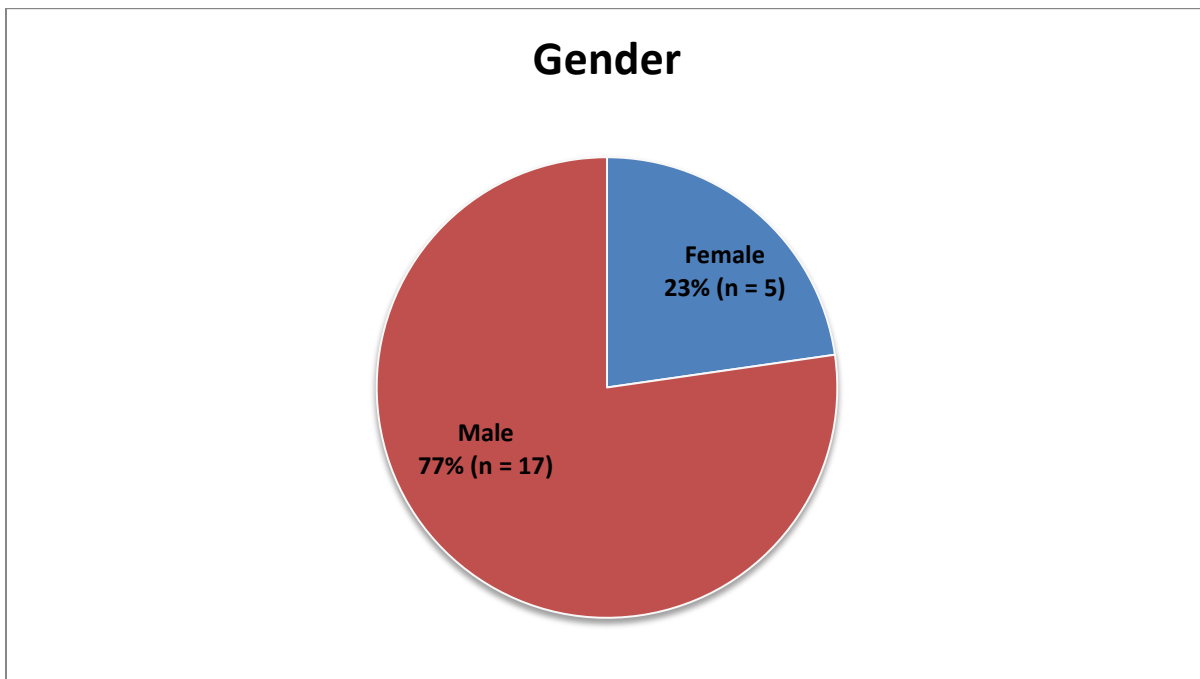
As shown above, youth between the ages of 5-9 (n = 7) and 10-13 (n = 7) each represented 32% of the sample, followed by youth between the ages of 14-17 (n = 4) at 18%, then youth ages 0-4 (n = 3) at 14%; only one youth in the sample was between the ages of 18 and 21. Seventy-seven percent (77%) of the youth were male. In terms of race, the majority of youth

were White (59%), followed by Hispanic at 27%. Three youth (14%) were Bi-racial. English was identified as the language spoken at home for 91% of the families (n = 20).
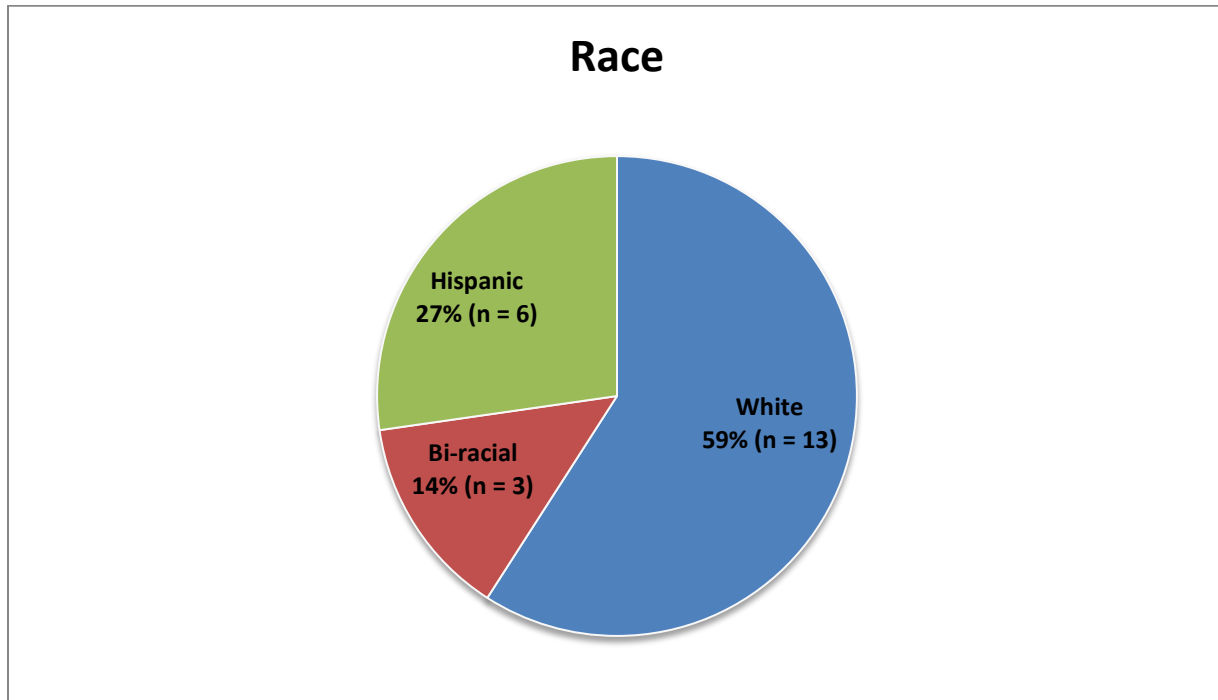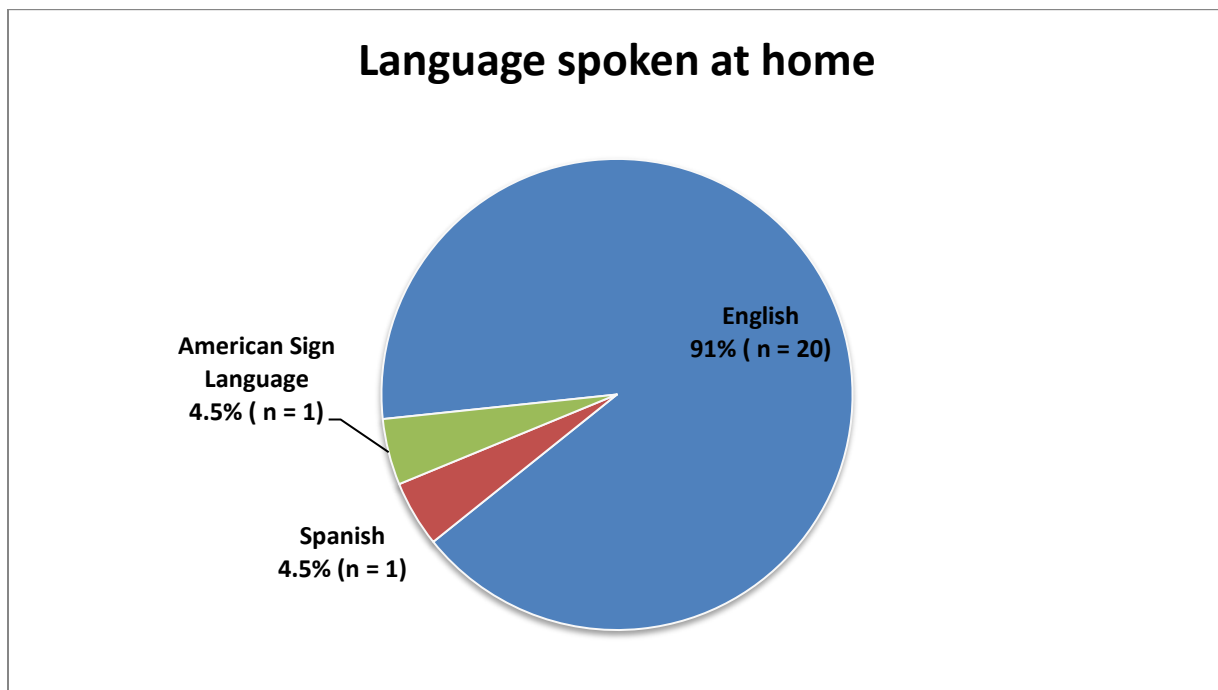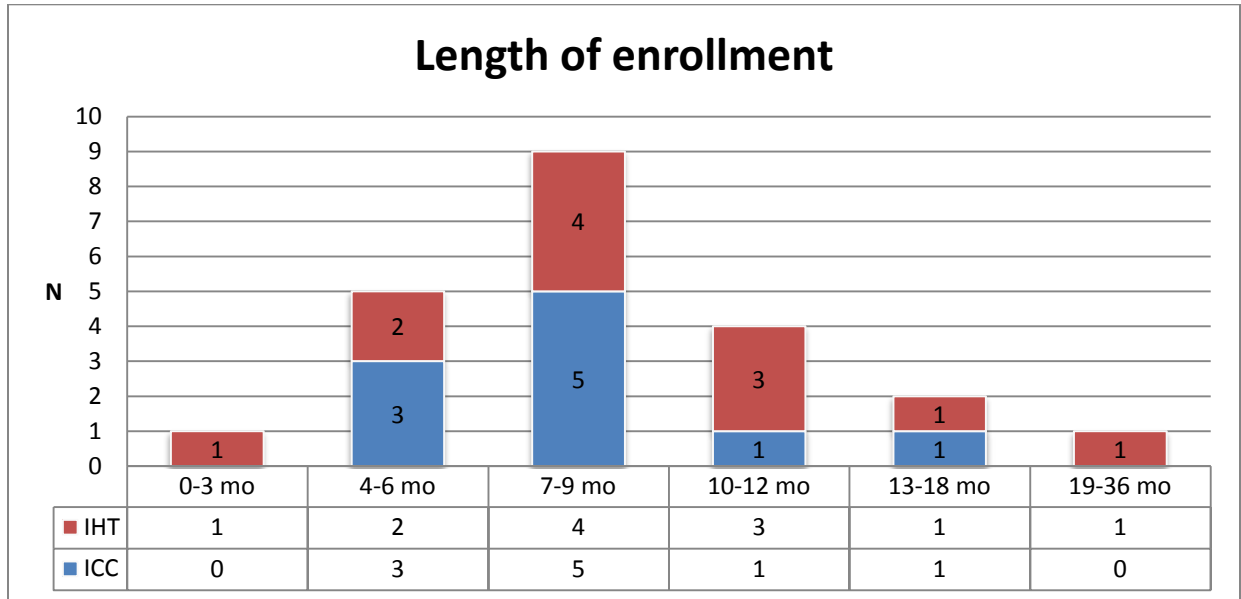
At the time of the review, the largest number of youth (n = 9) had been receiving services between 7-9 months, with five of these youth enrolled in ICC and four youth enrolled in IHT. Five youth, three youth in ICC and two youth in IHT, had been enrolled between 4-6 months and four youth, three in IHT and one in ICC had been enrolled between 10-12 months. One IHT youth each was enrolled between 0-3 months and 19-36 months. As all of the youth in the sample remained in active treatment at the time of the review, their length of stay at the time of discharge is not yet known.

Behavioral health services

	ICC	IHT	IHBS	TM	FS&T	Ind therapy	Psychiatry
■ IHT	0	12	2	1	1	3	4
■ ICC	10	1	2	5	7	5	1
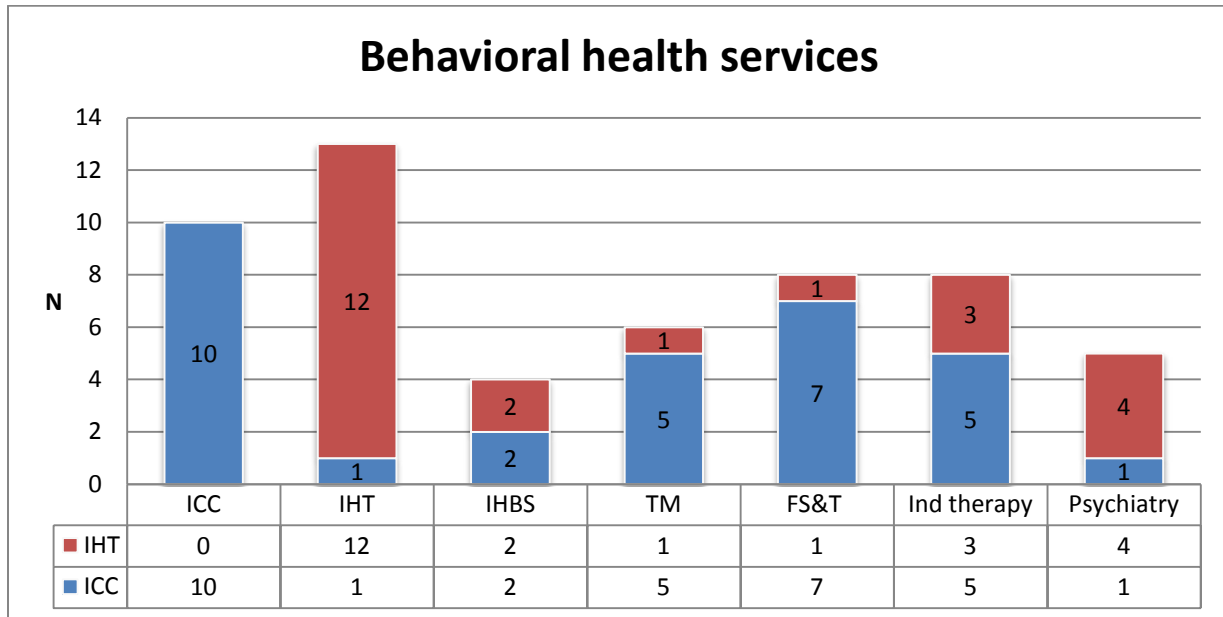
Note: Youth may be enrolled in more than one behavioral health service therefore the total number above is greater than 22.

The types of behavioral health treatment/interventions currently being utilized by the youth reviewed are shown in Figure 7. The most frequently utilized service was IHT with 13 youth or 59% participating in this service, followed by ICC (n = 10 or 45%) and Individual Therapy (n = 8 or 36%). Eight youth, or 32%, had Family Support and Training (FS&T), with the majority of those youth having concurrent enrollment in ICC (n= 7).[13] Six youth, or 27%, of the sample, were participating in Therapeutic Mentoring (TM), with all but one also enrolled in ICC. Five youth (23%) had psychiatry services, with all but one enrolled in IHT. In-home behavioral services (IHBS) was the least utilized intervention (n = 4 or 18%), with two of the youth having concurrent enrollment in ICC and two in IHT.

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[13] The individuals delivering this service are known as family partners.

Other service systems utilized

	DMH	DDS	DCF	Sp.Ed.	Probation	Other	None
■ IHT	0	0	6	4	1	0	4
■ ICC	1	1	5	5	1	1	0
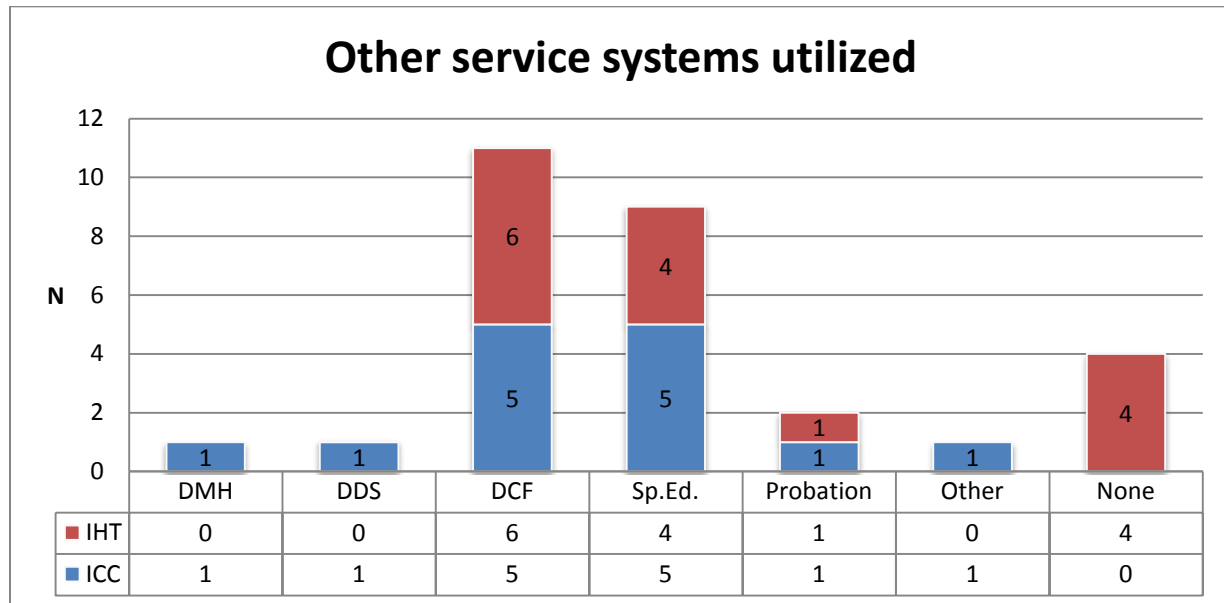
*Note: Youth may be involved with more than one service system therefore the total number above is greater than 22.*

Of the 22 youth reviewed, 18 were involved with a service system such as the Department of Mental Health (DMH), the Department of Developmental Services (DDS), or the Department of Children and Families (DCF).[14] All of the ten youth enrolled in ICC had at least one instance of involvement with another service system, with four of the ten youth having involvement with two systems. Of the twelve youth enrolled in IHT, eight were involved with at least one service system, with two youth involved with two systems, and one youth involved with three. The SOCPR protocols documented that 11 of the youth were involved with DCF, followed by special education (n = 9). A smaller number received services from Probation (n = 2), as well as DMH and DDS (n= 1 each). One youth had services from the Massachusetts Commission for the Deaf and Hard of Hearing. No youth were reported to be receiving services from DYS. Four of the IHT enrolled youth had no other service system involvement.

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[14] Per information found in the youth's record and confirmed through interviews with youth, family, and provider(s).
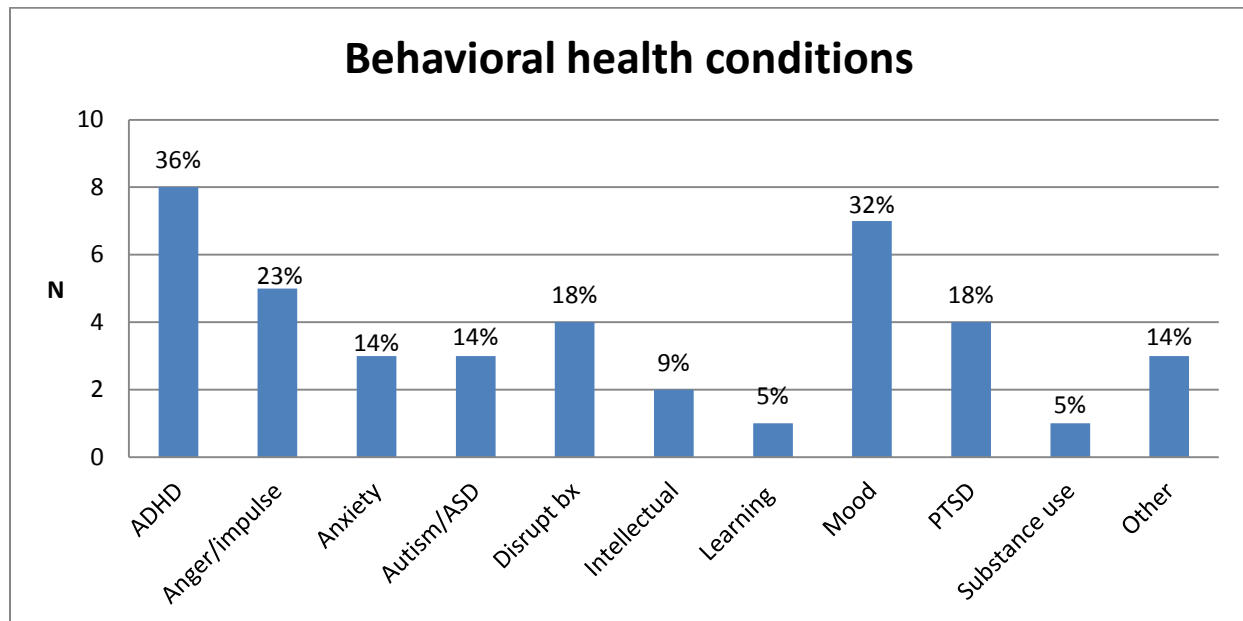
Note: Youth may have more than one diagnosis therefore the total above is greater than 100%.

The most common type of behavioral health condition reported among the youth reviewed was ADHD (36% or n = 8), followed by mood (32% or n = 7), anger/impulse control disorder (23% or n = 5), and disruptive behavior, Post-Traumatic Stress Disorder (PTSD) (18% n = 4). Youth with anxiety, autism, and other conditions each comprised 14% (n = 3 each).The least common reported conditions were substance use and learning disability at 5% (n = 1) each. It is important to note that (68%) of the youth reviewed had more than one reported behavioral health condition.

SOCPR mean domain scores

As described in the quantitative analysis section, mean scores were computed for the overall SOCPR score, as well as for each of the four SOCPR domains (Child-Centered and Family-Focused, Community-Based, Culturally Competent, and Impact). In addition, the minimum and maximum scores for families reviewed in each domain, as well as the standard deviation for each item of interest, were examined. This helped provide an understanding of the range of scores, the average score, as well as an indication of the variability from family to family. This section reports on these overall findings, and then on specific items of interest which demonstrate extreme scores.

Table 7 shows the overall score as well as those for each SOCPR domain for the entire sample of 22 families. SOCPR scores range from a low of 1 to a high of 7. Scores from 1 to 3 represent lower implementation of a SOC approach. A score of 4 indicates a neutral rating or lack of support for or against implementation. Scores in the 5 range represent good implementation of SOC principles, while those from 6 to 7 represent enhanced implementation of SOC principles.

For the Central region, SOCPR mean domain scores ranged from 4.91 to 6.13. The overall mean score of the cases examined was 5.54. The domain of Community-Based was the highest

scoring domain, followed by Culturally Competent, Child-Centered and Family-Focused, and finally, Impact. The scores indicate that in the Central region, provider agencies included in the sample performed best at including the Community-Based system of care value in service planning and provision. This is due in large part to the fact that ICC and IHT are services that are delivered primarily in home and community-based settings and are expected to be offered at times that are convenient for youth and families.

TABLE 7: CENTRAL REGION SOCPR DOMAIN SCORES

	Min	Max	Mean	Standard Deviation	95% CI	
					Lower Limit	Upper Limit
Overall	2.75	6.93	5.54	1.19	5.04	6.04
Domain 1: Child-Centered Family-Focused	2.38	6.94	5.31	1.37	4.74	5.88
Domain 2: Community-Based	3.64	7.00	6.13	0.86	5.77	6.49
Domain 3: Culturally Competent	1.90	6.90	5.55	1.39	4.97	6.13
Domain 4: Impact	1.50	7.00	4.91	1.89	4.12	5.70

Histograms were drawn to illustrate the range of SOCPR scores for the overall case and the four SOCPR domains. These figures are presented below. The overall mean score of the cases examined was 5.54. Forty-one percent (9 of 22 cases) fell into the 6 range representing enhanced SOC implementation, and seven cases (32%) scored in the 5 range, reflecting good SOC implementation.

Three cases (13.5%) had means in the 4 range. In two of these instances, the cases scored well across all domains with the exception of the Impact domain, either because services had just begun or the service mix was changing and had not yet begun to have an impact. Another scored poorly only in the Cultural Competence domain given that the provider had not fully explored the family's cultural values, beliefs, and preferences and therefore was not able to successfully incorporate this into the work being done with the family.
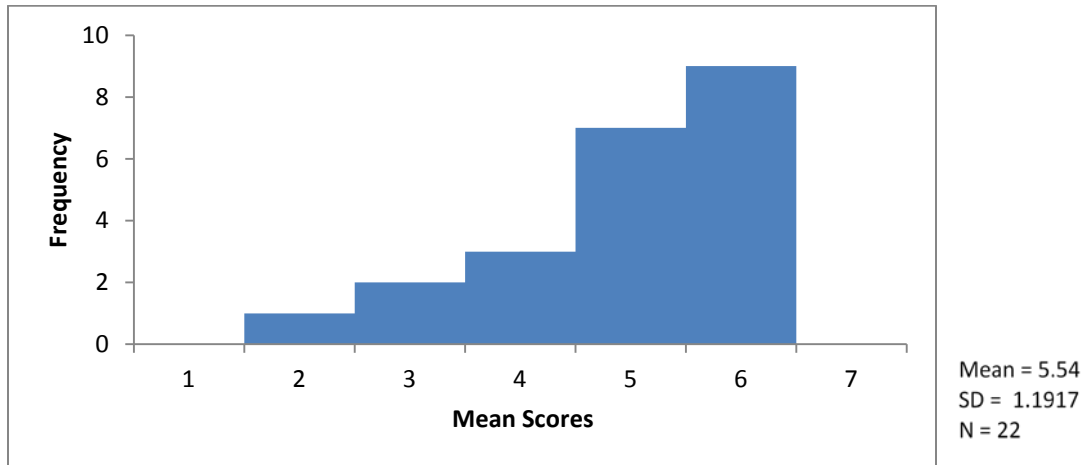
Mean = 5.54
SD = 1.1917
N = 22

Scoring the lowest were two cases (9%) with means in the 3 range and one (4.5%) with a mean in the 2 range, demonstrating poor implementation of SOC principles. The lowest scoring case was an IHT case with an overall mean of 2.75 which was also the lowest scoring case across three of the four SOCPR domains - Child-Centered and Family-Focused (2.38), Culturally Competent (1.90), and Impact (1.50). This case appeared to be a strong outlier in which DCF involvement with the family appeared to be driving the desire for IHT services versus assessment, service planning, and delivery based on the needs of the youth and family. As a result the family was not properly engaged in or benefitting from the services being delivered. The second lowest scoring case was an ICC case with an overall mean of 3.27 which was the lowest scoring case in the Community-Based domain (3.64), primarily because the caregiver needed an ASL interpreter but this service was not being accessed. The other case with a mean score in the 3 range (3.68) was an IHT case affected by poor coordination and a failure to identify important needs/goals and to add services appopriate to addressing those needs.

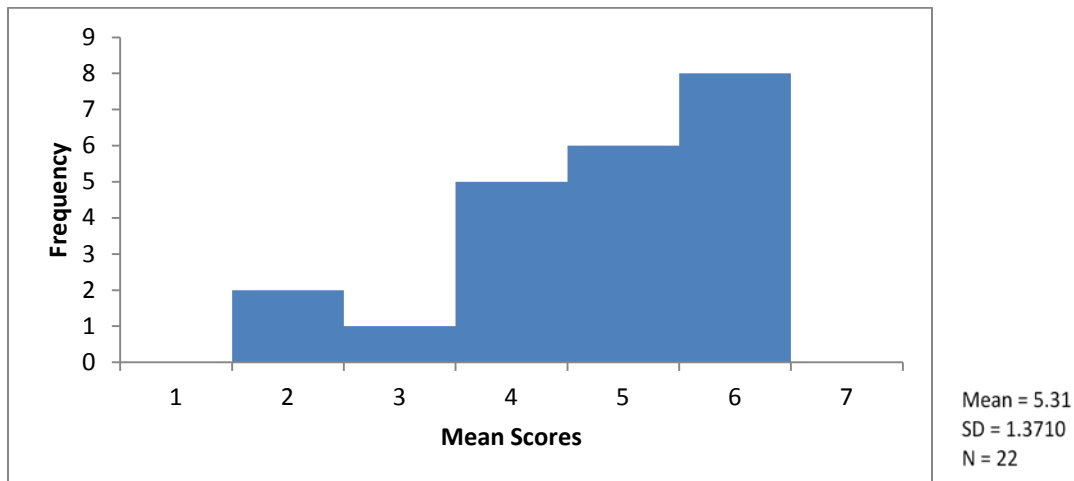**FIGURE 11: CHILD-CENTERED AND FAMILY-FOCUSED MEAN SCORES**

Mean = 5.31
SD = 1.3710
N = 22
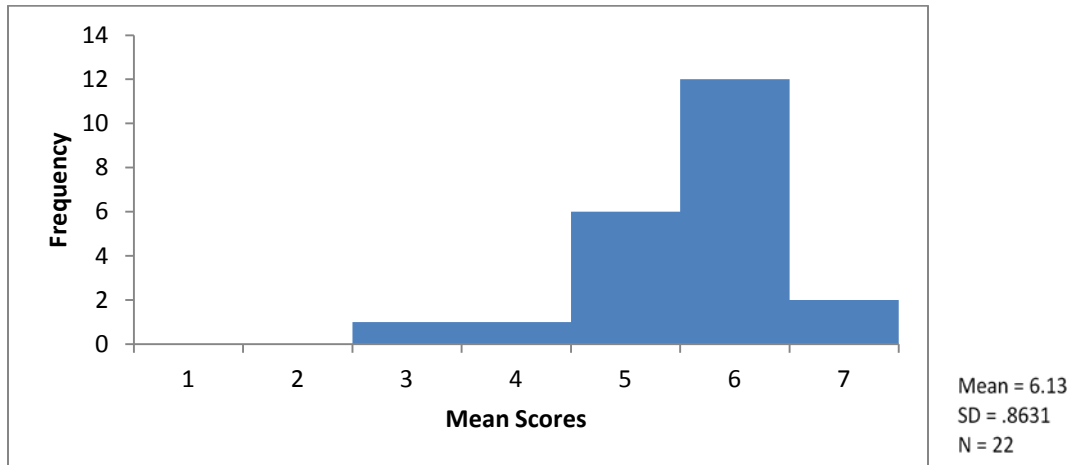
FIGURE 12: COMMUNITY-BASED MEAN SCORES

Mean = 6.13
SD = .8631
N = 22

FIGURE 13: CULTURALLY COMPETENT MEAN SCORES

Mean = 5.55
SD = 1.3916
N = 22

Mean = 4.91
SD = 1.8860
N = 22

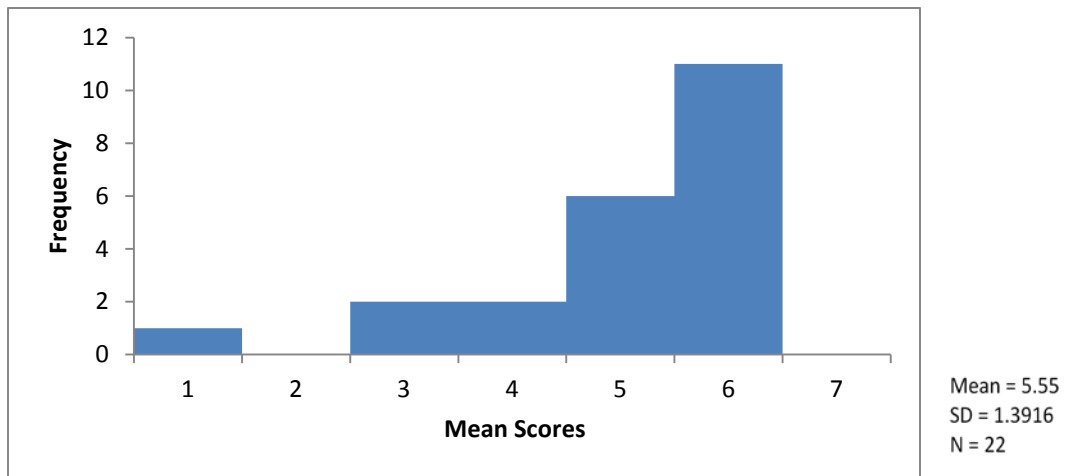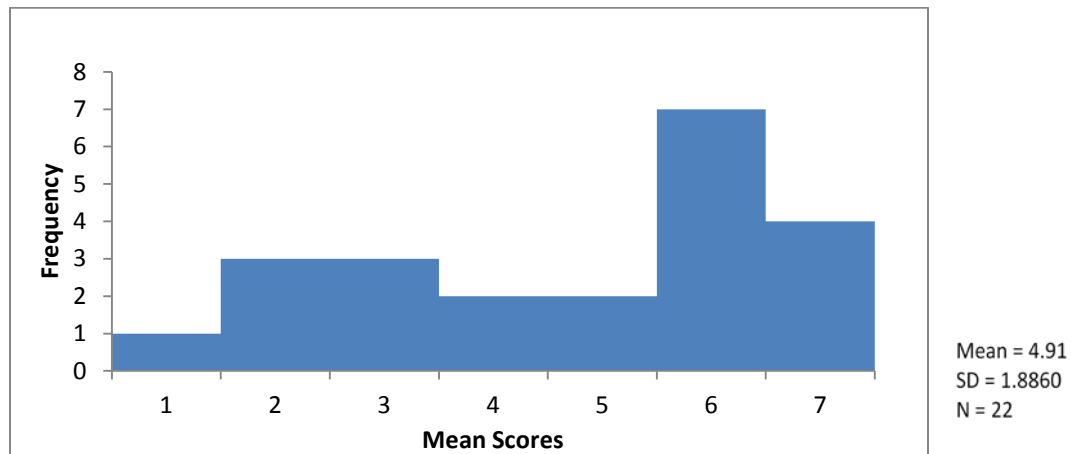## SOCPR individual question scores

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 22 families for the Central 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 5.31, which reflects good implementation of this SOC principle. In general, analysis of quantitative and qualitative data provided by SOCPR raters suggests that Central providers are delivering services that are child-centered and family-focused. Mean scores for 9 youth (41%) fell in the 6 range indicating enhanced implementation of this principle, and six youth (27%) had mean scores in the 5 range reflecting good implementation. Five youth (23%) had mean scores in the 4 range and two (9%) were in the 2-3 range, suggesting lower implementation of this principle for these cases.

Areas in this domain showing the greatest strengths included full and active participation by youth and families in service planning and delivery processes, service plan goals that reflect the needs of the youth and family, and informal acknowledgement by service providers of youth and family strengths. While individual item/question mean scores and qualitative comments suggest several areas needing potential improvement in this domain, those identified as needing the greatest level of improvement (i.e., scoring below 5), particularly among the IHT cases reviewed, related to service planning. Specifically, ensuring that service plans are integrated across providers and agencies, and formally incorporating youth and family strengths into service plan documents are areas needing improvement. Participation of formal and informal

providers in service planning was also identified as needing significant improvement. Important differences between IHT and ICC cases reviewed also revealed the need for some improvement among IHT providers related to assessments, ensuring types of service and supports provided reflect needs and strengths, and care coordination.

Sub-domain 1a: Individualized

The *Individualized* sub-domain includes four general areas: Assessment/Inventory, Service Planning, Types of Services/Supports, and Intensity of Services/Supports.

Assessment/Inventory: This first area contains three questions focused on the assessment conducted with the youth and family. Overall, the ICC cases reviewed generated more agreement from reviewers than IHT cases did that a thorough assessment was conducted which indentified and/or prioritized the needs and strengths of the youth and family. Fifty percent (50%) of reviewers agreed (70% ICC vs. 33% IHT) moderately or very much that a thorough assessment was conducted across life domains. Some reviewers reported that assessments were missing important domains (specifically spiritual, housing, education and finances), and that CANS were either missing from the chart or were outdated, as was some of the assessment information (i.e. it had not been revisited and updated). One reviewer stated, "the assessment is superficial and inadequate," and went on to describe how the IHT was unfamiliar with key family information critical for successful youth/family engagement and service planning. Similarly, another reviewer described an assessment which lacked "depth and clinical insight" by not acknowledging specific issues affecting the youth's life (e.g., past trauma, family substance abuse history.) Another noted that the assessment was "thin in content" and lacked narrative on many important aspects of the youth's strengths and needs. One reviewer felt a thorough assessment was not completed reflecting the youth's goals, diagnosis or current level of functioning.

Nevertheless, several reviewers reported strengths related to the assessment. A sample of these includes:

- "The assessment was very thorough and considered the youth's needs, strengths and history with the behavioral health system and state agencies."
- "Comprehensive assessment was completed in a timely manner and addressed the child and family's strengths and needs."
- "Very thorough assessment that reflected youth and mother's history."
- "CANS and comprehensive assessment were present and appeared to be clear. It was evident the provider truly understood the family."
- "Assessment was thorough and concrete…It was evident that there is understanding of the family dynamics and story."

About 59% of reviewers agreed (80% ICC vs. 42% IHT) moderately or very much that the needs of the youth and family had been identified and prioritized, and 50% agreed (70% ICC vs. 33% IHT) that the strengths of the youth and family had been identified. Some reviewers noted that needs had been identified but not fully explored and/or addressed. While one reviewer stated, "there was a lack of awareness of the strengths of this family," several others noted that while

strengths were not captured in the assessment, team members often were able to articulate them. For example, one reviewer stated that, "no strengths for the child were noted in the assessment but team members could articulate strengths for both child and mother." Another noted, "While providers were able to discuss the strengths for the child and caregiver, the records did not do a good job of recording them."

Other reviewers indicated that needs and strengths had been appropriately identified and/or prioritized. One stated that, "life domains represented specific needs that were prioritized how family wanted." Another commented that, "documentation is complete and detailed with strengths noted explicitly." A third simply stated, "strengths of the child and family were acknowledged."

Service Planning: The second area of focus within the *Individualized* sub-domain is the service plan. Only 41% of reviewers agreed moderately or very much that the service plan was integrated across providers. Further, only 25% (3 out of 12) of reviewers of IHT cases agreed this was the case compared to 60% (6 out of 10) of reviewers of ICC cases.

As one reviewer of an IHT case noted, "The plan has never been reviewed with other providers involved with this family." Two reviewers of IHT cases simply stated that there was no service plan that is integrated across providers; one went on to say that no evidence existed that the plan had been shared with other providers or with the caregiver. Two reviewers reported that the service plans did not acknowledge work being done by formal and informal supports. Further, one reviewer of an ICC case commented, "integration across providers does seem to be limited," and, "providers of supports to the family are not included in the team nor in developing the plan," though they are mentioned in some tasks related to service plan goals. Another commented that while the integration of providers/agencies was not evident in the plan, "the ICC addressed the integration of many providers during the interview."
On the other hand, one reviewer reported on a service plan which was characterized "by ongoing consistent communication between and among team members, including the family." Another noted that, "there is a single service plan that is integrated across the formal providers of ICC, FS&T and TM;" however, this reviewer also noted that other service providers (school special education and IHBS) were not integrated.

Approximately 59% of reviewers agreed that the service plan goals reflected the needs of the youth and family. One reviewer stated that, "the treatment plan adequately reflected the presenting need of the youth." Several noted specifically stated goals that clearly reflected identified need areas as well. A few also commented on the flexibility of plans to address changing needs over time.

A few reviewers did express concern that plans were inclusive of some but not all identified needs of the youth and families. Further, one reviewer reported that service plan goals focused exclusively on the youth's needs; however, "all interviews also included focus on the needs of the family." One noted that, "needs were incompletely explored," concluding that this may have impacted the caregiver's "indifferent" level of engagement in services. Another commented that

the "service planning has an unclear thread of connection to the needs," perhaps because needs had been stated in terms of symptoms rather than as individualized needs.

Only 32% of reviewers agreed that service plan goals incorporated the strengths of the youth and family. Further, only 17% of reviewers of IHT cases (2 of 12) agreed versus 50% (5 of 10) of those reviewing ICC cases. While some reviewers did note that service plan goals incorporated strengths identified for the youth and family, the majority found strengths to be missing and/or not fully addressed and built upon in service planning and delivery.

One reviewer of an IHT case noted "the clinician and TTS had difficulty identifying strengths of this family and incorporating them into the planning process." Another stated that "strengths were not fully explored in the assessment and not utilized." Similarly, a reviewer of an ICC case commented that, "strengths are not assessed and therefore not included formally in the plan," noting that this misses opportunities to articulate ways to build on strengths in the plan. One IHT reviewer simply stated, "the plan did not reflect the youth's strengths."

Some reviewers commented that while strengths may not be explicitly well-stated in service plan goals, they were acknowledged and/or articulated by providers. For example, one reviewer of an IHT case commented, "the strengths were not woven into the treatment plan; however clinician was aware of youth/family strengths." Another IHT case reviewer stated that while strengths were not reflected in written records, "the IHT clinician and TT&S worker knew of the child's strengths and were able to incorporate them into the work with the child." Likewise, a reviewer of an ICC case remarked, "strengths of the youth/family are not evident in the ICP goals; however, each formal provider interviewed addressed strengths of the youth and family easily and broadly."

A separate question asked if there was evidence that the provider had "informally" acknowledged and incorporated strengths into the service planning and delivery process. Sixty-eight percent (68%) of reviewers agreed that providers did. Comments from reviewers reflective of this included:

- "There is informal acknowledgement of mother's warmth and patience with her children and her good relationship with the child's school."
- "The plan informally recognizes mothers' strength..."
- "Informally all providers and the parent had consensus on some of the strengths of the parent and child."

Types/Intensity of Services/Supports: The final two areas focus on whether the types and the intensity of services and supports provided to the youth and family reflect their needs and strengths. About 52% of reviewers agreed moderately or very much that the types of services/supports provided did reflect needs and strengths, although this was true for 60% of ICC cases vs. only 45% of IHT. About 62% of reviewers agreed that the intensity of services/supports reflected needs and strengths. Reviewers noted things like "the appropriate services were identified" and "services provided met needs and stabilized the family," often listing the services the child and family were receiving with a clear link to the identified need

those services were addressing. Further, reviewers made comments like: "caregiver and providers felt the intensity of services were just right;" "mother states intensity has been just right;" and "the team has updated service plans goals in response to new information and interventions have been responsive to the child's and family's needs."

In both of these sub-domains it appears to follow that where needs and/or strengths were not fully identified, the types and intensity of services were frequently insufficient. Reviewer comments reflective of this include:

- "It appeared there may have been additional supports that would have benefitted this family."
- "Hard to say what the 'right intensity' should be since the service as delivered does not appear to meet child/family needs."
- "It is noticeable that caregiver needs supports beyond the care coordinator's role such as peer support."

Some other issues that were identified included the desire of some families for development of more natural and community supports, waitlists for additional MassHealth supports such as IHT and outpatient therapy, and youth/families that had not been well-prepared for impending transition out of services. One caregiver expressed "that there were too many services [Outpatient therapy, IHT, TT&S and afterschool program] and that it was somewhat too much at this time."

TABLE 8: 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.	5.23	1 (4.5)	1 (4.5)	3 (13.6)	0	6 (27.3)	4 (18.2)	7 (31.8)
2. The needs of the child and family have been identified and prioritized across a full range of life domains.	5.36	0	2 (9.1)	3 (13.6)	0	4 (18.2)	6 (27.3)	7 (31.8)
3. The strengths of the child and family have been identified.	5.14	0	3 (13.6)	2 (9.1)	0	6 (27.3)	6 (27.3)	5 (22.7)
Area: *Service Planning*								
4. There is a primary service plan that is integrated across providers and agencies.	4.50	2 (9.1)	4 (18.2)	3 (13.6)	0	4 (18.2)	3 (13.6)	6 (27.3)
5. The service plan goals reflect needs of the child and family.	5.77	0	1 (4.5)	0	0	8 (36.4)	6 (27.3)	7 (31.8)
6. The service plan goals incorporate the strengths of the child and family.	4.55	0	4 (18.2)	4 (18.2)	1 (4.5)	6 (27.3)	3 (13.6)	4 (18.2)

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 (%)
7. The service planning and delivery informally acknowledges/considers the strengths of the child and family.	5.68	0	0	3 (13.6)	1 (4.5)	3 (13.6)	8 (36.4)	7 (31.8)
Area: _Types of Services/Supports_								
8. The types of services/supports provided to the child and family reflect their needs and strengths.*	5.10	2 (9.5)	1 (4.8)	2 (9.5)	0	5 (23.8)	5 (23.8)	6 (28.6)
Area: _Intensity of Services/Supports_								
9. The intensity of the services/supports provided to the child and family reflects their needs and strengths.*	5.48	2 (9.5)	0	1 (4.8)	0	5 (23.8)	7 (33.3)	6 (28.6)

*N=22; Question 9 based on 21 responses as the reviewer felt they didn't have enough information to answer this question.

Sub-domain 1b: Full participation

The *Full Participation* sub-domain includes questions assessing how well the youth and family, along with service providers and informal helpers, participate in developing, implementing, and evaluating the service plan. Reviewers agreed moderately or very much 68% of the time that youth and families actively participate in the service planning process. About 77% of reviewers agreed moderately or very much that the youth and family influence the service planning process, and 68% of the time reviewers agreed that the family understood the content of their plans. Strengths mentioned by reviewers related to youth and family participation in the planning process included:

- "The primary caregiver and other family members participate with each identified formal provider and school staff. The IHT maintains communication with the psychiatrist and brings his input to the service planning process."
- "The ICC-FP-TM team is strong in supporting mother and son to be active participants and 'own' the plan. The TM in particular reported that he works with the youth to understand what they're working on and why, in an age-appropriate manner."
- "Youth and mother see their voices in the goals and planning and in the types of services he is receiving. Mother acknowledges that she has final say over goals and plans."
- "All formal providers and the primary caregiver acknowledge that the family 'drives the process.' Primary caregiver feels heard by all team members and enjoys the

relationships she has with each team member, 'They listen to us.' ICC states that the family 'drives the whole process.'"

Specific challenges in this area identified by reviewers included instances where the youth or family members were not included in a meaningful way in the planning process. For example one reviewer noted that "the caregiver felt that the plan was not in her own words, but in the words of the therapist. She felt she did not have much impact into the planning process and that there was a misunderstanding of goals." One reviewer of a youth with IHT noted that the family had not been provided with a copy of their plan, while another expressed concern that neither the youth nor the family had been involved in transition planning.

Reviewers agreed moderately or very much 86% of the time that the youth and family were actively participating in services. Reviewers for only three of the 22 youth reviewed - two receiving IHT and one receiving ICC - disagreed that the youth and family were active participants in the planning process.

In terms of participation by formal providers and informal helpers, only 38% of reviewers agreed moderately or very much that they were involved. No major difference was observed on this item for ICC versus IHT providers. Reviewers identified many challenges here, particularly with engaging school personnel and/or informal supports in the planning process. It was noted that while providers of CBHI services may be included in planning efforts, this was not always true of other service providers.

TABLE 9: 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).	5.59	1 (4.5)	1 (4.5)	1 (4.5)	0	4 (18.2)	8 (36.4)	7 (31.8)
11. The child and family influence the service planning process (initial plan and updates).	5.64	0	2 (9.1)	2 (9.1)	0	1 (4.5)	10 (45.5)	7 (31.8)
12. The child and family understand the content of the service plan.	5.73	1 (4.5)	1 (4.5)	0	0	5 (22.7)	7 (31.8)	8 (36.4)
13. The child and family actively participate in service.	5.86	1 (4.5)	0	2 (9.1)	0	0	11 (50)	8 (36.4)
14. The formal providers and informal helpers participate in service planning (initial plan and updates).*	4.86	2 (9.5)	1 (4.8)	2 (9.5)	1 (4.8)	7 (33.3)	3 (14.3)	5 (23.8)

*N=22; Questions 13 and 14 are based on 21 responses as the reviewer felt they didn't have enough information to answer this question.

Sub-domain 1c: Care coordination

In the *Care Coordination* sub-domain, 68% of reviewers agreed moderately or very much that one individual appeared to be responsible for coordinating youth and family services and was doing so successfully. There was a noticeable difference here between ICC and IHT cases reviewed, with only 50% of reviewers (6 out of 12) of IHT cases agreeing vs. 90% (9 out of 10) of ICC. A review of comments for youth with IHT suggested a general lack of clarity about responsibility for care coordination. One reviewer noted there did not seem to be "clear facilitation of meetings." In another, the reviewer stated that there was "no one helping to coordinate services with this family." When prompted by the reviewer on this issue, the clinician suggested that coordination might be the responsibility of DCF because they had recently become involved with the family. In another IHT case, the reviewer noted that "there is no clear person who is coordinating the services with all providers for this family."

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

- "It was evident across providers and family who the coordinator was."
- "The IHT clinician has frequent contact with the Therapeutic Mentor."
- "Mom reports that the team works very effectively and in sync. All interviewees identified ICC as the person who coordinates."
- "Family feels that they are receiving excellent coordination services and has learned a lot from the ICC."
- "The ICC reportedly does a good job of coordinating the work of the Family Partner and the Therapeutic Mentor with the mother and the mother feels supported in the process."

About 62% of the time reviewers indicated that service planning appears to be responsive to the changing needs of the family and that plans are updated in a timely fashion. Comments in this regard included:

- "When goals were updated around behaviors, the care plan was revised. According to the family, the plan is revised as needed and is well communicated with [the] family."
- "The team demonstrates a good knowledge of community resources and they make referrals in response to changing needs of the family."
- "The team is responsive in changing needs or concerns as they arise."
- "[The] treatment plan reflects the family's upcoming move and support for that transition."
- "Goals have been added and modified as appropriate to the expressed needs of the child and family."

Despite this, in a few instances reviewers felt services were not responsive to the changing needs of the youth and family. One reviewer noted that there was "no evidence of any adjustment to the plan" despite a major change in the life of the family. Another observed that

the IHT provider had not "led a process to discover what the family really wants, and has responded to lack of progress mostly by persisting with the same approach." For another family with IHT, housing needs arose for the parent and were not addressed in the plan. It is also important to note here that reviewers agreed moderately or very much that the planning was responsive to the family's changing circumstances in about 80% of ICC cases vs. 45% of IHT cases.

TABLE 10: SUB-DOMAIN 1C CARE COORDINATION

SUBDOMAIN 1c: Care coordination	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
15. There is one person who successfully coordinates the planning and delivery of services and supports.	5.18	3 (13.6)	1 (4.5)	2 (9.1)	0	1 (4.5)	7 (31.8)	8 (36.4)
16. Service plan and services are responsive to the emerging and changing needs of the child and family.*	5.43	0	3 (14.3)	1 (4.8)	0	4 (19)	6 (28.6)	7 (33.3)

*N=22; Question 16 based on 21 responses as the reviewer felt they didn't have enough information to answer this question.

Domain 2: Community-Based

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

As indicated earlier, of the four SOCPR domains, the *Community-Based* domain had the highest mean score (M = 6.13). Fourteen of the 22 cases (64%) fell into the enhanced implementation range with scores in the 6 to 7 range. Another six (27%) were in the 5 range, reflecting good implementation of this SOC principle. Two youth had scores reflecting sub-optimal performance, with one mean score falling in the 4 range and the other in the 3 range.

The sub-domains of *Access to Services* and *Minimal Restrictiveness* scored the highest overall. This indicates that services are accessible to youth and families and are offered at convenient times, in convenient locations, and in the primary language of the family. Furthermore, services are provided in comfortable environments that are the least restrictive and most appropriate. These areas represent strengths for the Central providers. One area highlighted for potential improvement in the *Integration and Coordination* sub-domain involves the need for a smoother and more seamless process for connecting youth and families with additional services and supports. IHT providers in particular could also improve in terms of *Early Intervention,* by more quickly assessing and clarifying the youth and family's needs and putting the appropriate

services and supports into place, and related to *Integration and Coordination,* by fostering two-way communication between all team members involved with the youth and family.

Sub-domain 2a: Early intervention

In the *Early Intervention* sub-domain, reviewers agreed moderately or very much 68% of the time that providers quickly assessed and clarified the youth and family's initial concerns, and 59% of the time that once the needs were clarified, appropriate services and supports were initiated. The rapidness of response and intervention were mentioned by several reviewers as practice strengths of providers. One reviewer of a youth with ICC highlighted this by stating, "all team members were quite responsive to the needs of the family and collaborated in identifying and implementing service delivery based on those needs." Another reviewer noted that "the ICC and FP responded quickly to the referral from DCF and quickly engaged with the mother." A reviewer of a youth with IHT commented that "all parties identified that services began very soon after the referral was made and that the clinician had worked with the caregiver to identify the initial needs and concerns for the child."

However, several reviewers also mentioned challenges in this area, suggesting that delays in either clarifying initial needs or in obtaining services and supports to meet those needs, was of concern. One reviewer mentioned that a "follow-up plan with the school after initial meeting was not clearly stated." Another indicated that while initial needs were quickly assessed and suggested a need for a behavioral intervention, "a referral for IHBS was not made until several months later." In another case, there appeared to be a long lag time between when the referral was made and when services began, with the parent telling the reviewer that if the "intervention had happened when they had been referred, the services would have had a more positive impact on her son more quickly."

Both questions in this sub-domain reflected significant differences between ICC and IHT cases reviewed. Reviewers of youth with ICC agreed moderately or very much 80% of the time that needs were clarified quickly and that the appropriate services and supports were offered, whereas there was only agreement for 58% of IHT cases that needs were clarified quickly, and 42% of reviewers agreed moderately or very much that the IHT provider responded by offering the appropriate combination of services and supports.

TABLE 11: 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.	5.41	1 (4.5)	2 (9.1)	2 (9.1)	0	2 (9.1)	7 (31.8)	8 (36.4)
18. As soon as the child and family entered the service system, the system responded	5.14	1 (4.5)	4 (18.2)	0	0	4 (18.2)	7 (31.8)	6 (27.3)

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 (%)
by offering the appropriate combination of services and supports.								

Sub-domain 2b: Access to services

Three general areas comprise the *Access to Services* sub-domain: whether services were provided at *convenient times*, in *convenient locations*, and in the *appropriate language*. Reviewers agreed that services were provided to youth and families in convenient locations (100%) and at times (100%) that families indicated worked for them. Reviewers noted that services were by and large provided in the family's home or nearby community locations, noting comments like, "the team could not do a better job of scheduling at the family's convenience," "they work around our schedules," and, "meetings occurred early and late to accommodate family needs."

Ninety-six percent (96%) of reviewers agreed moderately or very much that both oral communication and written documentation about services and supports were provided to youth and family in their primary language.

TABLE 12: 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.	6.77	0	0	0	0	0	5 (23)	17 (77)
Area: Convenient Location								
20. Services are provided within or close to the home community.	6.95	0	0	0	0	0	1 (5)	21 (95)
21. Supports are provided to increase access to service location.*	3.00	0	0	1 (100)	0	0	0	0
Area: Appropriate Language								
22. Service providers verbally communicate in the primary language of the child/family.	6.77	0	0	1 (4.5)	0	0	1 (4.5)	20 (91)
23. Written	6.73	0	0	0	1	0	3	18

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 (%)
documentation regarding services/service planning is in the primary language of child/family.					(4.5)		(13.6)	(82)

*N = 1; Respondents did not need to answer question 21 if they responded "Agree Very Much" to question 20.

Sub-domain 2c: Minimal restrictiveness

All reviewers (100%) indicated that services were provided in an environment that families found comfortable, and 95% agreed moderately or very much that they were provided in the least restrictive and most appropriate environment. One reviewer commented that the "family is very comfortable and feels free to say what they want in the environment where meetings take place." Another noted, "Services were provided in the least restrictive environment and services were well scheduled with families [sic] day to day living."

TABLE 13: 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.	6.95	0	0	0	0	0	1 (5)	21 (95)
25. Services are provided in the least restrictive and most appropriate environment.	6.73	0	0	1 (4.5)	0	0	2 (9.1)	19 (86)

Sub-domain 2d: Integration and coordination

In this sub-domain, 59% of reviewers agreed moderately or very much that there was on-going two way communication among and between all team members. Here again a difference between ICC and IHT was observed, whereby 70% of reviewers of ICC cases agreed moderately or very much that communication between team members and the family was good, the same was true of only 50% of the IHT cases reviewed. In general, reviewers noted that clinical documentation and key interviews reflected good communication between service system representatives or providers and family members. Comments reflective of this included:

- "There is much evidence of consistent communication/collaboration between the primary caregiver, all providers, and school staff in progress notes and correspondence received from the psychiatrist and other providers."
- "Excellent use of technology with this team to keep each other informed."
- "There is a sense of well-rounded communication by all other providers."
- "Communication along providers is well documented in service plan."
- "The team, as defined as ICC, TM, FP, and mother, communicates well."

Communication was not consistent with all team members, however. One reviewer of an ICC case noted that while communication between behavioral health service providers was good, "communication with and among other providers 'on the periphery' is not so strong." A similar issue was reported for a youth with IHT: "communication is between IHT and DCF, and between IHT and mother. There is not a larger team with communication, although school and PCC are also providers and the family has important informal supports." In another instance where communication was fragmented, the reviewer stated that "there was a lack of communication among the providers and families [sic] members involved with this youth. No one reached out to the school and there was minimal communication with DCF and the parent aide assigned by DCF." Overall, where provider types were noted in terms of posing a communication challenge, DCF, school, and probation were specifically mentioned.

Only 50% of reviewers agreed moderately or very much that there was a smooth and seamless process for linking the youth and family with additional services when necessary. This question had the lowest mean score at 4.82 of all the questions in the Community-Based domain. Challenges in this area included referrals not being made despite clearly identified needs, delays experienced by a few families in obtaining services either due to a wait list for IHBS or, in one case, the lack of availability of an IHT service provider competent in ASL. In a few cases, reviewers identified concerns related to transitioning families out of services, commenting that, "no planning for services for transition," and, "team could have put more thought into transitioning family out of services. [The] family did not feel that there is a smooth transition and family questioned their ability to continue coordination after ICC was gone."

TABLE 14: 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.	5.05	1 (4.5)	3 (13.6)	2 (9.1)	0	3 (13.6)	8 (36.4)	5 (22.7)
27. There is a smooth and seamless process to link the child and family with additional services if necessary.	4.82	2 (9.1)	3 (13.6)	2 (9.1)	0	4 (18.2)	5 (22.7)	6 (27.3)

Domain 3: Culturally Competent

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

whether informal supports are included in services. The sub-domains associated with Culturally Competent Services are: *Awareness*, *Sensitivity and Responsiveness*, *Agency Culture*, and *Informal Supports.*

The *Culturally Competent* domain had a mean score of 5.55 which represents good implementation of this SOC principle. Half (50%) of the youth reviewed had mean scores in the 6 range suggesting strong practice in this domain. Another six youth (27%) had mean scores in the 5 range suggesting good implementation of this SOC principle. Two youth had mean scores in the 4 range, and three (14%) had scores in the 1 to 3 range, reflecting the need for improvement. The greatest area of strength was evident in the *Agency Culture* sub-domain, which assesses how well youth and families are assisted in understanding the culture of the agency providing them with services, the rules and regulations, and what is expected of them. Inclusion of informal or natural supports in the service planning and delivery process stood out as an area for improvement, receiving the lowest mean score (4.41) of all items in this domain.

Sub-domain 3a: Awareness

The *Awareness* sub-domain includes three general areas: Awareness of Child/Family Culture, Awareness of Provider's Culture, and Awareness of Cultural Dynamics.

Awareness of Child/Family Culture: About 71% of reviewers agreed moderately or very much that providers recognized youth within the context of their culture and their community, and 82% agreed that providers know about the family's concepts of health and family. Seventy-six percent (76%) agreed that providers understood that a family's culture influenced their decision-making process. Positive comments from reviewers in this area included:

- "Caretaker verbalized that she felt the providers recognize and respect the importance of family, respect for people and the values of a 'hard-working family' in their interactions with her and her child. 'They understand how important family is to me.'"
- "The team is sensitive to the importance of religion and the church in the mother's life."
- "The team recognized culture and influence culture in decision making. They provided services that [were] comfortable for her values and lifestyle."
- "Providers are aware of family's desire to have family living together in same home as well as the value of each child understanding both the American culture and Latino culture."
- "The provider appeared to do a great job exploring family's culture. The provider understood family values and beliefs. SNCD represented very accurately to the family's culture and plan included sensitive information about how to approach certain tasks such as setting boundaries with their church."

When reviewers noted concerns in this area, they observed that providers either had a very narrow view of culture (only viewed through lens of race/ethnicity or how holidays are observed), or they had only limited recognition that culture was an important area to explore with the family.

Awareness of Provider's Culture: Seventy-three percent (73%) of reviewers indicated that providers understood their own values and principles and how that might influence how they worked with youth and families. Comments from reviewers mentioned that where there were commonalities such as religion, language, cultural background, or being a parent, it enhanced their understanding of the work with the youth and family. Several reviewers also noted however that is was not uncommon for providers to not have reflected on their own culture and therefore have limited awareness of how their own values and beliefs might impact their work with the family.

Awareness of Cultural Dynamics: Sixty-four percent (64%) of reviewers agreed that providers were aware that there may be subtle cultural dynamics present between themselves and the families with whom they worked. Several reviewers mentioned that providers were particularly sensitive to how differences in values, beliefs, ethnicity/race, or socio-economic status impacted their work with the youth/family. Others noted that the provider had not fully explored or considered this issue.

TABLE 15: 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.*	5.76	0	3 (14.3)	0	0	3 (14.3)	5 (23.8)	10 (47.6)
29. Service providers know about the family's concepts of health and family.	5.82	0	2 (9.1)	1 (4.5)	0	1 (4.5)	10 (45.5)	8 (36.4)
30. Service providers recognize that the family's culture, values, beliefs and lifestyle influence the family's decision-making process.*	5.62	0	2 (9.5)	2 (9.5)	0	1 (4.8)	9 (42.8)	7 (33.3)
Area: Awareness of Providers' Culture								
31. Service providers are aware of their own culture, values, beliefs & lifestyles and how these influence the way they interact with the child and family.	5.50	0	2 (9.1)	2 (9.1)	0	2 (9.1)	11 (50)	5 (22.7)
Area: Awareness of Cultural Dynamics								

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 (%)
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.	5.41	1 (4.5)	2 (9.1)	0	0	5 (22.7)	9 (40.9)	5 (22.7)

N=22; Questions 28 and 30 based on 21 responses.

Sub-domain 3b: Sensitivity and responsiveness

Scores in the *Sensitivity and Responsiveness* sub-domain showed that 62% of reviewers agreed moderately or very much that services were responsive to the values and beliefs of the youth and families. The data also indicated that providers were able to take their awareness of the cultural beliefs of the families they served and translate these into action steps 68% of the time. Examples highlighted by reviewers in this area included: honoring a family's preference for a female therapist, focusing treatment on the importance of family, modifying the work with a parent based on his parenting style, and accommodating the family's preferences for when to meet. Several reviewers did note however that the provider had failed to explore the family's values, preferences, and beliefs, thus making it difficult to take action or modify their practice in a meaningful way.

TABLE 16: 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.*	5.52	0	2 (9.5)	2 (9.5)	0	4 (19)	5 (23.8)	8 (38)
34. Services are responsive to the child and family's values, beliefs and lifestyle.	5.77	0	1 (4.5)	2 (9.1)	0	4 (18.2)	6 (27.3)	9 (40.9)

*N=22; Question 33 based on 21 responses as the reviewer felt they didn't have enough information to answer this question.

Sub-domain 3c: Agency culture

Within the *Agency Culture* sub-domain, 68% of reviewers agreed moderately or very much that providers recognized a family's participation in service planning and in the decision-making process is influenced by their knowledge/understanding of the expectations of the provider. Further, 73% indicated that providers assist the child and family in understanding and navigating the agencies they represent.

Comments from reviewers included several examples of good practice in the Agency Culture sub-domain:

- "Family reported that the provider explained their services and did a full complete orientation with them. The family appeared to understand how decisions are made and what the expectations were."
- "All three providers are acutely aware of the unique challenges that Deaf individuals face in understanding and navigating services systems. They therefore work extensively with the mother to understand how services can help her."
- "The family was well informed about the agency/program expectations as well as navigating the other providers involved with team."
- "There is documentation of the family's orientation to the provider organizations and receipt of informational materials at Intake of both provider agencies. Caretaker states that 'they went over everything.'"

A small number of practice challenges were identified in this area such as: a concern that an IHT clinician had not helped a parent understand her service delivery options, with the parent seemingly only involved with services to satisfy DCF; and a reviewer of a youth with IHT mentioning that the parent was unclear about who to contact if she had concerns about the service.

TABLE 17: 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	5.77	1 (4.5)	1 (4.5)	0	1 (4.5)	4 (18.2)	5 (22.7)	10 (45.5)
36. Service providers assist the child and family in understanding/navigating the agencies they represent.	6.05	0	1 (4.5)	0	0	5 (22.7)	6 (27.3)	10 (45.5)

Sub-domain 3d: Informal supports

Only 46% of reviewers indicated that service planning and delivery intentionally included informal or "natural" sources of support for the youth and family. Comments from reviewers of cases receiving lower ratings indicated that either informal supports had not been identified, or that family members did not want certain informal supports included, and in some of these instances, providers failed to help the family identify alternative sources of informal support in their environments.

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.	4.41	4 (18.2)	2 (9.1)	2 (9.1)	1 (4.5)	3 (13.6)	6 (27.3)	4 (18.2)

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 whether these services appropriately met their identified needs. The Impact domain had the lowest overall mean score of 4.91. Mean scores for 11 youth (50%) fell in the 6-7 range suggesting that the services and supports had enhanced impact. Two youth (9%) had mean scores in the 5 range suggesting good impact. Two youth (9%) had mean scores in the 4 range, and seven (32%) had mean scores in the 1-3 range, suggesting areas of service planning and delivery that could be strengthened in order to improve the situation of the youth and families served and more appropriately meet their needs. It is also important to keep in mind that the youth in the sample were still in active treatment at the time of the review, with six of the 22 youth enrolled six months or less. 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

For almost 50% of families, reviewers agreed moderately or very much that services and supports provided to the *family* as a whole helped improve their circumstances. However, slightly fewer (46%) agreed the *youth's* situation had improved as a result of the services and supports s/he received. For several families where little to no improvement was indicated, reviewers described difficulty on the part of the provider(s) in engaging the youth or family. One reviewer suggested that involving a family partner for a youth with IHT could have been a useful intervention to engage a reluctant grandparent. For another, poor engagement resulted in the family's "lack of follow-through," which was identified as a significant barrier. A change in IHT clinician and "disagreements" with their Therapeutic Training & Support (TT&S) worker had stalled progress for one family. A lack of attention to important family or youth needs was a reason cited by reviewers for the limited improvement of some youth, with unresolved school issues cited for at least four families.

Despite this, there were a number of positive reviewer comments indicating improvements. One caregiver, reported that the child's "behavior at school has completely changed," while another stated that, "everything has been helpful," and that, "the support is amazing." For one parent, the IHT clinician's help in connecting her with "behavioral health supports" was acknowledged as critical to helping to improve the family's overall situation. For another youth in IHT, it was mentioned that "across the board, everyone felt that having services was the best thing that

could have happened for the child and family." A significant reduction in the frequency of "meltdowns," from 3-4 per day to 3-4 per week, was reported by one reviewer for a youth in ICC.

TABLE 19: 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	4.82	0	4 (18.2)	3 (13.6)	0	5 (22.7)	6 (27.3)	4 (18.2)
	FAM	4.86	1 (4.5)	4 (18.2)	2 (9.1)	0	4 (18.2)	5 (22.7)	6 (27.3)

CH=Child; FAM=Family

Sub-domain 4b: Appropriateness

Nearly 57% of reviewers agreed moderately or very much that that the services and supports being provided to both the *youth* and their *families* were appropriate for their needs. For youth in ICC, the services that had been put in place for the youth and family, such as a Therapeutic Mentor and a Family Partner, had appropriately met their needs. One reviewer indicated that the care coordinator and Family Partner had "met the family where the family [is at] in their journey." Another family with ICC explained that the "intensity of services was just right and [they] would [not] change a thing about their services."

However, some reviewers indicated that the services and supports were not appropriate for the child or family. One reviewer suggested that the intensity of the ICC service was more than the parent needed, stating, "the good outcomes could likely have been achieved with a less intensive service and a coordinator working with more focus." Another reviewer suggested that the services offered to the family were not "based on a good assessment of real family needs and strengths," and went on to say that, "many options to improve fit and effectiveness have been missed."

TABLE 20: 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	5.10	1 (4.8)	3 (14.3)	1 (4.8)	0	4 (19)	7 (33.3)	5 (23.8)
	FAM	5.05	1 (4.8)	4 (19)	1 (4.8)	0	3 (14.3)	5 (23.8)	7 (33.3)

CH=Child; FAM=Family

*Analysis of Question 39 based on 21 responses.

IHT supplemental questions results

In addition to the standard set of questions contained in the SOCPR protocol, nine additional questions were added to the Massachusetts version of the SOCPR. The additional questions were created to assess if the 12 youth in the sample with IHT serving as their "clinical hub" are receiving all medically necessary remedial services including appropriate care coordination. Therefore, these questions were not completed for the 10 youth in the sample who had ICC serving as their clinical hub.

Question 1 inquired about the need for or receipt of multiple services and the need for coordination of those services. Sixty-six percent (66%) of reviewers (n = 8) agreed that the youth needed or was receiving multiple services AND needed a care planning team to help coordinate those services.

Question 2 asked about receiving services from state agencies or special education and the need for coordination of those services. Thirty-three percent (33%) of reviewers (n = 4) indicated that the youth needed or was receiving services from state agencies or special education AND needed a care planning team to help coordinate those services.

TABLE 21: 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	4 (33.3)
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	8 (66.6)

Question 3 asked if the level of care coordination, in this case IHT, was appropriate. Only 25% (n = 3) of the reviewers agreed moderately or very much that it was.

TABLE 22: 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.	4 (33)	0	3 (25)	0	2 (17)	2 (17)	1 (8)

For question 4, three quarters of reviewers (75%) indicated that the youth not had been enrolled in ICC previously. For the three families that had been previously enrolled in ICC, two families were no longer enrolled because there was a reported failure to engage the families in the service. The other family successful graduated from ICC.

TABLE 23: PRIOR ICC ENROLLMENT

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

Question 5 showed that the option of receiving ICC had only been discussed with two of the 12 families by the IHT team. For the two families where the IHT clinician discussed the option of ICC and the family declined; one family reportedly was not interested (though the reviewer indicated that the question of ICC referral was only discussed in the beginning), while the other was not ready to commit to the intensity of the ICC service. When asked why the option of ICC was not discussed with the family, the most common reason in five of the ten cases was that it was determined that ICC was not needed. In one case the reviewer reported that the clinician was still assessing what services would be appropriate and had not yet discussed ICC with the parent. In another circumstance, the IHT clinician changed and the current clinician was unsure if ICC had been offered to the family and no documentation of a discussion regarding ICC could be located in the record. No reason was provided by the reviewer in three cases.

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	10 (83)

Question 6 asked if the youth needed assistance from their provider in working with the schools. For about three quarters (75%) of the youth, reviewers agreed moderately or very much that the youth/family needed assistance in working with the school system.

TABLE 25: 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.	0	0	1 (8.3)	1 (8.3)	1 (8.3)	5 (42)	4 (33.1)

Question 7 asked reviewers to indicate if the IHT team was in contact with all the service systems involved with the youth and family. Forty-two percent (42%) agreed moderately or very much that the IHT team was connecting with the other service systems.

TABLE 26: 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.	0	5 (42)	1 (8)	0	1 (8)	2 (17)	3 (25)

For question 8, reviewers were asked to indicate if the multiple service systems involved with the youth participate in care planning. About one-third (33%) of reviewers agreed moderately or very much that the service systems were involved in the planning for youth.

TABLE 27: 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 (33)	1 (8)	0	0	2 (17)	2 (17)	3 (25)

Question 9 asked for information about the other hub dependent services that youth were receiving at the time of the review. Four youth were participating in TM, FS&T, or IHBS representing about 33% of the 12 youth who had IHT serving as their "clinical hub."

TABLE 28: OTHER HUB DEPENDENT SERVICES

Q9. Indicate the other "hub dependent" services supported by IHT	Response	n[15] (%)
Q9i. Therapeutic Mentoring	Yes	1 (8)
Q9ii. Family Support and Training	Yes	1 (8)
Q9iii. In-Home Behavioral Services	Yes	2 (17)

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[15] Represent unique youth. None of the four youth had more than one of the "hub-dependent" services.

Discussion

Strengths of the service system

Overall, the findings from this review show that ICC and IHT providers in the Central region are generally demonstrating a system of care approach to service planning and delivery, performing best at including the Community-Based SOC value in service planning and provision. Areas of particular strength for providers in this region included:

Service accessibility

Services are accessible to children and families and are offered at convenient times, in convenient locations, and in the primary language of the family. Central region providers were clearly respectful of the preferences of youth and families with regard to their choice of service location, appointment times, and language. Furthermore, reviewers found that *services were provided in comfortable environments that were the least restrictive and most appropriate.*

Agency culture

Central region providers excelled at helping the youth and family understand and navigate the agencies they represent. Helping families understand and navigate the agency includes important activities such as: educating families about their rights and responsibilities as a client of the agency, orienting them to what the service is (and is not), after-hours access, who to talk to if they have a concern about service delivery, confidentiality issues, etc. By orienting the family to the agency "culture," providers engage families as partners in the process from the beginning and can help to empower families by ensuring they have the information they need to advocate for themselves.

Opportunities for improvement

Although ratings for the majority of youth reviewed fell in the enhanced (n = 9) or good (n = 7) range, findings indicated the greatest opportunities for improvement in the following areas:

Assessment

For IHT providers in particular, the thoroughness of assessments could be improved in terms of both depth (e.g. taking into account important psychosocial information) and breadth (e.g., expanding the range of life domains covered); in some instances this would appear to require greater clinical sophistication among staff conducting assessments and more oversight and review of assessment information by supervisory staff. *IHT providers also struggled with accurately identifying and prioritizing youth and family needs.* Even in those instances where the needs had been identified, some reviewers found that issues had not been fully explored or addressed, leaving the assessment seeming superficial and inadequate.

Given that the assessment process serves as the foundation for much of the work that follows, the importance of a thorough assessment that takes into account the perspective of multiple informants must not be underestimated. For some providers, it seems that the assessment is a static event as opposed to a continuous process that drives changes to the service plan and the work with the youth and family. The results of the IHT supplemental questions also raised concerns about the adequacy of the assessment for youth enrolled in IHT. For approximately

66% or eight of the 12 youth where IHT was serving as the clinical "hub," reviewers indicated that the youth was receiving multiple services and needed a care planning team to coordinate services (see question 1 in the IHT supplemental section). These are youth who might benefit from a referral to ICC. This provides additional support for the finding that some of the IHT providers reviewed in this round may not have adequately assessed the needs of the youth and family and may benefit from additional guidance to determine what services are most appropriate for a youth and family.

Service planning and participation

The service planning process stood out as an area for growth for Central region providers. *Specifically, service plans should better incorporate child and family strengths into goals, and both service plans and the planning process should be better integrated across providers and agencies.* Formal, documented inclusion of strengths into service planning goals was lacking for all providers, but especially for IHT providers. Difficulty incorporating strengths into goals was likely a result of the fact that many IHT providers failed to identify strengths during the assessment process. How to formulate strength-based goals should be explored as a potential training opportunity for providers.

IHT providers were particularly challenged with respect to integrating service plans across providers. As a "hub" provider it would be expected that service planning documents clearly lay out the need for additional services and supports, and what goal(s) other service providers are attempting to address. Greater clarity around expectations for service planning for IHT providers who are serving as the care coordination "hub" appears warranted. Identification and dissemination of best practices on how to develop a cohesive and well-articulated plan across multiple service providers could be an important intervention for IHT providers.

Inclusion of both formal providers and natural supports in the service planning process could be improved, with more intentional inclusion of natural supports in both service planning and delivery. This was an area where both IHT and ICC providers could improve. Engaging school personnel and natural supports in the service delivery and planning process was a particular challenge for providers in the Central region. Providers were more successful in involving providers of CBHI services, especially when those service providers were in the same agency. In only five out of the 12 IHT cases reviewed did the reviewer agree moderately or very much that providers, school personnel or other state agencies involved with the youth participate in service planning. Nevertheless, school personnel and natural supports must be willing participants, and with respect to school personnel, must receive support for doing so from their organizations.

Alignment of services and supports

Ensuring that the type of services and supports a youth and family receives is based on their individually identified needs and strengths is another opportunity for growth, particularly for IHT providers. Again, the lack of fit between the needs of the youth and family and the services and supports put in place might be the result of an assessment that failed to adequately identify or prioritize the needs and strengths of the youth and family. Discussion during the reviewer

debriefing suggested that Family Support and Training would have been an appropriate intervention for several families but IHT providers had not fully considered this option.

Integration and care coordination

Greater clarity about responsibility for care coordination for youth with IHT is needed. While reviewers of youth with ICC agreed moderately or very much 90% of the time that there is one identified person who successfully coordinates the planning and delivery of services, this was true in only 50% of IHT cases. Further evidence of the need for improved care coordination was found in the IHT Supplemental Section, where only three reviewers agreed moderately or very much that the youth was receiving appropriate care coordination. For several families enrolled in IHT, a referral for ICC may have been indicated. Results of the IHT Supplemental Section indicated that the option of ICC had been discussed with only two of the 12 families participating in IHT.

IHT providers also could improve in terms of their *responsiveness to the emerging and changing needs of the youth and family*. For several families with IHT, reviewers indicated that the provider failed to update service plans and assessment information based on new issues or changing family circumstances.

A smoother and more seamless process is needed for connecting youth and families with additional services and supports. This was true of both the IHT and ICC providers reviewed. Transition planning in particular stood out as an area for improvement. Helping families think about and plan for transitioning from the beginning and identifying clear indicators for when everyone (e.g. the family, youth, natural supports, formal providers, etc.) will know it is time for services to end, should be a focus of provider training and coaching efforts. For all providers, developing clear policies and procedures with regard to making referrals for needed services, particularly those outside of their own agency, is another area to focus improvement efforts.

Early intervention

IHT providers could improve with respect to how quickly they clarify the youth and family's needs and then intervene by offering the appropriate combination of services and supports. Reviewers reported concerns with how long it took for some providers to assess what the youth and family's needs were and reported delays in providers in making appropriate referrals. Redesigning intake/referral processes and procedures to allow for a more rapid determination of what types of services and supports a family may need could be an area for providers to focus quality improvement activities. An effort to more quickly gather information from multiple informants (e.g. family, teachers, therapists, etc.) and existing reports and plans (e.g. educational plans, DCF service plans, testing results, discharge summaries, etc.) about the most pressing issues and concerns facing the family could also help providers to more quickly and accurately identify areas of need during the early assessment phase.

Conclusion

Overall the results of the Central SOCPR reviews suggested that providers are delivering care in a way that adheres to important SOC and CBHI values, with overall domain scores suggesting good implementation of SOC principles. Forty-one percent (9 of 22 cases) had

scores that fell into the enhanced implementation range, and seven cases (32%) scored in the 5 range, reflecting good implementation overall. Central region providers are particularly strong when it comes to ensuring that youth and families can make best use of services by providing services at convenient times, locations, and in the primary language of the family. Attention to ensuring that families understand the service provider agency and its rules and their rights and responsibilities as a client of that agency was also identified as a strength of providers in the Central region.

While overall, practice appeared good in the majority of areas reviewed, opportunity for improvement stood out related to: inclusion and participation of formal providers and natural supports in the planning process, incorporating strengths into goals, and connecting youth and families with needed services and supports. Other areas for improvement for IHT providers especially were related to quality of assessments, ensuring types of service and supports provided reflect needs and strengths, early intervention, and integration and care coordination.

This report, along with the information offered at the individual provider-specific debriefings that were convened by staff from MassHealth and EOHHS following the Central reviews, should be used to help inform quality improvement efforts and guide discussions with staff about the development of provider-specific strategies for building upon areas of strong performance and how service delivery to youth and families could be improved. The areas identified for growth could serve as important topics for in-service trainings, be given greater attention and focus in individual and group staff supervision, and/or become areas that are regularly reviewed as part of a provider's quality assurance processes. Recommendations for specific system-level interventions will be made in the final year-end report when trends across regions can be summarized and based upon a larger number of reviews.

Appendix A: Consent and Scheduling Webinar

System of Care Practice Review (SOCPR) for CBHI

Provider Webinar on
Consent & Scheduling Procedures
Kelly English and Amy Horton
Technical Assistance Collaborative
November 20, 2013
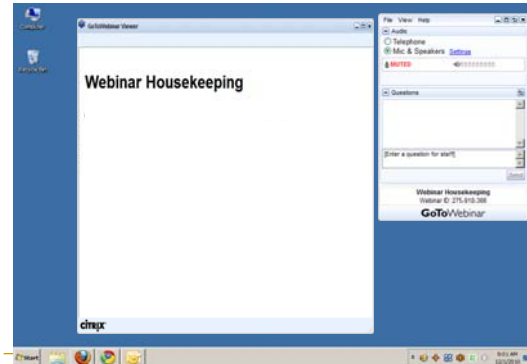
2

GoToWebinar Housekeeping: Time for Questions
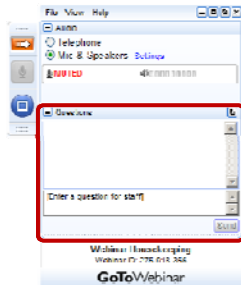
Your Participation

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

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

3

Introduction

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

4

What is the SOCPR?

- Method and instrument for assessing whether System of Care (SOC) values and principles are operationalized at the practice level
- The SOCPR is <u>NOT</u> an audit but rather a structured way to learn about how services are working for youth and families
- Results will be used to help identify areas where the system is performing well and where resources should be dedicated for system improvements

5

Your Role: Consent & Scheduling

The IHT clinician or care coordinator will be asked to:

- Describe the SOCPR process & obtain informed consent and authorization(s) to release information from the youth/family
- Notify TAC in 1-2 business days if family/youth does not consent to participate in SOCPR process
- Schedule interviews with a minimum of 4 respondents:
  1. Primary caregiver
  2. Youth if 12 or older (if not available then substitute with a provider familiar with the care planning process for the youth)
  3. Care coordinator or IHT clinician
  4. Family partner or TT&S worker (if not available then substitute with another provider familiar with the care planning process for the youth – therapeutic mentor, teacher, OP therapist, DCF worker, etc.)

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Consent to Participate

Consent Procedures

- IHT clinicians and care coordinators are responsible for obtaining consent from families/youth
- The primary caregiver and youth 18 or older who participate in interviews will receive a **$25 gift card to Target**
- Print TWO copies of each consent and release to have signed by the family
  - One for the family to keep
  - One to scan/email to TAC and then to keep for agency's own records

Consent Procedures

- TAC randomly selected three youth from your provider site to approach to gain consent
- A minimum of two youth per site is necessary
- We are oversampling by one youth at each site in the likely event that a youth declines to participate

Consent Procedures

- We will assign your provider site 2 'Primary' and 1 'Alternate' youths
- Approach families of the 2 primary youths to obtain consent and schedule the interviews
- Within 1-2 days of approaching family, let TAC know if family consented or declined
- If a 'Primary' youth/family declines, approach 'Alternate' youth/family to obtain consent and schedule the interviews
- If two youths decline to participate, TAC will select the next youth from a list of 15 at the site until the target of two is achieved

Consent Procedures

- The IHT clinician or care coordinator of the alternate youth should wait to contact the family until asked to by TAC because one or both primary youth declined to participate
  - Clinicians/care coordinators of alternate youth should be well-versed in SOCPR procedures in the likely event that youth 1 or 2 declines

Youth	Day	Required Info
1- Primary	1st Review Day	Consents, Releases & Schedule
2- Primary	2nd Review Day	Consents, Releases & Schedule
3- Alternate *Hold pending notification from TAC*	Not assigned	IF youth 1 or 2 declines, approach alternate for: Consents, Releases & Schedule

Obtaining Informed Consent

Three types of consent/assent:

- **1) Caregiver/Parental Consent:**
  - Completed regardless of youth's age
  - Ask caregiver to sign the *Caregiver Consent to Participate* section indicating they give their consent to participate
  - If the youth is ages 12-17, ask the caregiver to also sign the *Parental Consent for Child Ages 12-17* section
    - By signing this, the caregiver agrees allows their child to be interviewed
- **2) Youth (18 or older) Consent:**
  - Completed only if youth is 18 or older
- **3) Youth (ages 12-17) Assent:**
  - Completed only if youth is 12-17 years old

Obtaining Informed Consent

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

Age of Youth	Must Have
Under 12	•Caregiver Consent to Participate
12-17	•Caregiver Consent to Participate •Parental Consent for Child Ages 12-17 •Youth Assent
18 or older	•Youth Consent to Participate •Caregiver Consent to Participate (youth must sign a release authorizing the caregiver to be interviewed)

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Caregiver Consent

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

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

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

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Youth (18 or older)Consent

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

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

15

Youth (ages 12-17) Assent

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

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

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Consent FAQs

Q: When should I contact TAC to let them know if a family agreed (or not) to participate?

A. *Please notify Amy Horton at TAC by leaving a voice mail at 617-266-5657 x122 within 1-2 business days of approaching a youth/family. It is imperative that we know if a family has agreed (or not) ASAP so that we can randomly select another youth to participate if need be. If a family declines, please briefly indicate the reason why the caregiver/youth declined to participate.*

Q: What if one of the youth randomly selected to participate in the SOCPR is scheduled to "close" by the time the interviews will occur. Should I still approach them to participate?

A: *Yes. As long as a youth is actively enrolled in services at the time we do the final random selection, we are required to approach them to seek consent. The reasoning behind this is because even if a family closes within the time they are selected and the time the review occurs, chances are the providers and family remember the services well enough to provide a thoughtful review experience.*

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Consent FAQs

Q: If a youth is in the custody of the Department of Children and Families (DCF), who should sign the consent and release of information forms?

A: *The DCF worker for the youth must sign the caregiver consent and release of information forms for youth in their custody.*

Q: Are consent forms available in languages other than English?

A: *Yes. We have versions in Spanish as well as several other languages. Please contact Amy Horton if you need forms in a language other than English.*

Q: How do I return the signed consent forms to TAC?

A: *The preferred method is by scanning the forms and emailing them to Amy Horton at ahorton@tacinc.org . You can also fax them to the attention of Amy Horton at 617-266-4343. If you fax them please call Amy Horton at 617-266-5657 x 122 to let her know you have sent them.*

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Release of Information

Authorization to Release Info Form

- Indicates that youth/family allows specific people to be interviewed and have a record review conducted
- Complete and send TAC one Release for each person who will be interviewed
- Forms should be signed by:
  - Youth, if 18 or older
  - Primary caregiver/parent if youth under 18
- Forms completed for IHT Clinicians or Care Coordinators must also include the provider's agency name
  - This grants SOCPR reviewers permission to view the youth's record at the provider's site

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Authorization to Release Info- Page 1

Name and DOB of youth

Name of person (IHT Clinician, Care Coordinator, TT&S Worker) that family agrees can be interviewed. *Please write provider's agency name if applicable*

These are topics the family allows the interviewee to discuss with SOCPR Reviewer

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Authorization to Release Info- Page 2

Youth 18 or over should complete this section

Caregiver or parent of youth should complete this section

Release of Information FAQs

Q: How many releases of information do I need to have signed?

The parent/caregiver or youth (if 18 or older) must **sign a separate release of information form for each person who is scheduled to be interviewed.**

For All Youth
- One for the IHT clinician or care coordinator
- One for the family partner or TT&S worker (or other formal provider)

Additional Releases For Youth Under 18
- One for another formal provider (applicable when the youth is under 12 or if the parent does not give consent for the youth to be interviewed)

Additional Releases For Youth 18 or Older
- If the youth is 18 or older, the youth _must sign a release_ for the reviewer to interview his/her caregiver

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Release of Information FAQs

Q: Are release of information forms available in languages other than English?

A: Yes. We have versions in Spanish as well as several other languages. Please contact Amy Horton if you need forms in a language other than English.

Q: How do I return the signed release forms to TAC?

A: The preferred method is by scanning the forms and emailing them to Amy Horton at ahorton@tacinc.org . You can also fax them to the attention of Amy Horton at 617-266-4343. If you fax them please call Amy Horton at 617-266-5657 x 122 to let her know you have sent them.

Scheduling

Record Review Scheduling

- Record reviews will take place at the provider agency
- Providers are responsible for locating a private space in the office where a youth's records can be reviewed
- Record reviews should occur before any of the interviews
- Record reviews should be scheduled for 2 hours
- Clinicians and Care Coordinators **do not** need to be present for the record review
    - However, please have someone available to show the reviewer around and help get them situated

Record Review Scheduling

- Reviewers will need access to the youth's record maintained by your agency, which includes:
    - Comprehensive Assessment
    - CANS
    - Care/Treatment Plan
    - Intake and Referral Information
    - Progress Notes
    - Releases
    - *For youth enrolled in ICC:* Strengths, Needs, and Culture Discovery (SNCD)
- Some files may be hard copies and some may be electronic
    - If you cannot limit access to the selected youth's files only, please print out copies of the files for the reviewers
- Please have all records available and ready at the time the record review is scheduled to start

Interview Scheduling

- IHT Clinicians or Care Coordinators are responsible for scheduling interviews
- A minimum of **four (4) interviews** should be scheduled for each youth
- Interviews should be scheduled with:
    - Primary Caregiver/Parent
    - IHT Clinician or Care Coordinator
    - Family Partner or TT&S Worker or other formal provider if no FP or TT&S *(Note: If youth is in DCF custody the second formal provider interview should be with the DCF worker)*
    - Youth (if 12 or older) or another formal helper (teacher, outpatient therapist, therapeutic mentor, etc.) if youth is under 12 or caregiver does not want youth interviewed

Interview Scheduling

- All interviews should be scheduled on the day assigned to the youth
- Please keep in mind that the reviewer will need time to get to the next interview, so build in travel time between interviews
- Youth interviews should be scheduled **after** normal school hours

Early January (14-16) Scheduling

Early January Review Schedule

Monday, January 13	Tuesday, January 14	Wednesday, January 15	Thursday, January 16	Friday January 17
Reviewer Training	Reviewer Training/ Record Reviews	Reviews (1 per provider)	Reviews (1 per provider)	Reviewer Debriefing
9:30 – 5:00 Reviewer Training w/USF	9:30 – 1:00 Reviewer Training w/USF	Interview w/ Care Coordinator or IHT clinician *	Interview w/ Care Coordinator or IHT clinician *	Debriefing for reviewers only (with USF)
	1:30 - 6:00pm Record Reviews* (2 per provider)	Interview w/ Family Partner, TT&S, or 2nd formal provider	Interview w/ Family Partner, TT&S, or 2nd formal provider	
		Interview w/ caregiver	Interview w/ caregiver	
		Interview w/ youth (if 12 or older) or 3rd formal provider	Interview w/ youth (if 12 or older) or 3rd formal provider	

January 13 -17 Participating Providers:

Service Reviewed: ICC	Service Reviewed: IHT

Providers should plan to arrange space for up to 4 reviewers to review records Tuesday PM, as well as private space for formal provider interviews on Wednesday & Thursday

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Sample Early January Schedule

Tuesday, January 14		Wednesday, January 15		Thursday, January 16	
		9:00 – 10:30 AM (1 hour 30 min)	Interview with care coordinator or IHT clinician	10:00 – 11:00 AM (1 hour)	Interview with TT&S or family partner at provider agency
		10:30 – 11.30 AM (1 hour)	Interview with TT&S or family partner at provider agency	11:00 – 12.30 PM (1 hour 30 min)	Interview with care coordinator or IHT clinician
		11:30 – 12:30 PM (1 hour)	Interview with Therapeutic Mentor	12:30 – 1:00	Lunch
1:30 – 3:30 (2 hours)	Record review youth #1 at provider agency	12:30 – 1:00 PM	Lunch	1:00 – 1:30	Travel to provider site
		1:00 – 1:30	Travel to family home	1:30 – 3:00 (1 hour 30 min)	Interview with parent at family home
3:30 – 5:30 (2 hours)	Record review youth #2 at provider agency	1:30 – 3:00 PM (1 hour 30 min)	Interview with parent at family home	3:00 – 4:00 (1 hour)	Interview with youth (age 14) at family home

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Scheduling Template for Early January

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Late January (27-28) Scheduling

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Late January Review Schedule

Monday, January 27	Tuesday, January 28	Wednesday, January 29
Reviews (1 per provider)	Reviews (1 per provider)	Reviewer Debriefing
AM: Record Reviews*	AM: Record Reviews*	Debriefing for reviewers only
Interview w/ Care Coordinator or IHT clinician *	Interview w/ Care Coordinator or IHT clinician *	
Interview w/ Family Partner, TT&S, or 2nd formal provider	Interview w/ Family Partner, TT&S, or 2nd formal provider	
Interview w/ caregiver	Interview w/ caregiver	
Interview w/ youth (if 12 or older) or 3rd formal provider	Interview w/ youth (if 12 or older) or 3rd formal provider	

January 27-29 Participating Providers:

Service Reviewed: ICC	Service Reviewed: IHT

Providers should plan to arrange space for up to 2 reviewers to review records Monday & Tuesday AM, as well as private space for formal provider interviews.

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Sample Late January Schedule

Monday, January 27		Tuesday, January 28	
9:00 – 11:00 AM (2 hours)	Record review youth #1 at provider agency	9:00 – 11:00 AM (2 hours)	Record review youth #2 at provider agency
11:00 – 12:30 PM (1 hour 30 min)	Interview with care coordinator or IHT clinician	11:00 – 12:00 (1 hour)	Interview with TT&S or family partner at provider agency
12:30 – 1:00 PM	Lunch	12:00 – 12:30 PM (1 hour 30 min)	Lunch
1:00 – 2:00 PM	Interview with TT&S or family partner at provider agency	12:30 – 1:00	Interview with care coordinator or IHT clinician
2:00 – 3:00 PM	Interview with Outpatient Therapist	1:00 – 1:30	Travel to family home
3:00 – 3:30	Travel to family home	1:30 – 3:00 (1 hour 30 min)	Interview with parent at family home
3:30 – 5:00 PM (1 hour 30 min)	Interview with parent at family home	3:00 – 4:00 (1 hour)	Interview with youth (age 17) at family home

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Scheduling Template for Late January

Scheduling FAQs

Q: Should I schedule all the interviews at the provider site?

A: No. Only interviews with the provider and the record review need to occur at the provider site. Interviews with the caregiver/youth should occur at their home unless for some reason they would prefer an alternate location. When completing the scheduling form please make sure you note the address where the interview should occur.

Q: Do all of the interviews need to be scheduled during the days assigned to us?

A: Yes. If a family absolutely cannot participate that week due to prior commitments, then they are unable to participate in this round of SOCPR reviews and you should contact TAC immediately so that we can select another youth from your agency.

Scheduling FAQs

Q: For youth in DCF custody who should I schedule interviews with?

A: You should use your discretion here to determine who is in the best position to respond to the "caregiver" interview questions. In general it should be the person who has been the most involved in the services the youth is participating in and with whom the youth resides. This might be a foster parent, a grandparent, or the birth parent if they are actively involved in the service delivery process with you. DCF workers are not considered caregivers for this purpose of the interview but will need to sign the consent forms and the release of information form. We also suggest that the second formal provider interview be scheduled with the DCF worker for youth in DCF custody.

Wrapping Up

Receiving Documents

➢ Process:
1. TAC will send an email to providers that includes the password to the password protected Schedule file
2. TAC will send an email to providers that includes a link to TAC's Sharefile site
3. After clicking on the link, you will be asked to provide your name, title, email, and agency name
4. Then you can download the folder to your computer and open the files

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Returning Documents to TAC

➢ Return completed **consents and releases** by scanning and emailing them to Amy Horton at ahorton@tacinc.org or by faxing them to 617-266-4343

➢ Return completed **schedules** by saving the excel document and emailing it to Amy Horton at ahorton@tacinc.org

➢ **Consents, releases, and schedules must be sent to TAC by Friday, December 20, 2013.**

General FAQs

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

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

Q: Will translators be available if the family does not speak English?

A: Yes. TAC can arrange for a translator please contact Amy Horton at 617-266-5657 x 112 this as soon as possible so we can make the necessary arrangements.
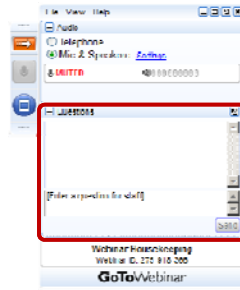
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TAC Contacts

For Questions and Concerns about Consent & Scheduling

Amy Horton
Human Services Program Assistant
617-266-5657 ext. 122
ahorton@tacinc.org

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Questions??

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Appendix B: Consent, Assent, and Release of Information Forms

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   ☐ All Medical Information & Treatment

☐ History of hospitalizations   ☐ Participation and Progress in Treatment

☐ Medications   ☐ Court/Probation/Parole Information

☐ School Functioning   ☐ How Needs Affect Daily Living Activities and Academic Progress

☐ Drug and Alcohol Use   ☐ 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.*

Ques-tion #	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 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2 ☐ +3 ☐ **Agree** Disagree very much / Disagree moderately / Disagree slightly / Neutral / Agree slightly / Agree moderately / Agree very much
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.*

Ques-tion #	Question	Data source	Rating/Response
5	Has the IHT team ever discussed the option of ICC with the youth/family?	**This question will need to be explicitly asked during the IHT provider interview as well as the family interview.**	☐ Yes *If yes, briefly explain below the family's reason for declining ICC.* ☐ 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 ☐ / -2 ☐ / -1 ☐ / 0 ☐ / +1 ☐ / +2 ☐ / +3 ☐ **Agree** Disagree very much / Disagree moderately / Disagree slightly / Neutral / Agree slightly / Agree moderately / Agree very much
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 ☐ / -2 ☐ / -1 ☐ / 0 ☐ / +1 ☐ / +2 ☐ / +3 ☐ **Agree** Disagree very much / Disagree moderately / Disagree slightly / Neutral / Agree slightly / Agree moderately / Agree very much
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 ☐ / -2 ☐ / -1 ☐ / 0 ☐ / +1 ☐ / +2 ☐ / +3 ☐ **Agree** Disagree very much / Disagree moderately / Disagree slightly / Neutral / Agree slightly / Agree moderately / Agree very much
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: Summative Question Organization

SOCPR Summative Questions

DOMAIN 1: Child-Centered and Family-Focused

Sub-domain: Individualized

Area: Assessment/Inventory
1. A thorough assessment or inventory was conducted across life domains.
2. The needs of the child and family have been identified and prioritized across a full range of life domains.
3. The strengths of the child and family have been unidentified.

Area: Service Planning
4. There is a primary service plan that is integrated across providers and agencies.
5. The services plan goals reflect needs of the child and family.
6. The service plan goals incorporate the strengths of the child and family.
7. The service planning and delivery informally acknowledges/considers the 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.

Area: Intensity of Services/Supports
9. The intensity of the services/supports provided to the child and family reflects their needs and strengths.

Sub-domain: Full Participation

10. The child and family actively participate in the service planning process (initial plan & updates).
11. The child and family influence the service planning process (initial plan & updates).
12. The child and family understand the content of the service plan.
13. The child and family actively participate in services.
14. The formal providers and informal helpers participate in service planning (initial plan & updates).

Sub-domain: Care Coordination

15. There is one person who successfully coordinates the planning and delivery of services and supports.
16. Service plans and services are responsive to the emerging and changing needs of the child and family.

SOCPR Summative Questions

DOMAIN 2: Community-Based

Sub-domain: Early Intervention

17. As soon as the child and family began experiencing problems, the system clarified the child and family's needs.
18. As soon as the child and family entered the service system, the system responded by offering the appropriate combination of services and supports.

Sub-domain: Access to Services

Area: Convenient Times
19. Services are scheduled at convenient times for the child and family.

Area: Convenient Locations
20. Services are provided within or close to the child and family's home community.
21. Supports are provided to the child and family to increase their access to service location(s). (Rate as "Does not Apply" if Summative rating #20 = +3)

Area: Appropriate Language
22. Service providers verbally communicate in the primary language of the child/family.
23. Written documentation regarding services/service planning is in the primary language of the child/family.

Sub-domain: Minimal Restrictiveness

24. Services are provided in an environment that feels comfortable to the child and family.
25. Services are provided in the least restrictive and most appropriate environment(s).

Sub-domain: Integration and Coordination

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 child.
27. There is a smooth and seamless process to link the child and family with additional services if necessary.

SOCPR Summative Questions

DOMAIN 3: Culturally Competent

Sub-domain: Awareness

Area: Awareness of Child and Family's Culture

28. Service providers recognize that the child and family must be viewed within the context of their own cultural group and their neighborhood and community.
29. Service providers know about the family's concepts of health and family.
30. Service providers recognize that the family's culture (values, beliefs and lifestyle) influences the family's decision-making process.

Area: Awareness of Provider's Culture

31. Service providers are aware of their own culture (values, beliefs and lifestyles) and how it influences the way they interact with the child and family.

Area: Awareness of Cultural Dynamics

32. Service providers are aware of the dynamics inherent when working with families whose culture (values, beliefs and lifestyle) may be different from or similar to their own.

Sub-domain: Sensitivity and Responsiveness

33. Service providers translate their awareness of the family's culture (values, beliefs and lifestyle) into action.
34. Services are responsive to the child and family's culture (values, beliefs and lifestyle).

Sub-domain: Agency Culture

35. Service providers recognize that the family's participation in service planning and in the decision making process is impacted by their knowledge/understanding of the expectations of the agencies/programs/providers.
36. Service providers assist the child and family in understanding/navigating the agencies they represent.

Sub-domain: Informal Supports

37. Service planning and delivery intentionally includes informal sources of support for the child and family.

SOCPR Summative Questions

DOMAIN 4: Impact

Sub-domain: Improvement

  38a. The services/supports provided to the **child** have improved his/her situation.
  38b. The services/supports provided to the **family** have improved their situation.

Sub-domain: Appropriateness

  39a. The services/supports provided to the **child** have appropriately met his/her needs.
  38b. The services/supports provided to the **family** have appropriately met their needs.