System of Care Practice Review Regional Report of Findings: Western

TAC
TECHNICAL ASSISTANCE
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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. A series of five regionally-based reviews of the care delivered by Intensive Care Coordination (ICC) and In-Home Therapy (IHT) providers are planned. This report presents the results from the reviews that occurred in May 2014 for providers serving the Western 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.

Western region review summary

The care of 25 randomly selected youth who received services from ICC or IHT providers in the Western region was reviewed using the SOCPR. Youth between the ages of 5-9 (n = 10) represented 40% of the sample, followed by youth between the ages of 10-13 (n = 8) at 32% of the sample. Sixty-eight percent (68%) of the youth were male. In terms of race, the largest

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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.

proportion of youth reviewed were White, at 44% (n = 11) of the sample, followed by Hispanic at 36% (n=9). English was identified as the language spoken at home for 78% of the families. At the time of the review, the largest number of youth (n = 9) had been receiving services between 4 to 6 months, with five of these youth enrolled in ICC and four youth enrolled in IHT. Twenty-one, or 84% of youth 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 special education, followed by DCF (n = 9). Four youth received services from DMH while two received Child Requiring Assistance services. One youth each was involved with DDS and MCDHH. The most frequently utilized service was IHT with 15 youth or 60% participating in this service, followed by Individual Therapy (n = 14 or 56%) and ICC (n = 13 or 52%). Eighty 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 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 Western region, SOCPR mean domain scores ranged from 5.18 to 6.19. The overall mean score of the cases examined was 5.8.

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 Western 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	95% CI Upper Limit
Overall	4.35	6.95	5.80	.83	5.49	6.11
Domain 1: Child-Centered Family-Focused	3.63	7.00	5.71	1.03	5.30	6.11
Domain 2: Community-Based	5.10	7.00	6.19	0.63	5.94	6.43
Domain 3: Culturally Competent	3.30	7.00	5.81	1.03	5.41	6.22
Domain 4: Impact	1.75	7.00	5.18	1.32	4.66	5.70

As the histogram in Figure 1 shows, fifty-six percent (14 of 25 cases) fell into the 6 range representing enhanced SOC implementation, and seven cases (28%) scored in the 5 range, reflecting good implementation. Four cases (16%) had means in the 4 range, demonstrating the need for improvement in implementing SOC principles.

Mean = 5.80
SD = .8272
N = 25
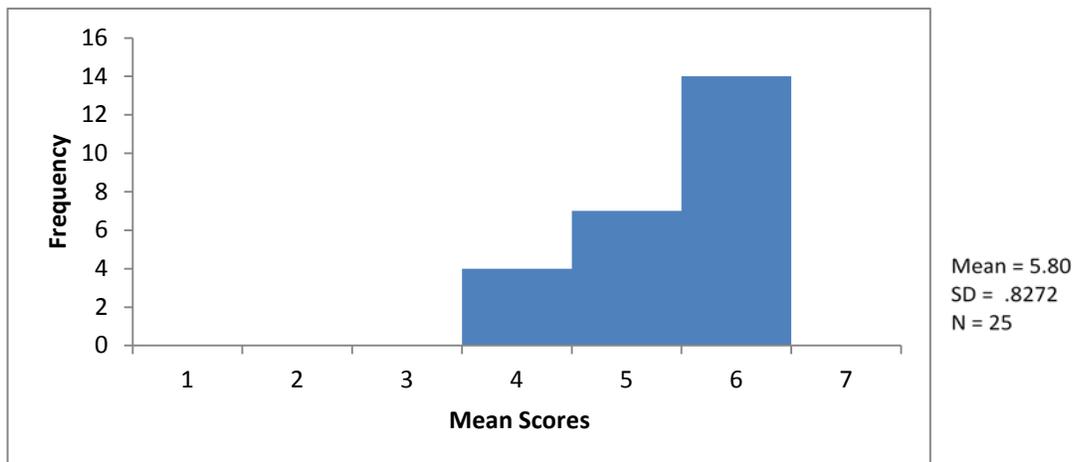
Identified strengths and opportunities for improvement

Overall, the findings from this review show that ICC and IHT providers in the Western 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.
- Western region providers are skilled at identifying and prioritizing needs and developing appropriate service plan goals.
- Youth and families are supported by providers to be full and active participants in the planning process.
- Service providers performed well at assisting children and families with understanding the service and navigating the agencies they represent.

Although overall ratings for the majority of youth reviewed fell in the enhanced (n = 14) or good (n = 7) range, findings indicated the greatest opportunities for growth toward the following:

- Service plans incorporate child and family strengths into goals.
- Service planning is 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 connects youth and families with additional services and supports.

Further, important differences between IHT and ICC cases reviewed in the Western Region revealed the need for improvements among IHT providers with respect to the thoroughness of assessments, identification of strengths and utilization of strengths in the service delivery

process, supporting youth and families to influence their own plans, 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 Western 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 Western region during May 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 May 2014 review cycle, the care of 25 randomly selected youth who received services from 13 provider sites, representing 12 unique provider organizations, was reviewed using the SOCPR. Six of these 13 provider sites were randomly selected IHT providers. The remaining seven provider sites represented six unique ICC provider organizations that serve the Western region, including two specialty providers. Thirteen of the youth had ICC serving as their care coordination "hub" while twelve 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 May 2014 review represented the fifth time the SOCPR has been used by the state to gather qualitative information about the service planning and delivery process in IHT and the fourth time it has been used with ICC providers. See Table 4 for a summary of review dates by region.

Review dates	Metro/ Boston	Northeast	Southeast	Central	Western
June 3-7 2013 (training round)	X				
June 24-26 2013 (training round)	X				
October 21-22 2013		X			
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 May 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 via conference phone to clarify any questions and address concerns raised by the Massachusetts team.

An additional five Massachusetts-based reviewers were trained during the January 2014 cycle. The training was conducted by the Technical Assistance Collaborative with each new reviewer partnered with an experienced Massachusetts-based SOCPR reviewer.

Provider selection

For the May SOCPR review, it was determined that the care of 25 youth from 13 provider sites in the Western region would be reviewed. Seven ICC providers with sites in the Western region were selected to participate. According to a recent Monthly CSA Access Report, the Western 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 November 2013 Massachusetts Behavioral Health Access (MABHA) report was used to randomly select six IHT providers serving the Western region. According to the report there were 14 IHT providers with 24 sites serving 1,737 youth, ranging from a high of 245 to a low of five, with an average capacity of 72 youth. By comparison, the six selected provider sites reported serving a total of 440 youth or 25% of the youth participating in IHT in the Western region. At the time the sample was selected the six sites were serving between 28 to 113 youth, with an average capacity of 73 youth.

Youth selection

Once the providers were identified, MassHealth requested that selected ICC providers prepare a report including the names 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. This process continued until the target of two youth from each of the selected organizations was reached for a total of 25 youth, two per provider site.[2]

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[2] One ICC provider had only one youth reviewed. This provider is a small specialty provider with sites in Western and Central Massachusetts. It was determined that this provider would have one youth reviewed from their Central Mass site and one youth reviewed from their Western Mass site.

To reach the goal of 25 reviews for the Western review round, a total of 44 families were asked to participate in the SOCPR. Of those families who either declined or were unable to participate approximately 42% were enrolled in ICC and 58% 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.

TABLE 5: REASONS FOR NOT PARTICIPATING

Reason	N of families
Anxious/overwhelmed	6
Unavailable/out of town	5
Unable to be contacted	4
Medical reasons	3
Other	1
Total	**19**

Consent process

In March 2014, TAC hosted a webinar for the randomly selected providers to educate them about the consent and scheduling processes. A copy of the presentation is located in Appendix A. Following the webinar, IHT clinicians or care coordinators for the randomly selected youth approached the youth (if 18 or older) or the parent/caregiver to ask if they would be willing to participate in the 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 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.[3] 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.[4] 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[5] 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 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.

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[3]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

[4] Ibid.

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

The interviews are based on a set of questions intended to obtain the 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 the 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 Western 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-five youth participated in the Western SOCPR review. Thirteen of the youth had ICC serving as their care coordination "hub" while 12 had IHT serving in that role. A summary of the demographic characteristics of these youth are presented in the figures below.

Age of Youth

18-21 yrs
4% (n=1)

Age, 0, 0%

0-4 yrs
4% (n=1)

14-17 yrs
20% (n=5)

5-9 yrs
40% (n=10)

10-13 yrs
32% (n=8)

Gender

Gender, 0, 0%

Female
32% (n=8)

Male
68% (n=17)

Race

Asian
4% (n=1)

Race, 0, 0%

Chooses not to self-identify
4% (n=1)

African-American
8% (n=2)

White
44% (n=11)

Hispanic
36% (n=9)

Bi-racial
4% (n=1)

Language spoken at home

American Sign Language
4% (n=1)

Spanish
18% (n=5)

English
78% (n=21)
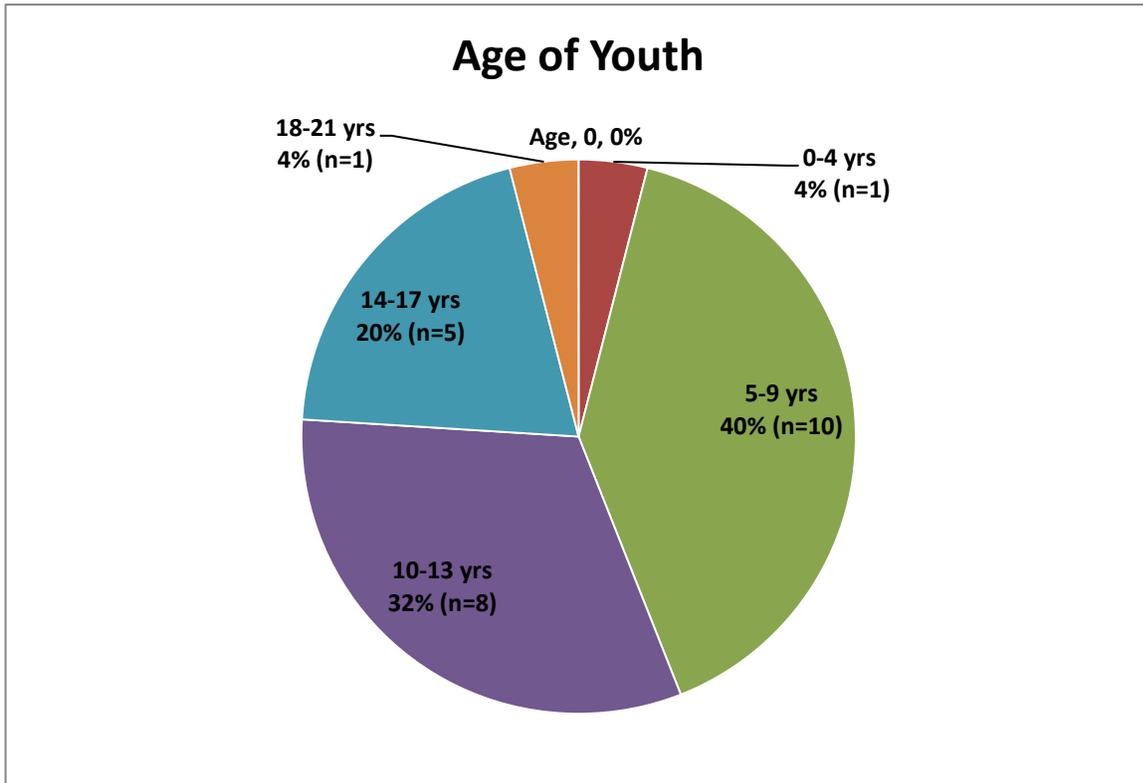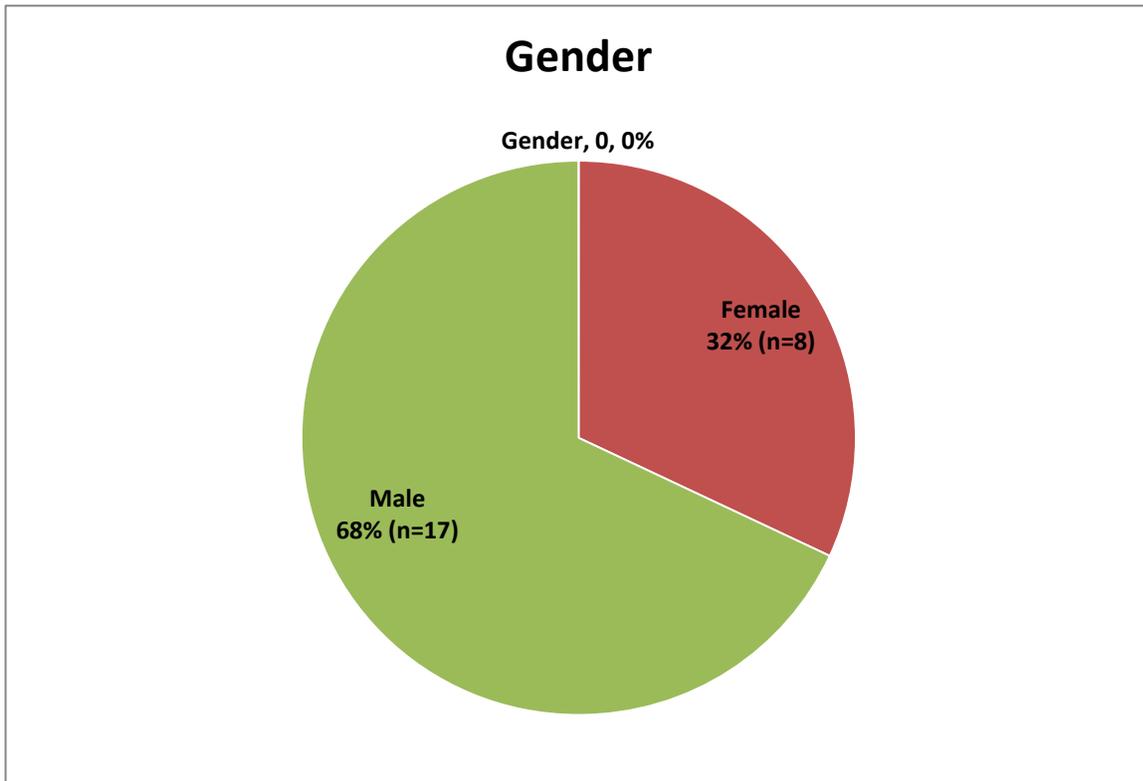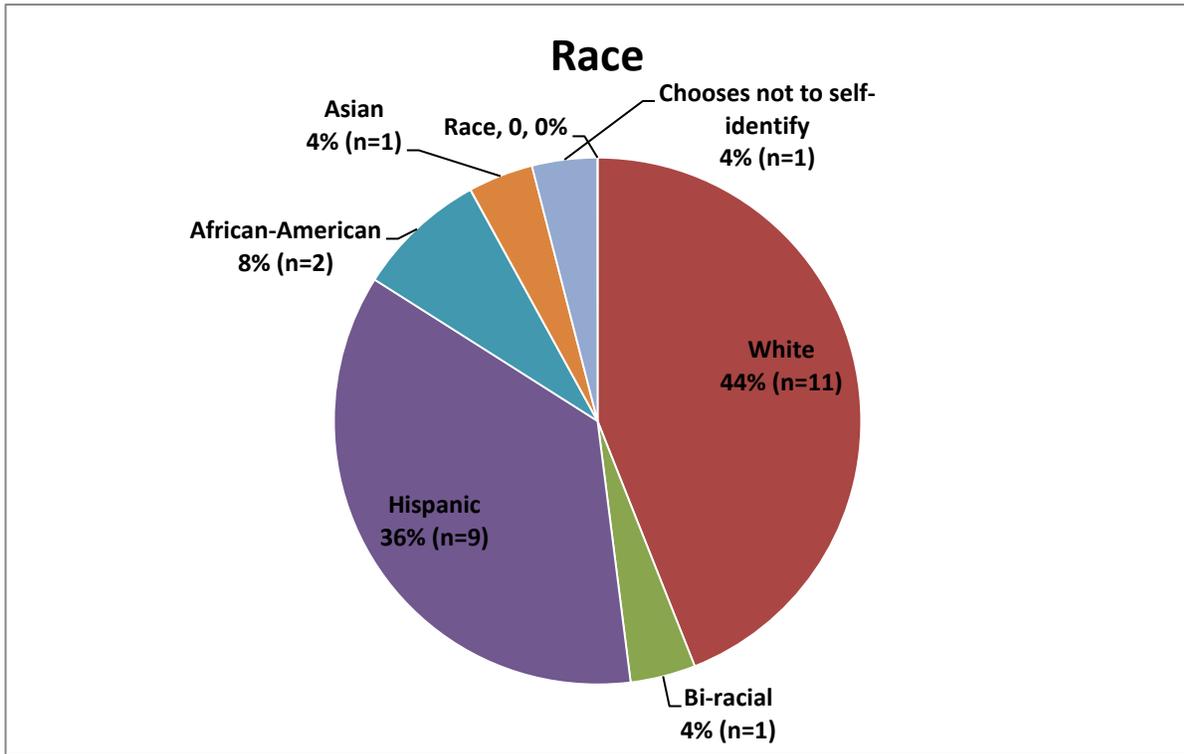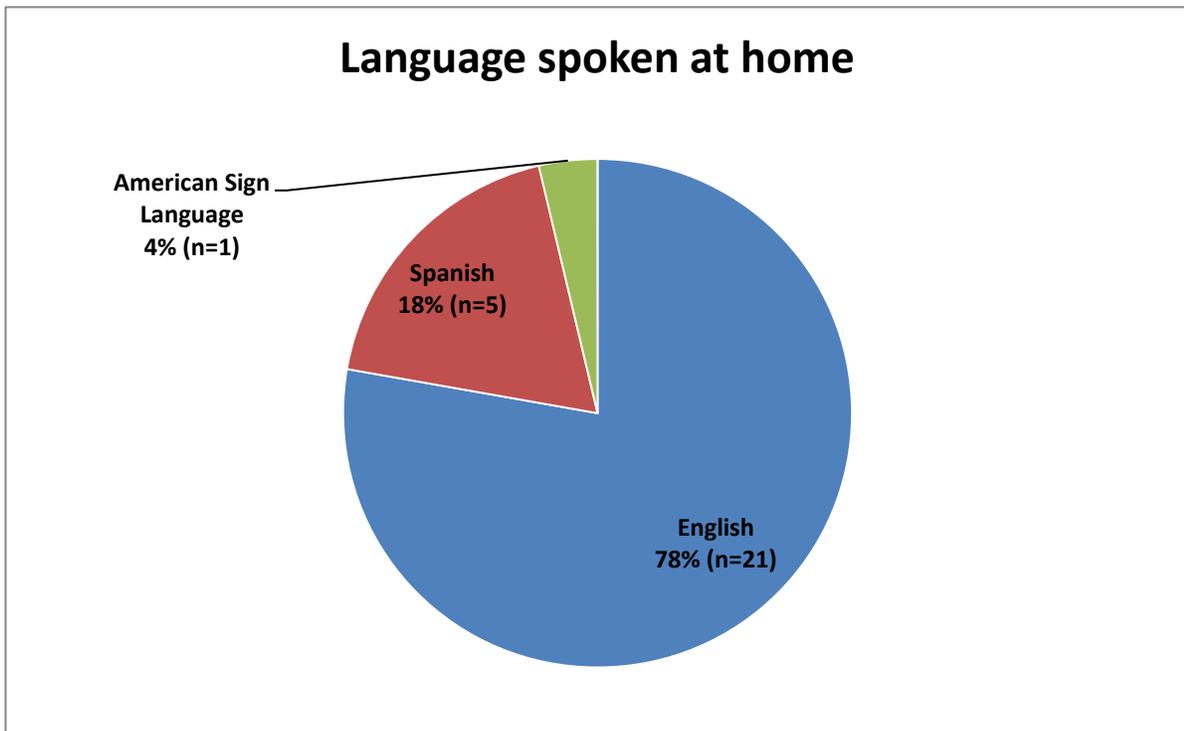
Note: Two youth speak more than one language at home; therefore the total number above is greater than 25.

As shown above, youth between the ages of 5-9 (n = 10) represented 40% of the sample, followed by youth between the ages of 10-13 (n = 8) at 32%, then youth ages 14-17 (n = 5) at 20%. Sixty-eight percent of the youth were male. In terms of race, the highest proportion of youth were White (44%), followed by Hispanic at 36%. Two youth were African-American, and one youth each was Asian, Bi-racial, and chose not to self-identify (4%). English was identified as the language spoken at home for 78% of the families (21), while 18% (n=5) spoke Spanish and one family (4%) communicated through ASL.

FIGURE 6: LENGTH OF ENROLLMENT AT TIME OF REVIEW
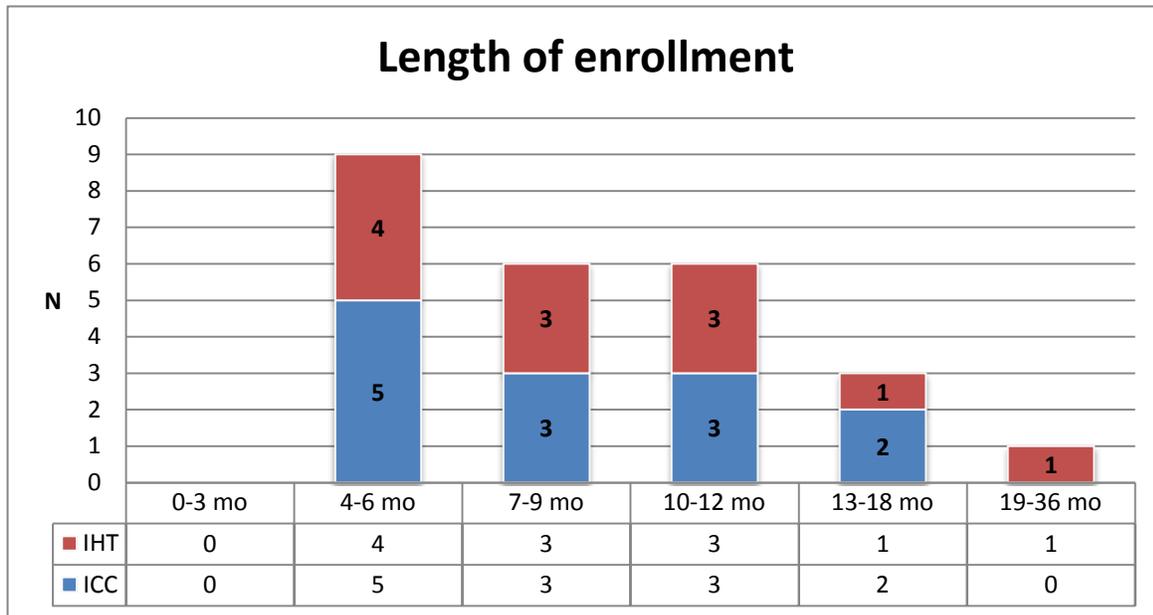
	0-3 mo	4-6 mo	7-9 mo	10-12 mo	13-18 mo	19-36 mo
IHT	0	4	3	3	1	1
ICC	0	5	3	3	2	0

At the time of the review, the largest number of youth (n = 9) had been receiving services between 4-6 months, with five of these youth enrolled in ICC and four youth enrolled in IHT. Six youth, three youth in ICC and three youth in IHT, had been enrolled between 7-9 months and 10-12 months. Three youth, two in ICC and one in IHT, had been enrolled between 13-18 months and one youth in IHT was enrolled 19-36 months. Two of the twenty-five youth (8%) were discharged between the time they were sampled and their reviews occurred. One of the youth was enrolled for 4-6 months and the other was enrolled for 7-9 months before discharge. Since the remaining twenty-three youth in the sample remained in active treatment at the time of their review, their length of stay at the time of discharge is not known.

Behavioral Health Services

	ICC	IHT	TT&S	IHBS	TM	FS&T	Ind therapy	Psych.	Day Treat./ Partial Hosp.
■ IHT	0	12	9	0	0	0	9	6	1
■ ICC	13	3	1	3	3	11	5	4	0
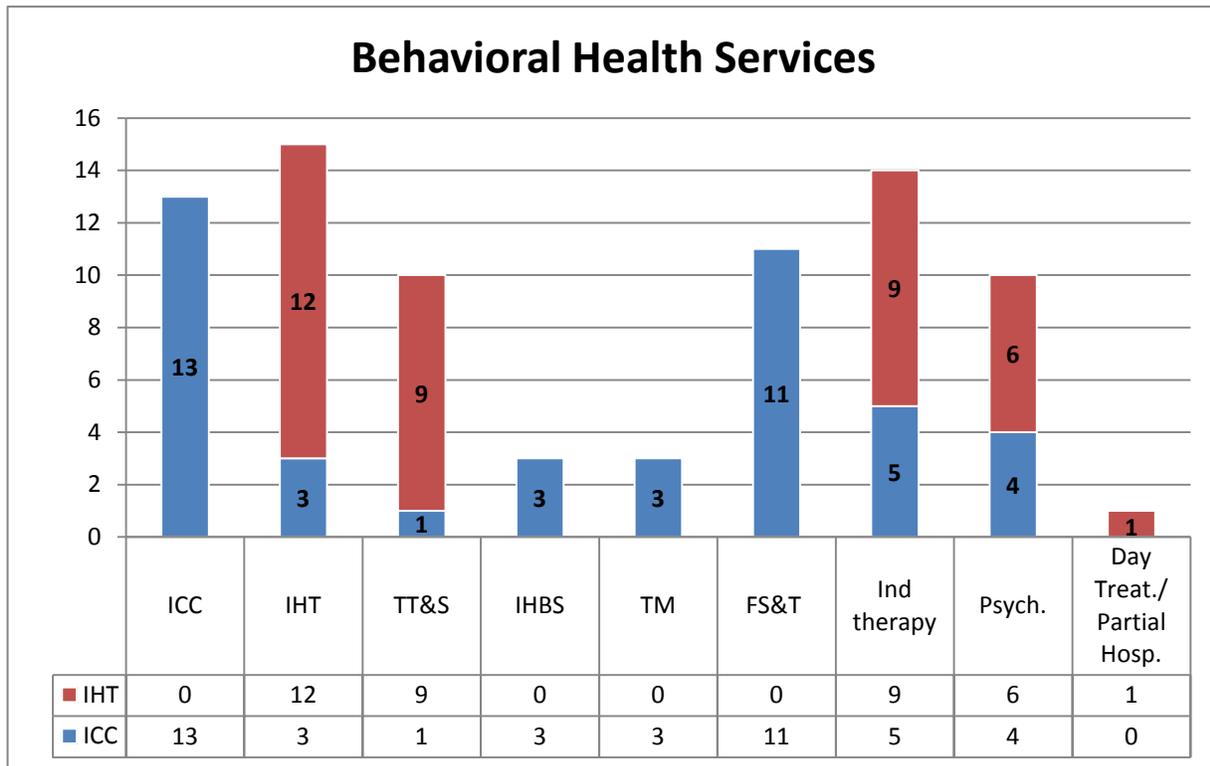
Note: Youth may be enrolled in more than one behavioral health service therefore the total number above is greater than 25.

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 15 youth, or 60%, participating in this service, followed by Individual Therapy (n = 14 or 56%) and ICC (n = 13 or 52%). Eleven youth, or 44%, had Family Support and Training (FS&T), with all of those youth having concurrent enrollment in ICC.[6] Ten youth, or 40% of the sample, were participating in Therapeutic Training & Support (the paraprofessional component of IHT), with the majority of those youth having concurrent enrollment in IHT (n = 9). Ten youth, or 40%, were also enrolled in Psychiatry, with six being enrolled in IHT and 4 enrolled in ICC. IHBS and Therapeutic Mentoring both had 12% of the sample, or 3 youth, enrolled, all with concurrent enrollment in ICC. Day Treatment/Partial Hospital was the least utilized intervention (n = 1 or 4%).

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

Other service systems utilized

	DMH	DDS	DCF	Sp.Ed.	CRA	Other	None
■ IHT	2	0	2	6	1	0	2
■ ICC	2	1	7	5	1	1	2
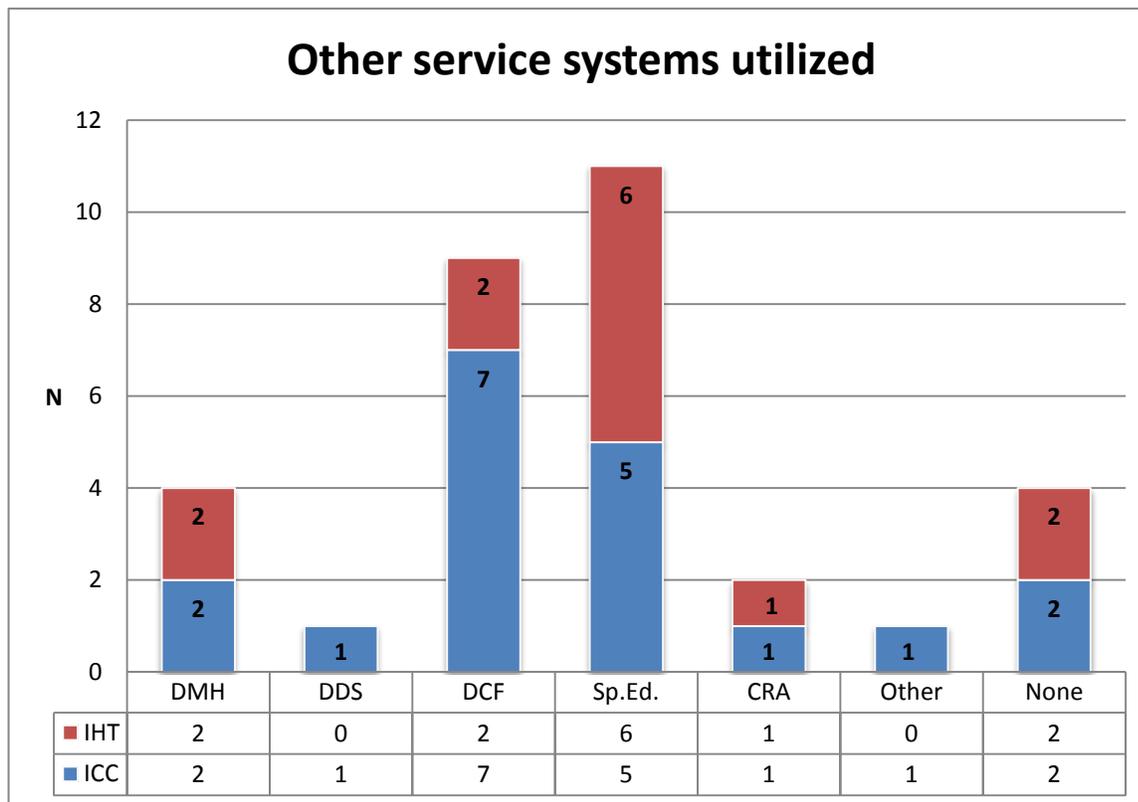
Note: Youth may be involved with more than one service system therefore the total number above is greater than 25.

Of the 25 youth reviewed, 21 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 eleven of the youth were involved with Special Education, followed by DCF (n = 9). Eleven of the thirteen youth enrolled in ICC had at least one instance of involvement with another service system, with seven of the eleven youth having involvement with two systems. Of the twelve youth enrolled in IHT, ten were involved with at least one other service system, with one youth involved with two other systems. Four youth were involved with DMH, with two of them concurrently enrolled in ICC and the other two concurrently enrolled in IHT. Two youth, one enrolled in ICC and one enrolled in IHT, received Child Requiring Assistance (CRA) services. One ICC enrolled youth received services from DDS and another ICC enrolled youth received services from the Massachusetts Commission for the Deaf and Hard of Hearing. No youth were reported to be receiving services from DYS or Probation. Four youth, two enrolled in ICC and two enrolled in IHT, had no other service system involvement.

Behavioral health conditions
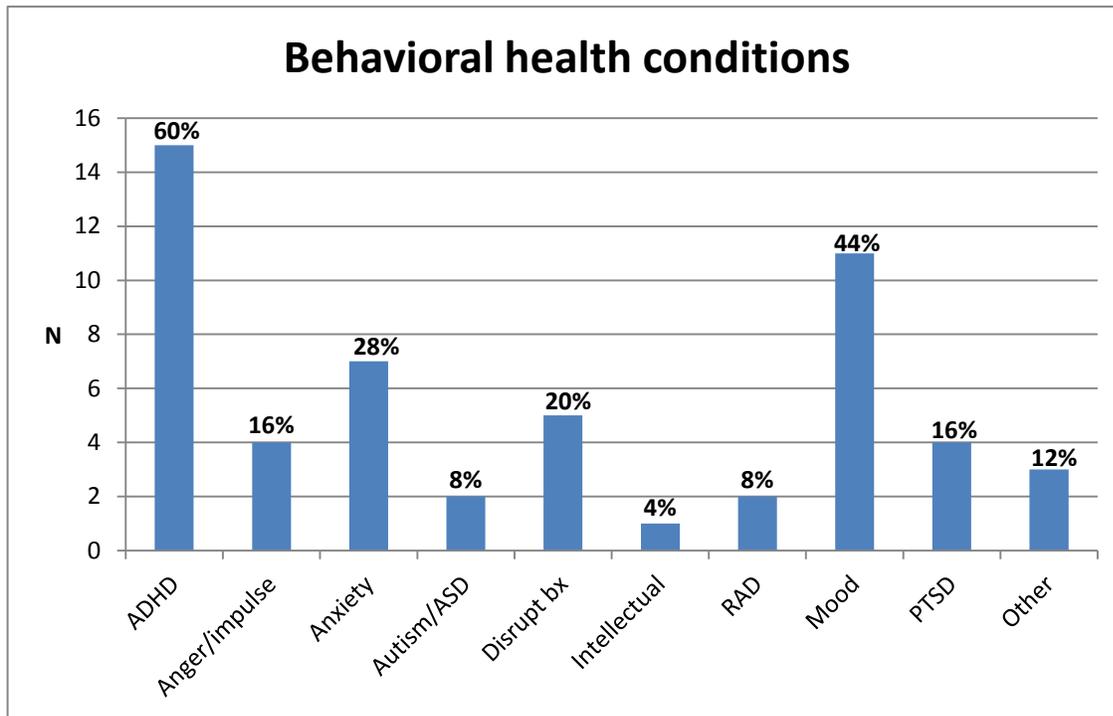
Note: Youth may have more than one diagnosis therefore the total above is greater than 100%.

The most common type of behavioral health condition reported among the youth reviewed was ADHD (60% or n = 15), followed by mood disorder (44% or n = 11). Both anxiety and medical conditions were reported among 28% of youth (n = 7). Twenty percent of the sample or 5 youth had a disruptive behavior disorder. Anger/impulse control problems and Post-Traumatic Stress Disorder (PTSD) were both reported at 16% (n = 4) each. Another three youth (12%) had 'Other' conditions listed.[7] Youth with autism and Reactive Attachment Disorder (RAD) comprised 8% of the sample (n = 2), while 4% of the sample (n = 1) had a learning disability. It is important to note that twenty (80%) 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

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[7] 'Other conditions' included: Pica, Anorexia, and Adjustment disorder with mixed disturbance

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 25 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 Western region, SOCPR mean domain scores ranged from 5.18 to 6.19. The overall mean score of the cases examined was 5.80. 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 Western 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: WESTERN REGION SOCPR DOMAIN SCORES

	Min	Max	Mean	Standard Deviation	95% CI Lower Limit	95% CI Upper Limit
Overall	4.35	6.95	5.80	.83	5.49	6.11
Domain 1: Child-Centered Family-Focused	3.63	7.00	5.71	1.03	5.30	6.11
Domain 2: Community-Based	5.10	7.00	6.19	0.63	5.94	6.43
Domain 3: Culturally Competent	3.30	7.00	5.81	1.03	5.41	6.22
Domain 4: Impact	1.75	7.00	5.18	1.32	4.66	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 5.80. Fifty-six percent (14 of 25 cases) fell into the 6 range representing enhanced SOC implementation, and seven cases (28%) scored in the 5 range, reflecting good implementation.

Four cases (16%) had means in the 4 range suggesting the need for improvement in implementing SOC principles. Three of these were youth with IHT and one had ICC. For the youth with ICC, improvements were needed in the Child-Centered and Family-Focused, Culturally Competent, and Impact domains. Specific issues were that: the service plan was not aligned or integrated with the work of other providers and DCF, needed services and supports (e.g. IHT, family partner) had not been put in place, the service had not been delivered with the intensity the family required (i.e. no contact for several weeks), participation in service planning by providers, school, and the youth was lacking, care coordination and communication with service providers and DCF was poor, and natural supports had not been engaged to help

support the family. ICC in this case was not found to appropriately meet the needs of this youth or family and had little impact on improving the family's situation.

For the two of the three youth with IHT areas for improvement were identified in the Child-Centered and Family-Focused, Culturally Competent, and Impact domains. For one of these youth, concerns focused on the fact that strengths were not identified nor incorporated into the service planning and delivery process, the plan was not integrated across providers nor had formal and natural supports been active participants in the planning process, care coordination was lacking, awareness of and responsiveness to cultural factors was limited, and natural and community-based supports had not been engaged; leading to limited impact of the services for this youth and family. Practice areas identified as needing improvement for the second youth, were with respect to individualized care, full participation of the family in service planning and delivery, limited care coordination with other service providers, lack of sensitivity and responsiveness to the youth's values, beliefs, and preferences, and no engagement of natural or community supports; services in this case were found to not have improved the family situation nor were deemed appropriate for the youth (i.e. could have likely been served with same benefit in outpatient). The third youth had low scores primarily the Child-Centered and Family-Focused and Culturally Competent domains with practice issues specifically needing improvement related to: the assessment quality, the family influence and participation in service delivery and planning, limited care coordination, poor exploration of the family's values, beliefs, and preferences leading to little adaptation of practice, and no inclusion of natural supports.

FIGURE 10: OVERALL MEAN SCORES

Mean = 5.80
SD = .8272
N = 25
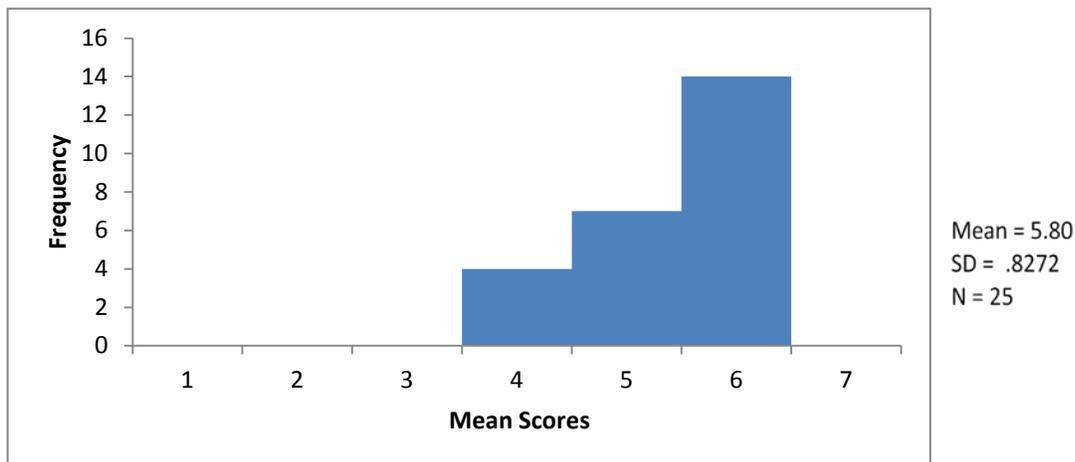
FIGURE 11: CHILD-CENTERED AND FAMILY-FOCUSED MEAN SCORES

Mean = 5.71
SD = 1.025
N = 25
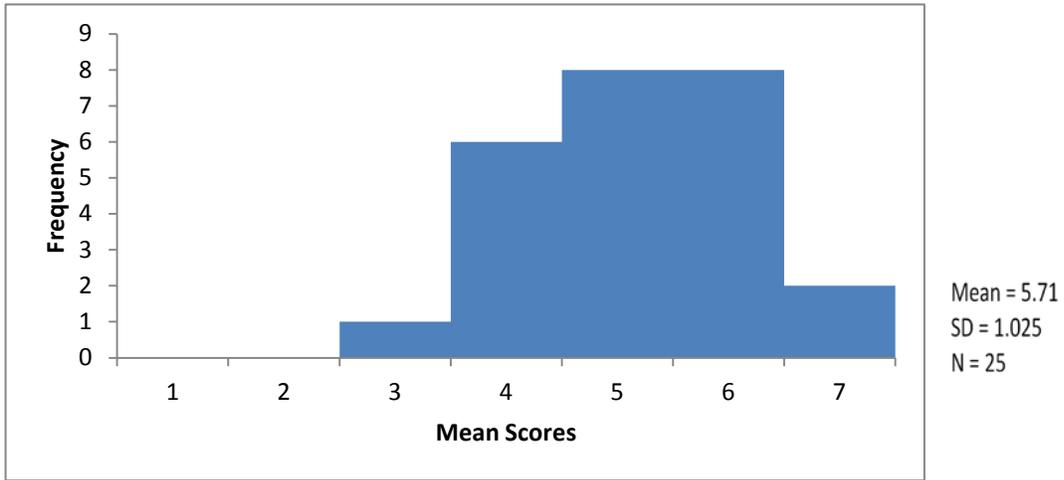
FIGURE 12: COMMUNITY-BASED MEAN SCORES

Mean = 6.19
SD = .6278
N = 25
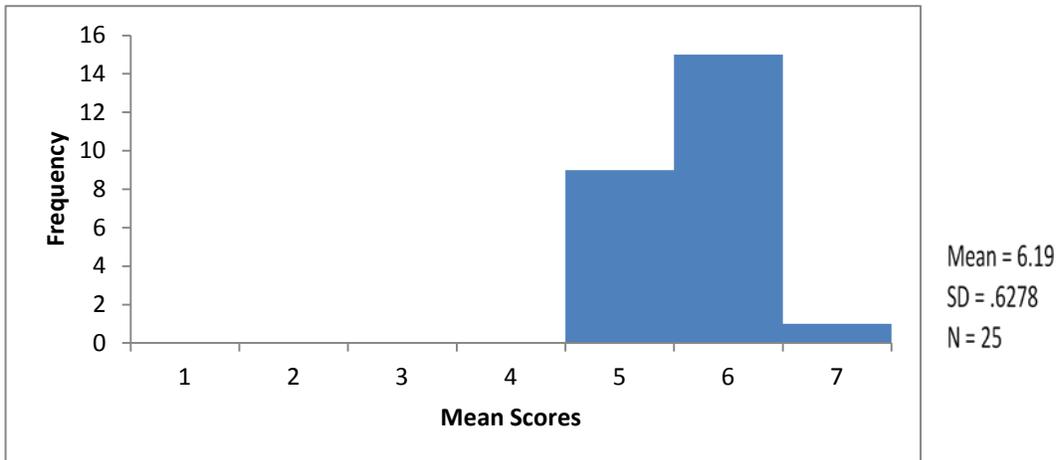
FIGURE 13: CULTURALLY COMPETENT MEAN SCORES

Mean = 5.81
SD = 1.032
N = 25
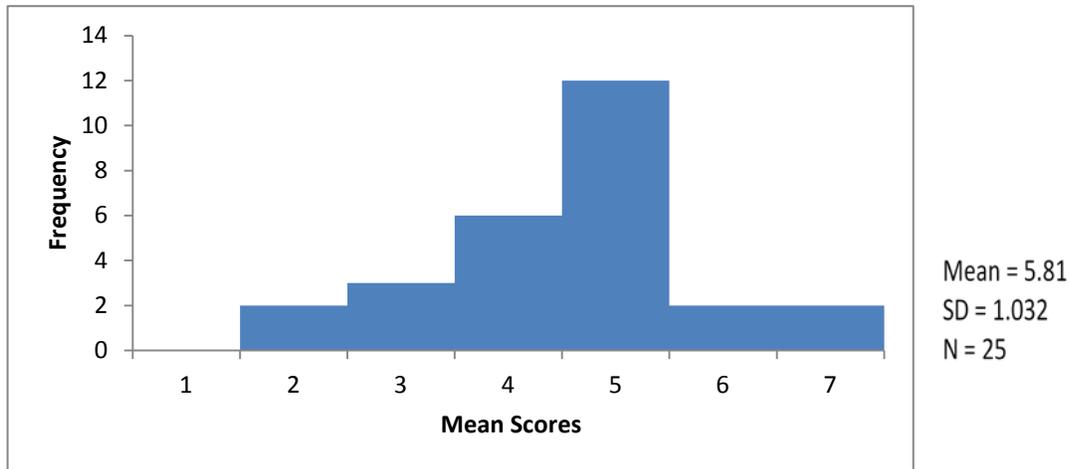
FIGURE 14: IMPACT MEAN SCORES

Mean = 5.18
SD = 1.316
N = 25
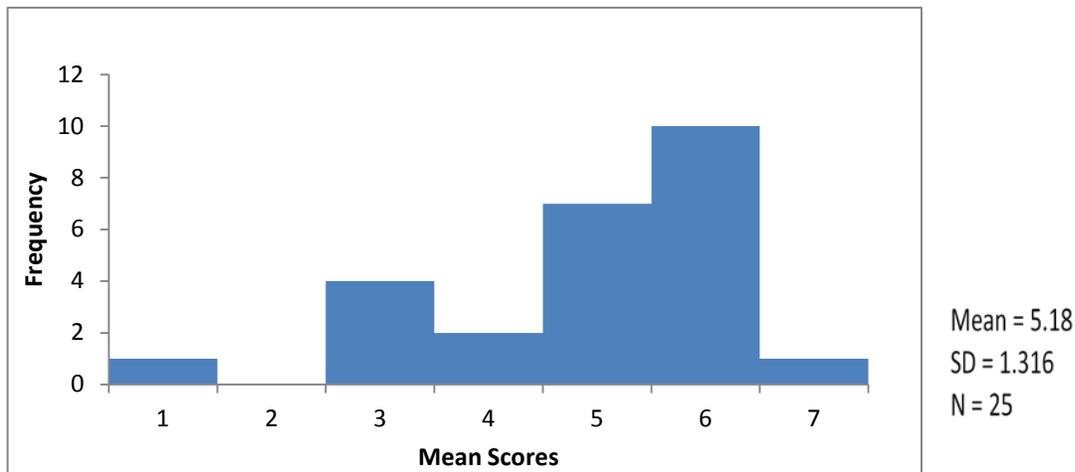
SOCPR individual question scores

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 25 families for the Western 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 5.71, which reflects good implementation of this SOC principle. In general, analysis of quantitative and qualitative data provided by SOCPR raters suggests that Western providers are delivering services that are child-centered and family-focused. Mean scores for ten youth (40%) fell in the 6 to 7 range indicating enhanced implementation of this principle, and eight youth (32%) had mean scores in the 5 range reflecting good implementation. Six youth (24%) had mean scores in the 4 range and one (4%) was in the 3-4 range, suggesting lower implementation of this principle.

Areas in this domain showing the greatest strengths included: good identification of child and family needs that were accurately prioritized across life domains, service plan goals that reflect the needs of the youth and family, full and active participation by youth and families in service planning and delivery processes, and clear understanding by families of the content of their service plans. Individual item/question mean scores and qualitative comments suggested several areas needing potential improvement in this domain. IHT providers in particular struggled with identifying strengths of the youth and family during the assessment process and also could improve their ability to provide successful care coordination. Both ICC and IHT providers could enhance their ability to incorporate identified strengths into treatment goals and better engage formal providers and informal helpers in planning.

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. Seventy-two percent (72%) of reviewers agreed moderately or very much that a thorough assessment was conducted across life domains. Several reviewers mentioned that the assessment was informed by multiple sources and incorporated a variety of modalities (e.g. interviews with key informants, reviews of prior assessments, CANS, etc.). A couple of reviewers commented that the provider was aware that the assessment was an ongoing or dynamic process. Almost half of the reviewers commented about the thoroughness of the assessment noting:

- "It addressed a full range of life domains."
- "The SNCD (Strengths Needs and Culture Discovery) at least touched on every relevant life domain and generated some useful information about the family culture."
- "The IHT team has a good working understanding of the needs of this youth and family."
- "A thorough assessment was conducted across the majority of domains."

Several reviewers however reported that the assessment was missing important information, was incomplete, or offered only a limited picture of the youth and family. One reviewer highlighted this by commenting, "The assessment did not capture the complete family history for this youth and there was missing family information as well as treatment history." Another reviewer reported that there was, "No reference to mom's history that might be significant and only cursorily to child's history." Reviewers also described that the assessment consisted only of

"check-off" lists with no written formulation offering a deeper understanding of the youth and family's needs and strengths.

Eighty percent (80%) of reviewers agreed moderately or very much that the needs of the youth and family had been identified and prioritized, and 56% agreed (85% ICC vs. 25% IHT) that the strengths of the youth and family had been identified. An analysis of reviewer comments mentioned that many of the ICC or IHT providers had done a good job of identifying and prioritizing the needs of the youth and family. A reviewer of a youth with ICC stated, "The ICC, the team, and the parent did a great job identifying the needs and strengths of both the youth and the family." With another reviewer describing that, "The needs of the child were clearly and appropriately prioritized; safety and stabilization first." Several other reviewers specifically mentioned that the identification of needs and strengths happened in a timely way with one reviewer commenting, "[The] mother felt that the IHT understood the problem quickly."

In eleven instances, reviewers specifically commented that the provider had done a good job of identifying youth and family strengths during the assessment process, though this was more common for youth with ICC. Comments reflective of this included:

- "The team was very aware of child and parents strengths and relied on them in their work."
- "Strengths listed with some sophistication e.g. not just that he likes games but that he can think strategically as evidenced in his playing games."
- "The ICC identified strengths for both mom and the daughter and included them in the assessment."

Seven reviewers mentioned that strengths were missing in the assessment, were identified only for the youth and not other members of the family, or that when strengths were identified they were limited or not strengths that could be drawn upon for the work with the family. Examples included:

- "ICC and FP appear to have developed a weak formulation of child strengths and limited understanding of and insight into child's personality, interests, and abilities."
- "Mom's difficulties and youth's difficulties emphasized more than strengths."
- "The inventory of strengths was minimal."
- "Assessment documentation did not include any family strengths."

Service Planning: The second area of focus within the *Individualized* sub-domain is the service plan. Exactly sixty percent (60%) of reviewers agreed moderately or very much that the service plan was integrated across providers. This was more common for ICC, with only 42% (5 out of 12) of reviewers of IHT cases agreeing this was the case compared to 77% (10 out of 13) of reviewers of ICC cases. Integration of the plan and planning process across providers was mentioned at least seven times with statements such as:

- "All interviewees know the goals and strategies on the plan. Outpatient therapist (started 2 months ago) is incorporating the IHT plan into her treatment plan in preparation for transition out of IHT."
- "The ICC maintains a primary service plan that is integrated across providers. The formal providers were aware of the strengths, needs and concerns for this family."
- "Although each provider may have a different objective/plan under this goal they are all working to reach this goal."

Concerns about the lack of integration of the plan and planning process were also noted by several reviewers. One reviewer commented that, "While there was a treatment plan in the record that was guiding the IHT work, it was not clear that other providers or system partners were involved in its development." Another reviewer expressed concern about the lack of consensus across providers and the family stating, "There was some disagreement on the part of the providers as well as the caregivers regarding the goals on the plan."

In 80% of the cases reviewed the reviewer agreed that the service plan goals reflected the needs of the youth and family. Almost two-thirds of reviewers commented that the service plan goals were connected to needs identified through the assessment process. One reviewer stated that, "The team appears to have a full understanding of the needs of the family and child and the service plan appears to address all of these needs." Another described that the plan, "was focused on the family prioritized needs across multiple domains." While another reviewer summed this finding up by commenting that, "There is a clear plan focused on those needs that everyone agrees upon and it reflects a good understanding of the child on the part of the IHT and ICC." Some reviewers, however, did express concern that important needs were not identified or addressed in the planning process. As an example, one reviewer stated that, "The treatment plan did not address interventions for the primary concern which was family conflict and coordination of treatment across a divorced family."

Only 44% of reviewers agreed that service plan goals incorporated the strengths of the youth and family. Further, only three reviewers specifically commented the service plan goals incorporated strengths, with almost half highlighting that this was a practice challenge. A reviewer described this issue by reporting, "The service plan does not mention any strengths for the child or family, nor were providers able to identify strengths beyond the fact that the parents care about their daughter and are strong advocates." Another went on to write that, "Not clear from the record how the goals incorporate child's and mom'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, 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 percent (60%) of reviewers agreed that providers did. However, only 42% of reviewers of IHT cases (5 of 12) agreed versus 77% (10 of 13) of those reviewing ICC cases. Comments from reviewers reflective of this included:

- "While not explicitly included in the stated goals, the child's strengths are otherwise acknowledged by the team members interviewed as well as by this caregiver."
- "The providers were aware of the strengths of the youth, in particular her love for animals and were able to incorporate this into the planning process."
- "Plan incorporates strengths of child – his strategic thinking, love of drawing, and quick intellect as a basis for many therapeutic activities."

Types/Intensity of Services/Supports: The final two areas in the individualized sub-domain focus on whether the types and the intensity of services and supports provided to the youth and family reflect their needs and strengths. Seventy-two percent (72%) of reviewers agreed moderately or very much that the types of services/supports provided reflected the youth's identified needs and strengths. Seventeen, or 68%, of reviewers agreed that the intensity of services/supports reflected the youth and family's needs and strengths. Numerous reviewers mentioned that providers had done a good job of putting services and supports in place that closely matched the needs and strengths of the youth and family. Comments reflective of this included:

- "Services were obtained that addressed the needs and strengths of the family across multiple domains. These included non-BH domains such as housing and employment."
- "It is evident that IHT is a good fit for the family because the child struggles at home with being defiant, following directions and needs constant redirection. The family is committed to working with services and willing to try new interventions."
- "The ICC did a good job of connecting services and supports for this youth that related to the concerns and strengths of the youth. An example is that the youth was connected with a TM and a therapist that understood RAD and adoption issues."
- "IHT, TT&S, Individual Therapy, Medication and School supports (504 Plan) have been helpful for the child and family and reflect their needs and strengths as acknowledged by the caregiver and providers."

Reviewers did identify some practice challenges related to the types of services and supports. Specifically reviewers found that additional services and supports were needed or that the current service was not the right fit for the family. For example one reviewer mentioned that, "Therapeutic Mentor services was identified as a service that could help the family, a referral was put in and there were no notes on follow up." A reviewer of a youth with IHT found that, "The level of coordination needed with this family is more than should be expected from IHT, and the whole situation would benefit from ICC." While another reviewer of an IHT case noted that, "This family would benefit from more effective care coordination."

When describing the intensity of the services, many reviewers noted that both the family and the team believed the intensity of the services was appropriate. A reviewer highlighted this by commenting, "All of the team members felt that the current intensity of the services and supports were just right." While another stated, "all agree that intensity is just right. Child has made significant progress, according to interviewees." Some reviewers did report concerns in this area. For example a reviewer noted that, "At the time of the interview the family had not seen

the ICC in over 3 weeks and there had been a lack of follow through around providing additional supports and helping mom get those services."

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.	5.80	0	1 (4)	3 (12)	0	3 (12)	7 (28)	11 (44)
2. The needs of the child and family have been identified and prioritized across a full range of life domains.	6.08	0	0	2 (8)	0	3 (12)	9 (36)	11 (44)
3. The strengths of the child and family have been identified.	5.36	1 (4)	1 (4)	3 (12)	0	6 (24)	6 (24)	8 (32)
Area: Service Planning								
4. There is a primary service plan that is integrated across providers and agencies.	5.68	0	0	4 (16)	0	6 (24)	5 (20)	10 (40)
5. The service plan goals reflect needs of the child and family.	6.16	0	0	1 (4)	0	4 (16)	9 (36)	11 (44)
6. The service plan goals incorporate the strengths of the child and family.	4.88	0	3 (12)	4 (16)	2 (8)	5 (20)	6 (24)	5 (20)
7. The service planning and delivery informally acknowledges/considers the strengths of the child and family.	5.56	0	0	4 (16)	1 (4)	5 (20)	7 (28)	8 (32)
Area: Types of Services/Supports								
8. The types of services/supports provided to the child and family reflect their needs and strengths.	5.68	0	1 (4)	2 (8)	1 (4)	3 (12)	11 (44)	7 (28)
Area: Intensity of Services/Supports								
9. The intensity of the services/supports provided to the child and family reflects their needs and strengths.	5.56	0	2 (8)	2 (8)	0	4 (16)	10 (40)	7 (28)

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 72% of the time that youth and families actively participate in the service planning process. Sixty-eight percent (68%) of reviewers agreed moderately or very much that the youth and family influence the service planning process (85% ICC vs. 50% IHT), and 80% 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 parents reported full participation and investment in the service planning process, that they have come to lead the care planning process, and that they feel they determine the outcome of the process. The father stated, 'I like it because at the meetings they have a paper with the goals and our needs and strengths. We review them and discuss and it really helps me learn.'"
- "Caregiver is very involved with the planning and care for her child. Acknowledges that she participates and influences planning and service delivery decisions- 'very much so.'"
- "The family is fully integrated into the care planning process and actively participates with services."

A specific challenge in this area identified by several reviewers was that the child in particular was not included in a meaningful way or had not been engaged in the planning process. For example one reviewer noted that the, "Youth is quite immature for her age and so contributes to service planning minimally." Another expressed concern that there was, "Little evidence of engagement of the youth in planning. Heard a lot of 'she [the youth] didn't understand.'" While another reviewer mentioned that, "Youth was fairly non-participatory and generally disinterested and uninvolved."

Reviewers agreed moderately or very much 84% of the time that the youth and family were actively participating in services. Reviewers for only four of the 25 youth reviewed - two receiving IHT and two 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, 52% of reviewers agreed moderately or very much that they were involved. Reviewers identified many challenges here, particularly with engaging school personnel and/or informal supports in the planning process. Examples included:

- "The tracking program was never included in any of the service planning process and it does not look like school was invited to participate either."
- "IHT has attempted to involved DCF, school and other providers in service planning; however, some have been responsive and others have not. School is quite responsive and contributes to service planning but other entities/providers are not as responsive as she would like."

- "There are no informal supports engaged with the family despite having lived in the community for 8 years."
- "The school has not been engaged as a partner in the planning process despite serious concerns about truancy and inappropriate behavior at school. This is a huge missing piece."

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).	6.04	0	0	2 (8)	0	5 (20)	6 (24)	12 (48)
11. The child and family influence the service planning process (initial plan and updates).	5.76	0	0	5 (20)	0	3 (12)	5 (20)	12 (48)
12. The child and family understand the content of the service plan.	6.28	0	0	1 (4)	0	4 (16)	6 (24)	14 (56)
13. The child and family actively participate in services.	6.16	0	0	3 (12)	0	1 (4)	7 (28)	14 (56)
14. The formal providers and informal helpers participate in service planning (initial plan and updates).	5.16	0	2 (8)	4 (16)	1 (4)	5 (20)	7 (28)	6 (24)

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 42% of reviewers (5 out of 12) of IHT cases agreeing vs. 92% (12 out of 13) of ICC. A review of comments for several youth with IHT suggested that care coordination was either minimal or not happening at all. Comments reflective of this included:

- "Care coordination for this youth was not occurring at the expected intensity required given the complexity of this youth and family situation. No one could clearly identify who was "in charge" or responsible for coordination with most thinking it was the DCF worker."
- "There really was no care coordination."
- "Although IHT should be the hub and care coordinator, it seems more like everyone does their own thing and she makes periodic contact with those involved--school, out-patient."

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

- "The IHT clinician has done a remarkable job of keeping all the team members involved through a series of intense crises."
- "ICC successfully coordinates and plans delivery of services and updates other team members regularly."
- "The ICC has done a great job of coordinating the services and keeping all parties in the loop regarding prioritizing of needs/concerns. The ICC has had pre-meetings with the caregivers and the providers in preparation for team meetings."
- "The family is clear as to who is responsible coordinating meetings and services."
- "ICC is key person for care coordination. There is much communication between mother, CSA staff and IHT staff."

Reviewers indicated that 76% of the time, 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:

- "As issues came up the plan was modified - constant triage of needs that required immediate attention."
- "IHT team identified that when another sibling returned to home, extra supports were needed for family and OP was referred and identified."
- "The family reported that the services do well adapting to new needs and changes in the home. For example, the family reported that the services were very supportive for when grandmother moved in and helped her find services as though she has always been part of the process."

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.	5.48	1 (4)	2 (8)	2 (8)	0	3 (12)	8 (32)	9 (36)
16. Service plan and services are responsive to the emerging and changing needs of the child and family.	5.68	0	1 (4)	3 (12)	0	2 (8)	12 (48)	7 (28)

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 = 6.19). Sixteen of the 25 cases (64%) fell into the enhanced implementation range with scores in the 6 to 7 range. The remaining nine youth were in the 5 range, reflecting good implementation of this SOC principle.

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. Providers were also successful at quickly clarifying the youth and family's needs. These areas represent strengths for the Western providers. One area highlighted for potential improvement in the *Integration and Coordination* sub-domain involved 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 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 80% of the time that providers quickly assessed and clarified the youth and family's initial concerns, and 60% 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 highlighted this by stating, "The ICC began working with this family immediately upon entering into services and working with them on identifying the needs/concerns." Another reviewer noted that, "The IHT service began quickly when referred, and the IHT clinician responded with urgency to the immediate needs." A reviewer of a youth with IHT commented that, "The IHT was quick to recognize needs and began to address them with family."

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, "There was a 30 day wait from referral to start of service. In-Home therapy made sense at time of referral, but has not addressed family needs/issues." Another indicated that while initial needs were quickly identified, connecting the youth to psychiatry services had not yet occurred, "Youth immediately described as depressed and with almost lifelong anxiety yet there was no mention of or follow-thru on med evaluation for him." In another case, there appeared to be a long lag time of five months between when the referral was made and when services began, with the reviewer adding that, "There was no explanation in the chart and the IHT, who had a more complete working chart, could not explain the delay."

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.	6.04	0	1 (4)	1 (4)	0	3 (12)	9 (36)	11 (44)
18. As soon as the child and family entered the service system, the system responded by offering the appropriate combination of services and supports.	5.56	0	2 (8)	1 (4)	0	7 (28)	8 (32)	7 (28)

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 (96%) that families indicated worked for them. Reviewers also noted that services were by and large provided in the family's home or nearby community locations. Comments reflective of this included:

- "Family chooses times for IHT, ensuring both mother and son can participate. Outpatient therapy time also chosen by family."
- "The family reports that all meetings are scheduled to meet their needs."
- "IHT clinician meets family at home or at park depending on mother's preference. This allows maximum flexibility for the family."
- "Family seen at home at times that are convenient."

Ninety-two percent (92%) of reviewers agreed moderately or very much that oral communication was provided to the youth and family in their primary language, whereas eighty-eight percent (88%) agreed that written documentation about services and supports was provided to the youth and family in their primary language.

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.	6.84	0	0	0	0	1 (4)	2 (8)	22 (88)
Area: Convenient Location								

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 (%)
20. Services are provided within or close to the home community.	6.92	0	0	0	0	0	2 (8)	23 (92)
21. Supports are provided to increase access to service location.*	7.00	0	0	0	0	0	0	2 (100)
Area: *Appropriate Language*								
22. Service providers verbally communicate in the primary language of the child/family.	6.64	0	0	1 (4)	1 (4)	0	2 (8)	21 (84)
23. Written documentation regarding services/service planning is in the primary language of child/family.	6.32	2 (8)	0	0	1 (4)	0	2 (8)	20 (80)

*N = 2; 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 92% agreed moderately or very much that they were provided in the least restrictive and most appropriate environment. One reviewer commented that the, "Services are provided in home (and other community settings) which is least restrictive and most comfortable, according to all concerned." Another noted, "Services are provided in the family's home- the least restrictive and most appropriate environment. The child has not required hospitalization since being discharged in July 2013."

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.	6.84	0	0	0	0	0	4 (16)	21 (84)
25. Services are provided in the least restrictive and most appropriate environment.	6.60	1 (4)	0	0	0	1 (4)	2 (8)	21 (84)

Sub-domain 2d: Integration and coordination

In this sub-domain, 60% of reviewers agreed moderately or very much that there was on-going two way communication among and between all team members. A difference between ICC and

IHT was observed here, whereby 77% 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 42% of the IHT cases reviewed. Concerns expressed by reviewers of youth with IHT in this area included:

- "Communication with parents is less inclusive than best practice suggests. The parents are not involved in the clinical team meetings, although they are asked for input after clinical decisions are formulated."
- "IHT clinician tends to communicate TO people with less emphasis on receiving communication from others."
- "Family work does not happen and there is not communication/coordination with the sister's team. In-Home therapist does not have clear understanding of what outpatient therapist is addressing in treatment."
- "Communication is not consistent amongst the team members. There has been very little communication with the school despite the youth's attendance and troublesome behavior. Consistent communication with DCF was also a concern."

Despite these concerns, reviewers did offer examples of good communication. A reviewer of a youth with ICC commented that, "Communication among team members appears strong. It seems frequent enough to allow the team to be responsive to changing circumstances in the family and to effectively coordinate team activities." While another reviewer stated, "The ICC does a great job of communicating between all team members. She includes the ideas of all team members and keeps all team members apprised of any new changes or developments to the plan."

Only 48% 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 4.84 of all the questions in the Community-Based domain. Challenges noted by reviewers varied here; some reported concerns with access to individual therapy while others mentioned therapeutic mentoring, IHT, and linguistically appropriate services for a family with a deaf member. Staff turn-over, insurance issues, lack of follow-through on the part of the provider, long wait times, and poor fit between the identified provider and the youth or family's needs, were cited as reasons for the lack of a smooth and seamless process for connecting youth and families with additional supports and services.

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	5.24	0	3 (12)	3 (12)	0	4 (16)	9 (36)	6 (24)

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 (%)
members including the child.								
27. There is a smooth and seamless process to link the child and family with additional services if necessary.	4.84	0	5 (20)	3 (12)	1 (4)	4 (16)	6 (24)	6 (24)

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 5.81 which represents good implementation of this SOC principle. Fourteen (56%) of the youth reviewed had mean scores in the 6 to 7 range suggesting strong practice in this domain. Another six youth (24%) had mean scores in the 5 range suggesting good implementation of this SOC principle. Three youth (12%) had mean scores in the 4 range, and two (8%) 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 (4.32) 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: Eighty-four percent (84%) of reviewers agreed moderately or very much that providers recognized youth within the context of their culture and their community, and 80% agreed that providers know about the family's concepts of health and family. Eighty percent (80%) also agreed that providers understood that a family's culture influenced their decision-making process. Positive comments from reviewers in this area included:

- "They [the care coordinator and family partner] describe cultural competence as respect for the individual, 'meeting people where they're at,' and recognizing and examining how one's own attitudes and culture can influence interactions with the

individuals they serve. They feel that providing culturally sensitive services is an essential part of their job."

- "Caretaker and providers acknowledge the importance of family and education in their cultures and see it as a link between them."
- "The service providers were able to talk about the parent's culture in the context of previous parenting and the concerns that resulted on how the parent was parented."
- "It seemed clear that helpers encourage lots of talk about the power of family culture, including about how each family has its own concept of family."

When reviewers noted concerns in this area, they observed that providers had only limited recognition that culture was an important area to explore with the family. A couple of reviewers specifically mentioned that discussing issues pertaining to the family's values, beliefs, and preferences could have led to deeper engagement and enhanced connection with the family.

Awareness of Provider's Culture: Seventy-two percent (72%) of reviewers indicated that providers understood their own values and principles and how that might influence how they worked with youth and families. Reviewers offered several specific examples of how the provider's recognition of their own culture helped enhance their work with the youth and family. For example, one reviewer commented that, "The team is able to connect with the family at their level and because they share so much in common are better able to support them." A reviewer of a youth with IHT reported that the clinician "could describe her parenting style very clearly and used her own experience to model for this mother." While another reviewer noted that, "The clinician recognized that she had to check her own beliefs about women and work given the mother's social isolation and lack of natural supports." 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: Seventy-two percent (72%) of reviewers agreed that providers were aware that there may be subtle cultural dynamics present between themselves and the families with whom they worked. Comments from reviewers suggested that the provider's grasp of the family's culture and their awareness of their own culture led to a clear understanding of the cultural dynamics influencing their work with the youth and family. A few reviewers did report respondents were either confused by the question, had not considered the issue prior to the review, or acknowledged that cultural issues were not considered a focus of their work.

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	6.12	0	0	2 (8)	0	2 (8)	10 (40)	11 (44)

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 (%)
group and their neighborhood and community.								
29. Service providers know about the family's concepts of health and family.	5.96	0	0	3 (12)	0	2 (8)	10 (40)	10 (40)
30. Service providers recognize that the family's culture, values, beliefs and lifestyle influence the family's decision-making process.	6.08	0	0	2 (8)	0	3 (12)	9 (36)	11 (44)
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.	5.84	0	0	2 (8)	1 (4)	4 (16)	10 (40)	8 (32)
Area: Awareness of Cultural Dynamics								
32. Service providers are aware of the dynamics inherent when working with families whose cultural values, beliefs & lifestyle may be different from or similar to their own.	5.92	0	0	2 (8)	0	5 (20)	9 (36)	9 (36)

Sub-domain 3b: Sensitivity and responsiveness

Scores in the *Sensitivity and Responsiveness* sub-domain indicated that reviewers agreed moderately or very much for 64% of the youth reviewed that providers translated their awareness of the family's values, beliefs, and lifestyle into actions. An even higher percentage of reviewers, 72%, agreed that services were responsive to the child and family's values, beliefs and lifestyle. Examples highlighted by reviewers in this area included: awareness of intergenerational issues and inclusion of extended family in service delivery and drawing upon importance of family or education to further treatment goals. A few reviewers did note 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.

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 into action.	5.68	0	1 (4)	2 (8)	0	6 (24)	8 (32)	8 (32)
34. Services are responsive to the child and family's values, beliefs and lifestyle.	5.76	0	1 (4)	3 (12)	0	3 (12)	8 (32)	10 (40)

Sub-domain 3c: Agency culture

Within the *Agency Culture* sub-domain, 88% 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. This was true for 100% of ICC cases and only 67% of IHT cases. Further, 80% indicated that providers assist the child and family in understanding and navigating the agencies they represent, with 92% of ICC reviewers agreeing versus 67% of IHT reviewers.

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

- "Caretaker acknowledges that 'everything was explained' and 'I keep the paperwork.'"
- "Family is very well aware about agency rules and appears to know the expectations of the agency. Providers reported that they update families for any agency updates that would have any impact on them."
- "The parent was aware of the agencies policies, and how the agency worked. She had discussed learning about the agency culture at the beginning of services."
- "Providers continuously keep family in the loop by informing them of any major changes that would impact them."
- "All providers noted that they had helped the family to understand service array, benefits of services, limitations of services, client rights and other practical aspects of 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	6.32	0	0	0	0	3 (12)	10 (40)	12 (48)

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 (%)
knowledge/understanding of the expectations of the agencies/programs/provider.								
36. Service providers assist the child and family in understanding/navigating the agencies they represent.	6.12	0	0	2 (8)	0	3 (12)	8 (32)	12 (48)

Sub-domain 3d: Informal supports

Only 28% of reviewers (five ICC cases and two IHT cases) agreed moderately or very much that service planning and delivery intentionally included informal or "natural" sources of support for the youth and family. This question had the lowest mean score at 4.32 of all the questions across all domains. 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. Comments from reviewers in this area included:

- "Caregiver spoke about feeling isolated and needing informal supports. The team had not even considered a parent support group."
- "Not clear from chart that informal supports have been called upon or included in planning or services."
- "When grandmother left the house, it was not evident that the team stayed in touch with her or efforts to keep her on the team. It was not evident that other informal supports were brainstormed."
- "The IHT clinician has explored engaging informal supports but states that there are none."

TABLE 18: SUB-DOMAIN 3D INFORMAL SUPPORTS

SUBDOMAIN 3d: Informal Supports	Mean	Disagree very much n (%)	Disagree moderately n (%)	Disagree slightly n (%)	Neither agree nor disagree n (%)	Agree slightly n (%)	Agree moderately n (%)	Agree very much n (%)
37. Service planning and delivery intentionally includes informal sources of support for the child and family.	4.32	2 (8)	4 (16)	4 (16)	0	8 (32)	3 (12)	4 (16)

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 an overall mean score of 5.18. Mean scores for 11 youth (44%) fell in the 6-7 range suggesting that the services and supports had enhanced impact. Seven youth (28%) had mean

scores in the 5 range suggesting good impact. Two youth (8%) had mean scores in the 4 range, and five (20%) had mean scores in the 1-3 range, suggesting that service planning and delivery could be strengthened in order to improve the youth and families situation and more appropriately meet their needs. It is also important to keep in mind that 23 of the 25 youth were still in active treatment at the time of the review, with eight of the youth in active treatment enrolled for six months or less. Accordingly, reviewers would expect to find clinicians and families continuing to work to resolve outstanding issues and meet treatment goals. Otherwise, there would be no continuing need for the services.

Sub-domain 4a: Improvement

Sixty-four percent (64%) of reviewers agreed moderately or very much that services and supports provided to the *family* as a whole helped improve their circumstances. However, slightly fewer (60%) agreed the *youth's* situation had improved as a result of the services and supports s/he received. Areas of improvement that stood out included: enhanced feelings of parental competency in managing their child's behaviors and symptoms, reduced family conflict and improved communication patterns, better quality of life due to obtaining assistance with housing, getting a job, or medical care, functional improvements in school and home, as well as reduced behavioral health symptoms. Comments illustrative of these improvements included:

- "Stabilizing the family's housing and helping them develop money management strategies so that they are now saving some money have improved the family's situation."
- "The youth is receiving individual therapy now and his hallucinations have decreased."
- "Youth and mom have improved communication, and mom has begun to use a few different techniques that IHT has suggested."
- "The custodial parent (and the majority of the team) felt that the youth had improved and that her behavior was better, that they did not need to utilize mobile crisis, and that the youth was getting involved in outside activities."
- "Mother's parenting skills were improved and there was more consistency with follow through in her part."
- "The family has been provided tools to use to better support youth. The family reported, they have come a long way and because of the services, the child has changed for the better."

Several reviewers mentioned unmet needs or outstanding issues that limited youth or family progress. Areas noted include: better connections with natural/community supports, unresolved school problems, medication adjustments or evaluations, and establishment of connection to additional services/supports. A few reviewers commented that services were not particularly effective in reducing the youth's problematic behaviors or behavioral health symptoms. When describing the lack of improvement for a youth with ICC one reviewer commented that, "The biggest challenge is that services to date have not helped this little girl be more safe and stable, nor to access appropriate therapy and schooling." While a reviewer of a youth with IHT made a similar statement, "The youth continues to not attend school regularly. Symptoms of depression and defiance of parental and school rules have not improved."

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	5.28	3 (12)	0	0	0	7 (28)	11 (44)	4 (16)
	FAM	5.28	0	3 (12)	1 (4)	0	5 (20)	14 (56)	2 (8)

CH=Child; FAM=Family

Sub-domain 4b: Appropriateness

Sixty percent (60%) of reviewers agreed moderately or very much that that services and supports being provided to the *family* were appropriate for their needs. However, slightly fewer (56%) agreed the services and supports provided to the youth appropriately met his/her needs. Reviewers commented that ICC and IHT providers alike had appropriately addressed needs such as: helping families with housing stability, identifying and developing strategies for more effective management of the child's behavior at home, improving coping skills, and enhancing family communication. (It is not surprising that there are cases in which urgent basic needs such as housing must be resolved before the family will really be able to focus on issues such as behavior management.)

However, some reviewers indicated that the services and supports had not appropriately addressed the child and family's needs. A few reviewers mentioned that services such as ICC, therapeutic mentoring, IHT, or IHBS that could have been helpful had not been put in place. Reviewers also noted that for some providers a lack of clinical skill or sophistication had left some issues unaddressed. In a few cases reviewers mentioned that supporting families through transition was a major unmet need. For example, one reviewer stated: "The IHT is experiencing a challenge in knowing when to close and could use more evidence in showing X's progress. There is a potential for family functioning to decline when IHT leaves, despite the introduction of outpatient treatment." For a family with ICC the reviewer described that there had been little "time spent in transitioning the family out of ICC."

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	5.04	3 (12)	1 (4)	1 (4)	0	5 (20)	12 (48)	3 (12)
	FAM	5.12	0	3 (12)	2 (8)	0	6 (24)	12 (48)	2 (8)

CH=Child; FAM=Family

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 13 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. Reviewers indicated that 58% of the youth (n = 7) did not need a care planning team to coordinate services from the same or multiple providers.

Question 2 asked about receiving services from state agencies or special education and the need for coordination of those services. Sixty-six percent (66%) of reviewers (n = 8) indicated that the youth did not need a care planning team to coordinate services from state agencies or special education.

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	7 (58.3)
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. Half (n = 6) 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.	1 (8.3)	2 (16.7)	1 (8.3)	0	2 (16.7)	2 (16.7)	4 (33.3)

For question 4, eleven reviewers (92%) indicated that the youth not had been enrolled in ICC previously. The one family that had been previously enrolled in ICC was no longer enrolled because the, "intense coordination [was] not necessary." Additionally, the reviewer indicated that the notes reflected the ICC team "dissolved."

	Response	n (%)
Q4. Has the youth previously been enrolled in ICC?	No	11 (92)

Question 5 showed that the option of receiving ICC had been discussed with nine of the 12 families by the IHT team. For the nine families where the IHT presented the option of ICC, three of the families reportedly did not feel it was needed, whereas two families felt that they did not have time and that they already had too many services. Two of the families had been referred to ICC, with one being referred two weeks prior to the review. The other family was referred previously, but did not receive a response from the CSA. In one instance, the family wanted to try a tracker program instead of ICC; however, the IHT said during the interview that ICC should probably be reintroduced as an option with the family. Lastly, one IHT team did not refer the family to ICC because they did not believe the family was eligible due to their insurance. Of the three families that were not asked about ICC services, two of the clinicians did not feel that the family needed such intensive care coordination. No reason was provided by the reviewer in one case.

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	3 (25)

Question 6 asked if the youth needed assistance from their provider in working with the schools. For two-thirds (67%) 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.	1 (8.3)	1 (8.3)	0	0	2 (16.7)	7 (58.3)	1 (8.3)

Question 7 asked reviewers to indicate if the IHT team was in contact with all the service systems involved with the youth and family. Sixty-seven percent (67%) 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	1 (8.3)	0	0	3 (25.0)	6 (50.0)	2 (16.7)

For question 8, reviewers were asked to indicate if the multiple service systems involved with the youth participate in care planning. One-fourth (25%) of reviewers agreed moderately or very much that providers, school personnel, or other state agencies 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.	1 (8.3)	2 (16.7)	3 (25.0)	0	3 (25.0)	2 (16.7)	1 (8.3)

Question 9 asked for information about the other hub dependent services that youth were receiving at the time of the review. None of the 12 youth who had IHT serving as their "clinical hub" were participating in TM, FS&T, or IHBS, at the time of the review (according to the informants interviewed and the medical records reviewed).

TABLE 28: OTHER HUB DEPENDENT SERVICES

Q9. Indicate the other "hub dependent" services supported by IHT	Response	n (%)
Q9i. Therapeutic Mentoring	Yes	0
Q9ii. Family Support and Training	Yes	0
Q9iii. In-Home Behavioral Services	Yes	0

Discussion

Strengths of the service system

Overall, the findings from this review show that ICC and IHT providers in the Western 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:

Identifying needs and developing appropriate service plan goals
Providers in the Western region were skilled at *identifying and prioritizing the needs* of the youth and family across a full range of life domains and were able to *translate these needs into service plan goals*. Eighty percent (80%) of reviewers agreed moderately or very much that providers appropriately identified and prioritized the needs of the youth and family. Reviewers also found that the identification of needs happened soon after referral, with 80% of reviewers agreeing moderately or very much that the *provider quickly clarified the child and family's needs*. Once the youth and family needs were identified, reviewers found that through the service planning process, *providers developed goals that reflected the identified needs*.

Supporting the participation of the youth and family
Another area of strength of providers in this region was that they *helped engage families to be full and active participants in the service planning and delivery process*. Reviewers agreed moderately or very much 72% of the time that families were actively involved in the design and development of the service plan which led to great investment of families in their plan, with 84% of reviewers agreeing that the youth and family were actively participating in services. A critical part of supporting families to be true "owners" of their plans was that providers ensured that the youth and family understood the content of their service plan, with 80% of reviewers agreeing moderately or very much that this was the case.

Ensuring 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. Western 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*.

Recognizing importance of youth/family culture
A strength of Western region providers was recognizing that youth and families must be viewed within their own cultural context and community. This is an important aspect of ensuring culturally competent care, a key system of care value. Providers were also *cognizant of the fact that the family's values, beliefs, and lifestyle have an influence on their decision-making process*, with 80% of reviewers agreeing moderately or very much that this was the case. Exploring a family's values, beliefs, and preferences is a key part of the assessment process that can lay the groundwork for the service planning phase of the work and can help promote engagement with the family.

Orienting families to agency culture

Western 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, after-hours access, who to talk to if they have a concern about service delivery, confidentiality issues, etc. In addition, providers recognized 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 agency and the service.* By orienting families to the agency "culture" providers engage them as partners in the process from the beginning and empower families by ensuring they have the information they need to advocate for themselves.

Opportunities for improvement

Although overall ratings for the majority of youth reviewed fell in the enhanced (n = 14) 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. 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.

Identifying strengths

IHT providers in particular could improve with respect to *identifying strengths of the youth and family as part of the assessment process*. While 85% of reviewers for youth with ICC agreed moderately or very much that the strengths of the child and family were identified as part of the assessment process, only 25% of reviewers of IHT cases agreed this was the case. Reviewers mentioned that strengths were missing in the assessment, were identified only for the youth and not other members of the family, or that when strengths were identified they were limited or not strengths that could be drawn upon for the work with the family.

Service planning and participation

The service planning process stood out as an area for potential growth for Western region providers. *Specifically, service plans should better incorporate child and family strengths into goals.* Difficulty incorporating strengths into goals was likely a result of the fact that some providers failed to identify strengths during the assessment process. Once a need and a goal is clarified, exploring what strengths, resources, and capacities the family has available that can be drawn upon to help them meet their goal is an important part of the service planning and

delivery process. While both ICC and IHT providers could improve their performance as it related to incorporating strengths into goals, for ten of the thirteen youth with ICC reviewers agreed moderately or very much that care coordinators and family partners *informally* incorporated strengths identified through the assessment process into their day to day work with the family. The same was not true for youth with IHT, where reviewers agreed moderately or very much for only five of the twelve youth with ICC that this was the case. Again, this finding reflects the fact that reviewers found that exploration of strengths during the assessment process by IHT providers in particular was limited.

Another area for growth especially for IHT providers is *developing service plans that are integrated across providers and agencies*. For youth with IHT serving as their "hub," reviewers agreed moderately or very much for only 42% of the youth that their service plan was integrated across providers and agencies. While reviewers rated ICC providers higher as far as their ability to develop cohesive, integrated plans, *reviewers found that ICC and IHT providers alike were challenged with garnering the participation of formal providers and natural supports in the service planning and delivery process.* Further evidence of this was found in the IHT supplemental section where only one-fourth (25%) of reviewers agreed moderately or very much that providers, school personnel, or other state agencies were involved in the planning for youth. Of course, whether stakeholders participate is not within the full control of the provider. While providers should be working to outreach and engage school personnel, state agency staff, service providers, and natural supports in the planning process and helping educate them about the value of participating in a collaborative planning process, these same individuals must be willing participants. They also need support from their organizations to do so.

Finally, with respect to service planning and participation, IHT providers should work on *supporting youth and families to influence the service planning process*. While many reviewers endorsed that those providers of both IHT and ICC services supported families to be active participants in the service planning process, youth and families engaged in IHT did not appear to have as much *influence* over the planning process. This finding suggests that IHT providers could better support families and youth to have "voice and choice" in their service planning. For at least three families with IHT, reviewers mentioned separate "provider meetings" that were held without the family. Others mentioned that youth were not engaged in, nor had much influence over, the plan. A comment from a reviewer of IHT summarized this issue by stating, "[The] IHT did not consider her [mom's] choice and voice in terms of strategies and methods for alleviating the problem. Instead IHT suggested techniques that mom would never espouse or use. So although they agreed on the ultimate goal--get youth to attend school regularly--they were not on the same page as to how to get there. Mom felt left out of decision-making when it came to treatment strategies."

Integrating and coordinating care
Greater clarity about responsibility for care coordination for youth with IHT is needed. While reviewers of youth with ICC agreed moderately or very much 92% of the time that there is one identified person who successfully coordinates the planning and delivery of services, this was true in only 42% of IHT cases. Reviewer comments suggested that care coordination was minimal, not occurring at all, or that there was a diffuse responsibility for care coordination.

Further evidence of the need for improved care coordination was found in the IHT Supplemental Section, where only half of reviewers agreed moderately or very much that the youth was receiving appropriate care coordination.

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. Reviewers commented during the debriefing session that there appeared to be a need for provider organizations to develop a strategy to obtain expert consultation or clinical review when complex or challenging youth or family situations are present. Transition planning also stood out as an area for where providers could improve with respect to helping families connect with additional services and supports. 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. It is also worth noting here that none of the twelve youth who had IHT serving as their clinical hub were participating in other services such as family support and training, therapeutic mentoring, or in-home behavioral services. It is not exactly clear why these resources were not engaged to help meet the needs of youth and families, but IHT providers in the Western region should consider these services as possible options to meet the needs of the youth and families they work with.

A related issue identified during the debriefing session was that reviewers expressed that ICC and IHT staff members are not "escalating" issues of concern either up to supervisors or other clinical leaders at their organization. This issue again brought forth concerns about supervisory practices and oversight at some provider organizations.

Finally, IHT providers could improve with respect to *fostering ongoing two-way communication among and between all team members including the family*. As mentioned earlier, reviewers found that care coordination was not as strong for those youth with IHT. Creating more opportunities for dialogue and information exchange between providers and youth and family members could help improve the coordination of care for these youth.

Conclusion

Overall the results of the Western SOCPR reviews suggested that providers are delivering care in a way that adheres to important SOC and CBHI values. Fifty-six percent (14 of 25 cases) fell into the 6 range representing enhanced SOC implementation, and seven cases (28%) scored in the 5 range, reflecting good implementation. Four cases (16%) had means in the 4 range, demonstrating the need for improvement in implementing SOC principles.

Western region providers are particularly strong when it comes to ensuring that youth and families can make best use of services by ensuring that services are provided at convenient times, locations, and in the primary language of the family. With respect to the service planning process, providers were skilled at supporting youth and families' active participation in the service planning process, identifying and prioritizing needs and developing appropriate service plan goals. Providers in the Western region also recognized the importance of developing an awareness of the values, beliefs, traditions, and lifestyle of the youth and families they worked with. In addition, providers ensured that families understood the aspects of the service(s) they

were participating in and the rules and procedures of the provider agency as well as their rights and responsibilities as a client of that agency.

While overall practice appeared strong 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 the thoroughness of assessments, identification of strengths and utilization of strengths in the service delivery process, supporting youth and families to influence their own plans, 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 Western 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
January 28 & 30, 2014

Webinar Housekeeping
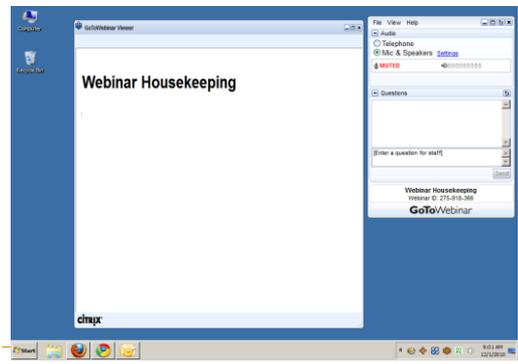
2

GoToWebinar Housekeeping: Time for Questions
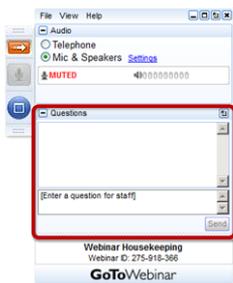
Your Participation

- 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 to let us know if family/youth consented/did 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

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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

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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

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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 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 (18 or older) 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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Tips for obtaining consent

- **Be familiar** with the consent form so you can answer questions
- **Explain the purpose** – mention that info will be used to help other families
- Help them understand **how** they were selected
- Info will **remain confidential**
- Tell them **what is expected** from them
- Interviewers will meet with them at the location and time **most convenient** for them
- Don't forget to mention that each family that participates will receive a **$25 gift card to Target**

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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

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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

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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

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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

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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

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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

Scheduling for March 17 & 18

March Review Schedule

Monday, March 17	Tuesday, March 18	Wednesday, March 19
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	

Sample March Schedule

Monday, March 17		Tuesday, March 18	
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	Lunch
1:00 – 2:00 PM (1 hour)	Interview with TT&S or family partner at provider agency	12:30 – 1:00 (1 hour 30 min)	Interview with care coordinator or IHT clinician
2:00 – 3:00 PM (1 hour)	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

Please work with the family and formal providers to schedule interviews at **times** and **locations** that are **convenient** for them on their **assigned review day.**

Scheduling Template for March SOCPR

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 Tuesday, February 25, 2014.***

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.

TAC Contacts

For Questions and Concerns about Consent & Scheduling, please contact:

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

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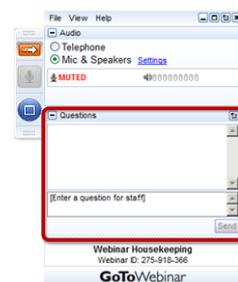
Appendix B: Consent, Assent, and Release of Information Forms

System of Care Practice Review (SOCPR)

YOUTH 18 OR OLDER CONSENT TO PARTICIPATE

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

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

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

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

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

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

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

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

Consent

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

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

_____   _____

Youth Signature   Date

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

_____   _____

Witness/ Program or Agency Representative   Date

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

<u>**Area: Convenient Times**</u>
19. Services are scheduled at convenient times for the child and family.

<u>**Area: Convenient Locations**</u>
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)

<u>**Area: Appropriate Language**</u>
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

<u>**Area: Awareness of Child and Family's Culture**</u>
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.

<u>**Area: Awareness of Provider's Culture**</u>
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.

<u>**Area: Awareness of Cultural Dynamics**</u>
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.