Exhibit 14

Outpatient as a "Hub" for MassHealth Youth under 21:
Results of FY2017 Outpatient Chart Review

February 12, 2018

MassHealth Office of Behavioral Health
Children's Behavioral Health Initiative

Contents

Introduction

This Outpatient Practice Review for MassHealth Members under 21 is intended to provide data related to the 2016 disengagement agreement in the Rosie D. lawsuit. Pursuant to the management authority vested in MassHealth as stewards of the Medicaid program, MassHealth has elected to deliver remedy services through a hub-based system. The judgment in the Rosie D. lawsuit stipulates that children with Serious Emotion Disturbances (SED), for whom the service was medically necessary, would be entitled to receive care coordination through Intensive Care Coordination (ICC) services. Importantly, the Judgment did not order the MassHealth to deliver care coordination outside of ICC. MassHealth decided to use the In-Home Therapy (IHT) and Outpatient Treatment (OP) as hubs to provide care coordination to MassHealth members. Outpatient services are not remedy services under the Judgment, and pre-existed the Rosie D. litigation. MassHealth has undertaken an annual process to assess the quality of care coordination provided to members under the age of 21 in the Outpatient "hub."

During the spring of 2017 MassHealth developed an assessment tool to be used by its Managed Care Entities (MCEs) as part of their annual outpatient (OP) record review process. After incorporating feedback on the tool from MCEs, MassHealth directed the MCEs to pilot the tool during July and early August of 2017. Approximately 25 records were reviewed with the tool during this period, and minor revisions were made as a result of this experience. The MCEs continued to use the tool for the remainder of their review period ending September 15, 2017. In addition, four staff members from MassHealth's Children's Behavioral Health Initiative (CBHI) group each conducted four outpatient reviews using the tool.

MassHealth refers to this ongoing assessment as the Outpatient Practice Review (OPR). This report on the first year of the OPR briefly describes the outpatient "hub" concept. It then describes the review tool and summarizes findings from the review period ending September 15, 2017. It characterizes the level of care coordination observed in the outpatient hub system as a baseline for future quality improvement. It concludes with recommendations for improving the tool and review process for use in the upcoming year.

The outpatient "hub" concept

MassHealth designed the three-level "hub" system that coordinates the delivery of remedy services for a very inclusive class of members. The hubs are tailored to the level of need and choice of child and family. These hubs are Intensive Care Coordination (ICC), In-Home Therapy (IHT), and Outpatient Treatment (OP). For children for whom high-intensity care coordination is medically necessary (and whose families want the service), care coordination can be provided by ICC, and ICC would serve as the hub through which those members would access the other remedy services, as needed. Children whose needs for care coordination do not meet medical necessity criteria for ICC, or who chose not to engage with ICC, but do meet medical necessity for IHT can receive IHT, and IHT can serve as their hub for accessing the other remedy services. Although the Judgment in the Rosie D. lawsuit does not make care coordination available to all MassHealth members, or even all class members, children who did not meet medical necessity for ICC or IHT, or who chose not to engage with ICC or IHT, can access remedy services with OP as the hub. A youth's hub may change as he or she is stepped up or down in response to changing clinical needs.

A youth in the OP hub will typically present as less complex and acute than a youth in an ICC or IHT hub. Expectations where OP is the care coordination hub are described extensively in MassHealth's *Outpatient Therapy as a CBHI Clinical Hub: Practice Guidelines*.[1] They include:

- Work with the family in a way that is consistent with System of Care Values;
- Engage families and youth about receiving services and about the service system;
- Complete a comprehensive initial assessment and formulation, including the Child and Adolescent Needs and Strengths tool (CANS), and evaluate the need for care coordination as well as other services and supports;
- Refer and facilitate access to other needed services, including higher levels of care coordination when needed; and
- Coordinate with other services and supports as needed.

The OP review tool

The version of the tool used in the period ending September 15, 2017 appears in Appendix 1.[2] It consists of four sections:

Section 1: Background information

This section includes member demographics, information about the site and reviewer, and about the number of OP visits received during the 12 months preceding the review. This section requires no reviewer judgment.

Section 2: Assessment and Planning

This section includes seven questions on which the reviewer uses clinical judgment to rate aspects of the assessment and planning process, on a four-point scale of agreement:

1. Not at all	2. Slightly	3. Substantially	4. Completely

Section 3: Teaming, delivery and coordination

This section requires the reviewer to identify possible supports and services ("collaterals") with which the OP provider should have communicated and collaborated, and then requires the reviewer to use clinical judgment to rate their agreement with whether the level of collaboration was adequate to meet youth and family need, using the following options:

1. Yes	2. Partially	3. No	4. Parent Declined

Section 4: Concurrent indicators

This section requires the reviewer to indicate whether certain indications were found in the chart of concurrent events that might signal high levels of acuity or complexity in the youth's situation or clinical

[1] Available at www.mass.gov/eohhs/docs/masshealth/cbhi/practice-guidelines-outpatient.pdf

[2] A few revisions were made to the SurveyMonkey version that are not reflected in Appendix 1. Both versions will be updated for the next review cycle.

status. Examples of these indicators include: child welfare reports, suspensions from school, and use of crisis services. Reviews of practice in other levels of care have demonstrated that clinicians, in their initial and ongoing assessment of a youth, sometimes underestimate acuity and complexity. A review that takes such an inadequate assessment at face value could underestimate the level of care coordination required. The inclusion of this independent information helps to verify the accuracy of the clinician's assessment. MassHealth expects to evaluate the usefulness of this section as a result of experience with the first year of the review process.

Data analysis

Reviewers entered data into an online survey system from which a data table of responses was downloaded for analysis.[3] Nineteen reviewers (15 from MCEs, 4 from the CBHI group at MassHealth) started 114 records in the system. The responses indicate that the instructions can be improved. There was a significant amount of missing data. For example, in eighteen records the reviewer indicated that the member did not have at least 8 OP visits (excluding medication visits). Where the number of OP visits was less than 8, the online survey prevents further review, and records were excluded from further analysis. In addition, several records had duplicate MassHealth IDs, indicating that some reviewers began data entry more than once for the same chart review. Six records had one duplication and two records had two duplications, resulting in 10 duplicated reviews in all. The duplicate records did not always agree in all fields entered, preventing consolidation of records in some instances. Careful comparison of records resulted in excluding 13 duplicate entries from further analysis, as detailed in Appendix 2. In addition, 8 records indicated that the youth had received either IHT or ICC concurrently with OP during the past year. In the records for 7 of these youths with concurrent treatment, the review continued no additional data and the records were excluded from further analysis. Finally, 3 reviewers indicated that the family was in OP, and had declined the offer of an ICC or IHT care coordination hub. Per the design of the tool, no further data was entered into these records and they were excluded from analysis. In one case, a reviewer's comments were used to revise their ratings. The reviewer stated "provider did not have psychosocial assessment in medical record"; as a result, MassHealth staff revised ratings of 2 and 3 on assessment to 1 or 2.

Records excluded due (a) too few visits; (b) concurrent receipt of IHT or ICC; or (c) having declined IHT or ICC did not overlap with records excluded from sets of duplicates. As a result, a total of 41 records were excluded and 73 were retained for analysis. However, the current sample is adequate for establishing a baseline, accomplishing the primary goal of this first wave of reviews. In order to achieve a larger sample going forward, the next review will be redesigned and cover a larger review period.

Reliability

Reviews completed by MCE staff were compared with those completed by staff from the CBHI group. There were discrepancies in assessments of the MCE and CBHI groups. For instance, MCE reviewers on average rated the questions on assessment and planning 0.6 points higher on a scale of 1 to 4 on Section

[3] MassHealth contracted with Technical Assistance Corporation (TAC) to translate the review tool into an online survey using SurveyMonkey. TAC sent a web link to each reviewer. When the reviewer clicked on the link, a new survey record began. When the review period ended, TAC sent the survey data to the CBHI group at MassHealth, which analyzed and reported on the data.

2. However, CBHI reviewers found more opportunities for collaboration. CBHI reviewers rated children as involved with 0.9 more services or supports than MCE reviewers. Both findings were statistically significant (p = 0.05).

CBHI reviewers and MCE reviewers did not differ in time expended per review, suggesting that rating discrepancies between the groups are not due to differences in effort on the part of reviewers. One step contemplated to minimize discrepancies between the groups is the re-orientation of MCE reviewers to the assessment process.

Summary of findings

Demographic data

For records retained for analysis, member demographics were as follows:

Gender of member

Female	35
Male	37
Transgender	1
Total	73

Age

There were reports with apparent errors in the age data. These reports were set aside. Remaining ages were taken as accurate. Ages ranged from 2 years 11 months through age 20. The mean age was 13 years 4 months and the median age was 13 years 7 months.

Primary language of member

English	72
unspecified	1
total	73

Provider

Charts from nineteen providers were reviewed:

Solid Ground Psychotherapy Associates	7
DCS Mental Health	6
Eliot Community Human Services	6

North Shore Clinicians Group	6
Pediatric Health Care Associates	6
South Bay Community Services (SBMH)	6
CFFS/JRI	5
BHN	4
CCBC	4
Clinical and Support Options	4
The Guidance Center	4
Arbour Counseling	2
JRI/CFFS	2
New Dawn Integrated Behavioral Health Center	2
Northeast Behavioral Health	2
Prospect Hill Consultants	2
Psychiatric Associates of Lynn	2
YOU Inc	2
CHD Mental Health	1
total	73

Provider sites were found in the following locations:

Lynn	8
Fall River	7
Gloucester	7
Medford	7
Peabody	7
north shore location	5
Cambridge	4
Springfield	4

Taunton	4
Northampton	3
Bourne	2
Brockton	2
Chelsea	2
Fitchburg	2
Lawrence	2
Leominster	2
Woburn	2
Worcester	2
Greenfield	1
total	73

Reviewers and plans

Nineteen reviewers entered data; 15 were from MassHealth's MCEs and 4 were MassHealth staff. The distribution of MCE by member was as follows:

PCC Plan/MBHP	30
Tufts Health Plan	14
NHP	13
BMC Healthnet	10
Health New England	4
Fallon	2
total	73

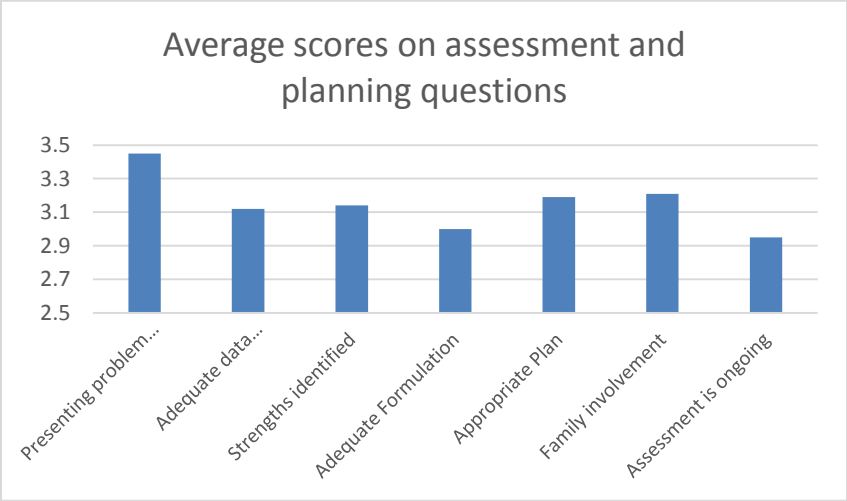
Other

The minimum number of OP visits in the current course of treatment, by design, was 8. The maximum was 84. The mean number of visits was 26.1; the median number was 20.

Assessment and Planning

Seven questions rated Assessment and Planning on a four point scale, where the reviewer describes degree of agreement that good practice was followed. Average responses for the questions are as follows:

Presenting problem clear	3.45
Adequate data gathered	3.12
Strengths identified	3.14
Adequate Formulation	3.00
Appropriate Plan	3.19
Family involvement	3.21
Assessment is ongoing	2.95
Mean	3.15

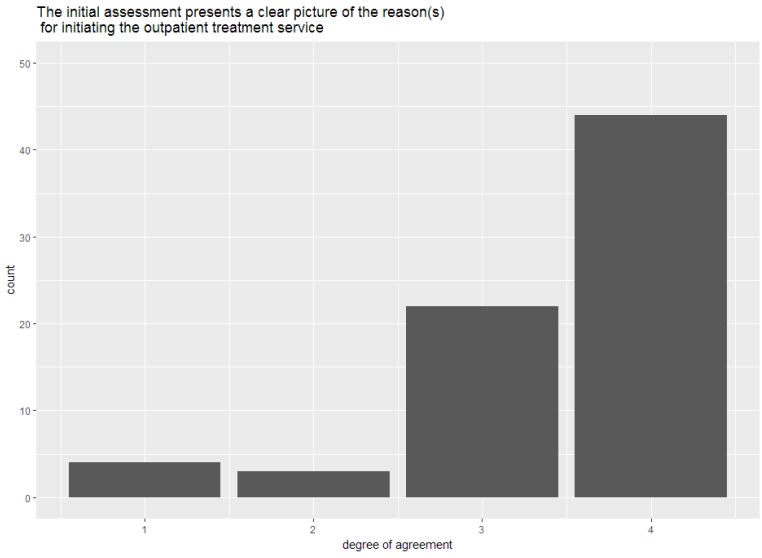


The distribution of responses for each question is shown below.

Item correlations are shown in Appendix 3.

1. *The initial assessment presents a clear picture of the reason(s) for initiating the outpatient treatment service.*

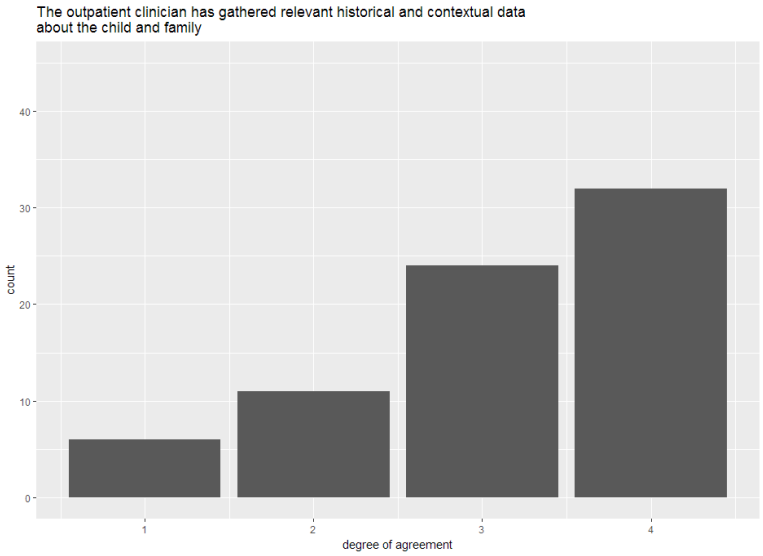
Response	Percentage
1	6%
2	4%
3	30%
4	60%



The average response for this question was higher than for other questions in this section. This item has the most prominent ceiling effect of OPR questions. In 60% of cases the reviewer found best practice.

This question correlates strongly (r=0.73) with question 2, Adequate Data, and (0.74) with question 4, Adequate Formulation.

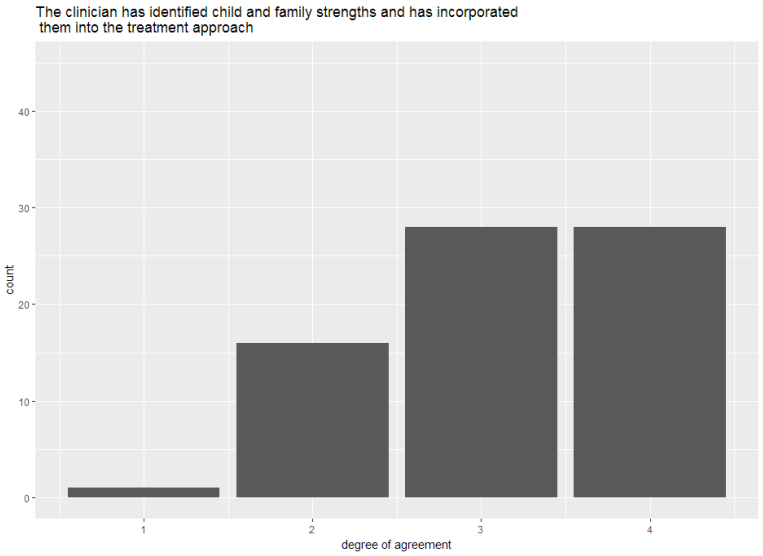
2. *The outpatient clinician has gathered relevant historical and contextual data about the child and family, sufficient to support an understanding of the child's diagnosis and functioning. This includes exploration, when relevant, of child and family history of trauma, loss, DV and substance abuse. (Initial assessment including CANS, and ongoing notes).*



Response	Percentage
1	8%
2	15%
3	33%
4	44%

Examining this area of practice requires that the clincian understand the significance of the data being sought, in order to shape further inquiry. A skilled clinician uses information already gathered to focus further assessment on those areas that are most significant in the individual case, or on critical areas that remain obscure.

3. *The clinician has identified child and family strengths and has incorporated them into the treatment approach.*

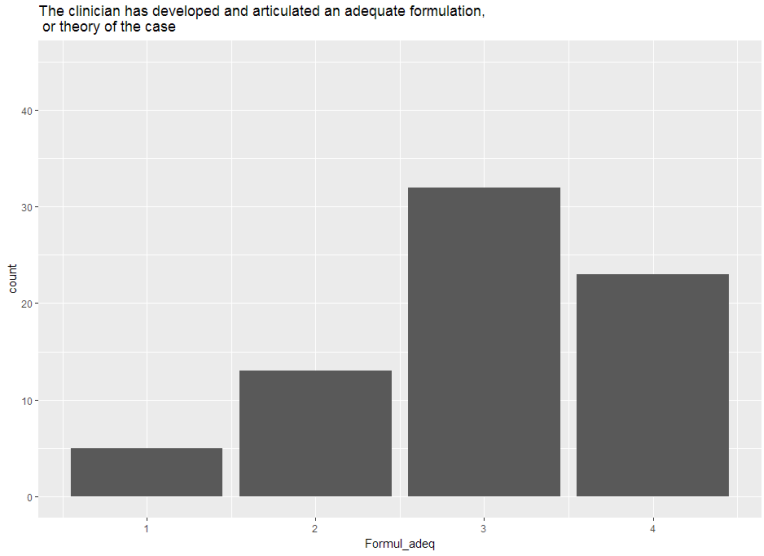


Response	Percentage
1	1%
2	22%
3	38%
4	38%

This question correlated strongly (0.79) with question 6, Family Involvement, and (0.65) with question 7, Assessment is Ongoing, suggesting that the processes of involving the family in planning is related to the clinician assessment of child and family strengths.

4. *The clinician has developed and articulated a formulation, or theory of the case, that explains how relevant factors in the child's life contribute to the presenting problem(s) and that provides a rationale for treatment interventions.*

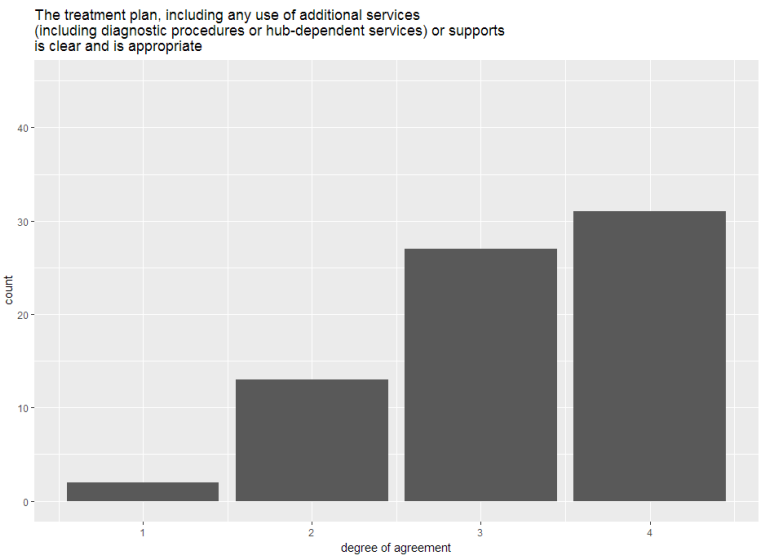
Response	Percentage
1	7%
2	18%
3	44%
4	32%



A developed plan for intervention requires a clear understanding of the case. This question correlated strongly with questions 1 and 2 related to clarity and extensiveness.

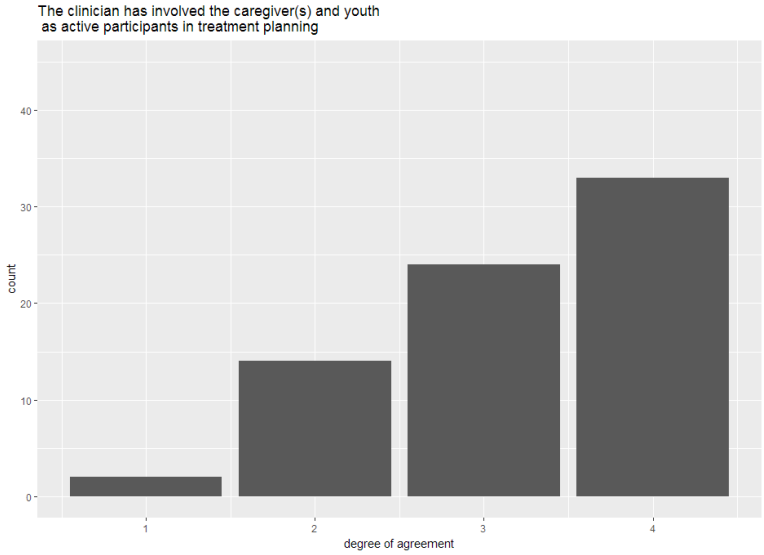
5. *The treatment plan, including any use of additional services (including diagnostic procedures or hub-dependent services) or supports is clear and is appropriate given the assessment and formulation.*

Response	Percentage
1	3%
2	18%
3	37%
4	43%



Documenting the treatment plan leads to effective treatment when working as a team. 43% of cases fell in the best practice range.

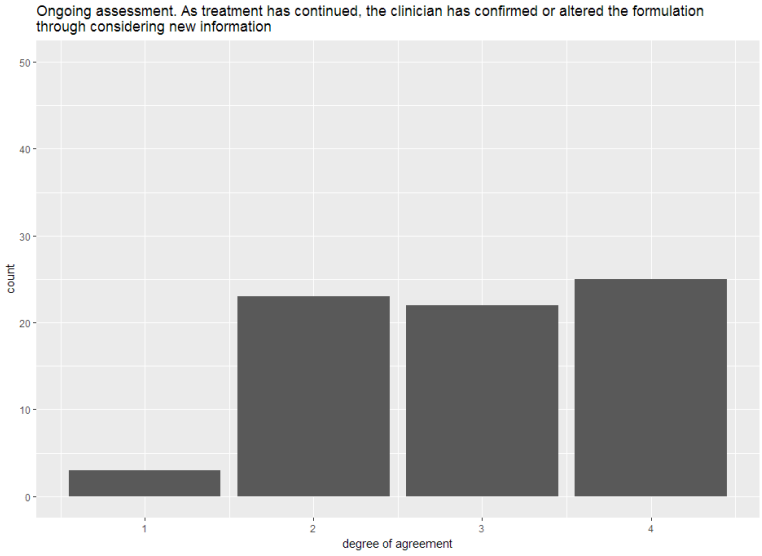
6. *The clinician has involved the caregiver(s) and youth (to the extent it is developmentally appropriate) as active participants in treatment planning.*



Response	Percentage
1	3%
2	19%
3	33%
4	45%

This item highlights an area of difference in practice between CBHI services, where family engagement and involvement tends to be high, and outpatient, where practice is variable. One question not addressed by the data is whether family involvement tends to be lower when OP services are provided at the school.

7. *Ongoing assessment. As treatment has continued, the clinician has confirmed or altered the formulation through considering new information. (This may be apparent in assessment updates or plan updates or in progress notes.)*



Response	Percentage
1	4%
2	32%
3	30%
4	34%

Of all the assessment questions, this question found the lowest level of adherence to best practice (34%). The reasons that this answer was assessed with lower levels of best practice responses will be explored.

Teaming, delivery and care coordination

This section of the review tool uses questions involving both fact and reviewer judgment. The contingencies that arise in clinical practice lead to difficultly in capturing the nuances of individual needs and circumstances while retaining reliability. This section of the tool is being revised for the FY2019 review cycle in response to issues identified in FY2018 reviews.

This section asks a series of questions about various potential services or supports that a child might need, and whether the OP clinician made adequate efforts to collaborate with these services or supports. Twenty-three categories of potential services or supports are listed, with an "other" option (infrequently used) to add up to three more.

The services or supports identified for the 73 retained cases in the review are as follows:

Service or Support	Frequency
Family, friends	68
School	56
Primary care	43
Psychopharmacologist	26
DCF	12
Childcare or afterschool	6
Therapeutic Mentor	6
Inpatient or partial hospital	5
Mobile Crisis Intervention	5
Other	5
Community supports	4
Family therapist	3
Probation or court	3
Group Therapist	1
CBAT or residential treatment	1
Family Partner	1
In-Home Behavioral Services	0
DMH	0
DYS	0
DDS	0
BSAS	0

The “other” category includes group home staff, sibling’s In-home Therapist, individual therapist, community support group, and adoption support program.

For the five youth who were not identified as having involvement of family or friends, three were seventeen or eighteen years old, one was ten, and one fifteen. It seems likely they were living independently, or in foster or group care. However, the current data is insufficient to determine with certainty.

The 17 youth who were not identified as having involvement with school had the following age distribution:

Age	Frequency
4	1
8	1
11	2
12	2
15	3
16	1
17	2
18	2
19	2
20	1

Age ranges suggest that some children may be outside the age for enrollment, or are voluntarily not enrolled. However, it is not clear from the data whether the youth was correctly identified as having no school involvement.

43 youths were identified as involved with a primary care provider (PCC). Of the 30 who did not have a PCC, in only one case did the reviewer indicate that a referral should be made. These two factors indicate that it is likely that more than 43 actually had a PCC, but OP clinicians failed to document this.

When reviewers identified involvement with a service or support, they were asked if collaboration would be beneficial, and whether the OP provided an adequate level of collaboration. When this question was implemented, three responses were allowed: Yes, No, and a blank response. The percentage of “Yes” responses varied widely and seemed appropriately high for collaterals such as family (Yes 89%), and school (Yes 80%).

When asked if collaboration provided by OP was adequate, reviewers had 4 response options: Yes, Partially, No, and Parent Declined. The option of Parent Declined was checked only once (for collaboration with the PCC).

Adequacy of care coordination across all possible services and supports varied by type of service or support. Detailed data by category of service or support are presented in Appendix 5. The complexity of the data is best summarized by averaging over all instances (simultaneously across youth and across possible services and supports). Some categories of services and supports arise more frequently than others, but all can be included by weighting them by their frequencies. Adequacy of care coordination across all instances was distributed as follows across 73 youth with 223 possible instances of coordination noted by reviewers:

	Yes	Partially	No	Parent declined
Count	108	39	75	1
Percentage	48%	17%	34%	0%

In 83% of instances, care coordination in OP was evaluated as “partially adequate” or “adequate”, and in 48% of instances it was “adequate”.

This way of summarizing care coordination provides convenient percentage benchmarks that could be used in setting quality improvement goals.

Concurrent Indicators

As previously explained, the Concurrent Indicators section (Section 4) was conceived as a measure of acuity and complexity that might be used to better understand the data. Concurrent indicators are documented events such as child abuse reports, hospitalizations, or school suspensions. These concurrent indicators provide insight into the broader context of obstacles the youth may be facing.

Concurrent indicators also are useful in characterizing the population under study. Concurrent indicators were found in the OP sample. Of 73 retained cases, about one half (36) had one indicator (total of 40 indicators), suggesting this sample of youth certainly experienced enough complexity and acuity to need care coordination. In most cases, however, youth did not experience multiple indicators or events.

The most common indicators (as shown in tables below) were MCI encounters (8 youth, 9 events) and 51a reports of suspected child abuse or neglect (7 youth, 7 events). The next most common were DCF placement (5 youth, 5 events), psychiatric hospitalizations (4 youth, 6 events) and suspensions from school (4 youth, 5 events). Please see the protocol (Appendix 1) for full definitions of the events.

Concurrent events	number of members
DCF 51a	7
DCF placement	5
DMH involved	0
DMH placement	0
DYS committed	0
DYS pulled back	0
MCI encounters	8

psych admissions	4
arrested	2
CHINS	1
delinquent	1
hosp trauma	0
hosp medical	0
family hospitalized	3
restraining order	0
homeless	1
expelled	0
suspensions	4
total members	36

Concurrent events	number of events
DCF 51a	7
DCF placement	5
DMH involved	0
DMH placement	0
DYS committed	0
DYS pulled back	0
MCI encounters	9
psych admissions	6
arrested	2
CHINS	1
delinquent	1
hosp trauma	0
hosp medical	0

family hospitalized	3
restraining order	0
homeless	1
expelled	0
suspensions	5
total events	40

In summary, about 50% of sampled youth had concurrent indicators suggesting that MassHealth youth in OP do experience disruption in their lives and that these indicators may provide useful information about their acuity and complexity.

Recommendations

Recommendations regarding the tool.

While the current tool proved suitable for ongoing use, MassHealth anticipates the following revisions to the tool:

1. Numbering items in the paper version of the tool to correspond as closely as possible to the way they are numbered in the electronic data collector (SurveyMonkey);
2. Clarifying that "Provider site" query asks for geographic location, not provider name;
3. Including data entry validation for Date of Birth and other validations, as needed;
4. Revising the question on page 1 that was designed to exclude cases where families had declined ICC or IHT. Do not instruct the reviewer to stop if the question is answered "yes" (i.e. amend existing skip logic). The rationale for this question was to exclude cases in which OP was performing care coordination that should be performed in another hub;[4]
5. Instructing reviewers to find information on member coverage type prior to starting the review;
6. Instructing the reviewer to complete the question regarding member primary language using supporting information, if not available from CANS;
7. Providing the reviewer with guidance on Section 2 ratings;
8. Splitting "family" from "friends" in the list of services and supports in Section 3.
9. Performing further analysis on how the Concurrent Indicators section can inform understanding of other sections.

Recommendations regarding the review process.

MassHealth anticipates the following revisions to the review process:

[4] However, MassHealth argues that this data falls outside the scope of the litigation based on the choice and agency of the member to opt out of the remedy services.

1. Ensuring that records pulled for review have the appropriate minimum number of visits. Eighteen records had fewer than the required 8 visits and were therefore not completed. Specify that medication visits should not be counted in choosing records for review;
2. Revising the data collection method to avoid multiple starts for the same member, which causes duplication of records;
3. Clarifying directions to MCEs regarding sampling methodology;
4. Convening reviewers to discuss the process and the tool before starting the next wave of reviews to address reliability. Distributing written guidance resulting from the meeting/call;
5. Building some redundant reviews into the MCE record review process as a way to measure interrater reliability directly;
6. Collecting data, to the extent possible, in the state's electronic system throughout the review period so reviews can be monitored and reviewers can be contacted about questionable responses; and
7. Instructing reviewers to check in advance of the review whether the member has CommonHealth or Standard coverage type. This fact can affect which services the member can receive, which could affect reviewer ratings of practice, and my not be available from the chart.

MassHealth projects that increasing the reliability in the next OPR review cycle through these revisions to the review process will result in lower overall assessments by reviewers. However, the lower scores will likely be a result of increased accuracy rather than diminished performance. Findings in the next cycle should be interpreted with this possibility in mind.

Recommendations regarding opportunities for service improvement.

This initial chart review shows variation in practice among outpatient providers in care coordination for members under 21.

Assessment and Planning: Quality Improvement Goals

Generally, practice was assessed higher in some areas than others, and there is opportunity for improvement in all of the assessments. The assessed opportunities for improvement are predominantly in the formulation phase of the assessment process, and in ensuring that assessment is an ongoing process.

MassHealth and its MCEs will review the seven assessment questions. MassHealth recommends a measure of assessment and planning that averages the seven questions. Average scores can be assigned percentile ranks as shown in Appendix 4. The averaged ratings use the following scale, and that response averages for the questions in this OPR ranged from 2.95 to 3.45, with an average across all questions of 3.15:

1. Not at all	2. Slightly	3. Substantially	4. Completely

In this distribution, the median (50th percentile) is 3.14. An average score of 3.5, corresponding to a case where half of the agreement with best practice was "complete" and half was "substantial", corresponds roughly to percentile 68. An average score of 3, corresponding to an average rating of "substantial" agreement, corresponds roughly to percentile 40. An average score of 2.5, corresponding to a case where half of the agreement with best practice was "substantial" and half "slightly", corresponds roughly to percentile 15.

As precedent for this methodology, MassHealth used a similar model in the MPR (tracking improvement progress in ICC and IHT). The MPR focuses on the top two rating levels of that tool ("good" and "exemplary" practice); that line often occurs between the 60th and 70th percentile. For the Assessment

section of the OP tool, this range corresponds to average scores of roughly 3.3 to 3.7. MassHealth and its MCEs will set improvement targets based upon their judgment of what is both appropriately ambitious and feasible.

Assessment and Planning: Quality Improvement steps

Further steps for improvement should be developed by MassHealth in conjunction with MCEs, and be informed by the findings of this report. The variability of scores within this section shows that some activities may need additional improvements.

MassHealth has already undertaken development of a sequence of online modules on Assessment and Clinical Understanding. These modules reinforce principles of collaborative assessment and placement consistent with teamwork and System of Care Values. This training sequence is expected to launch in 2018., and clinicians will be able to obtain continuing education credits.

Teaming, delivery and care coordination

The adequacy of teaming, delivery and care coordination varied according to the type of service or support. The need for such coordination also varies by type of service or support..

MassHealth's increasing focus on behavioral health integration and on collaboration and communication among providers will help focus on collaboration between OP and collaterals.

MassHealth directs OP providers for children and families to underscore individualization and cultural appropriateness, with engagement of a broad range of community resources and supports

Appendix 1: 2017 Review Tool

Outpatient (OP) Consultation Chart Audit Tool

MassHealth version of 2/12/2018

Section 1: Background information	
Provider agency name	
Provider site	
Reviewer name	
Date of review	
Member MCE	
Member MHID	
Member DOB	
Member gender	
Member primary language per CANS	
Earliest date of OP service during past 12 months (from chart)	
Number of OP visits during past 12 months (from chart: psychodiagnostic assessment, individual, family, or consultation; do not count group or medication visits; if total is less than 8, end review here).	
Since beginning OP during the last 12 months, has the member had any ICC or IHT? (*if so, end review here*)	
Is Evaluation of Need for ICC in chart, current to last six months?	
If so, were MNC for ICC met?	
If so, was ICC discussed with family?	
If so, was the outcome to refer or not to refer to ICC?	

Since beginning OP during the last 12 months, has the member declined a recommendation from the OP therapist for referral to ICC or IHT? (if so, end review here)	

Section 2: Assessment and Planning	
Reviewer please indicate your degree of agreement with the following statements (4 point scale):	Rating
1. The initial assessment presents a clear picture of the reason(s) for initiating the outpatient treatment service 1 Not at all 2 Slightly 3 Substantially 4 Completely	
2. The outpatient clinician has gathered relevant historical and contextual data about the child and family, sufficient to support an understanding of the child's diagnosis and functioning. This includes exploration, when relevant, of child and family history of trauma, loss, DV and substance abuse. (Initial assessment including CANS, and ongoing notes) 1 Not at all 2 Slightly 3 Substantially 4 Completely	
3. The clinician has identified child and family strengths and has incorporated them into the treatment approach. 1 Not at all 2 Slightly 3 Substantially 4 Completely	
4. The clinician has developed and articulated a formulation, or theory of the case, that explains how relevant factors in the child's life contribute to the presenting problem(s) and that provides a rationale for treatment interventions. 1 Not at all 2 Slightly 3 Substantially 4 Completely	
5. The treatment plan, including any use of additional services (including diagnostic procedures or hub-dependent services) or supports is clear and is appropriate given the assessment and formulation. 1 Not at all 2 Slightly 3 Substantially 4 Completely	
6. The clinician has involved the caregiver(s) and youth (to the extent it is developmentally appropriate) as active participants in treatment planning. 1 Not at all 2 Slightly 3 Substantially 4 Completely	
7. Ongoing assessment. As treatment has continued, the clinician has confirmed or altered the formulation through considering new information. (This may be apparent in assessment updates or plan updates or in progress notes.) 1 Not at all 2 Slightly 3 Substantially 4 Completely	
Sum of ratings from rows 1 through 7:	

Section 3: Teaming, Delivery and Coordination						
A. Possible Supports & Providers	B. There is evidence that the youth and family are involved with this collateral. If yes, check this column.	C. Collaborating by the OP Provider would be clinically beneficial. If yes, check this column. In most cases, B implies C. You can check C without B.	D. If yes to column C, is the amount of collaboration sufficient to meet the youth and family need? Choose from the options below:			
			1. Yes	2. Partially	3. No	4. Parent Declined
Community & Educational Supports						
1. Family/ Identified Supports						
2. School/ Educational Providers / Early Intervention						
3. Child Care/ After School Providers						
4. Community Supports (ex. Coach, Pastor, etc)						
Service Providers						
5. Youth's Medical Doctor/Nurse						
6. Psychiatrist/Psychiatric Nurse						
7. Family Therapist						
8. Group Therapist						
9. Psychiatric Hospital/Partial Hospital Provider						
10. CBAT/Residential Provider						
11. Mobile Crisis Provider						
CBHI Service Providers						
12. In-Home Therapist						
13. Intensive Care Coordinator						
14. Therapeutic Mentor						
15. In-Home Behavioral Services						
16. Family Partner						
State Agencies						
17. Department of Child and Family (DCF)						
18. Department of Mental Health (DMH)						
19. Department of Youth Services (DYS)						
20. Department of Developmental						

Services (DDS)						
21. Bureau of Substance Abuse Services (BSAS)						
22. Juvenile Court / Probation Office						
23. Department of Youth Services						
Other – Use Space to Write in Other Resources						
24. Other:						
25. Other:						
26. Other:						
Number of checks in column:						
Number of checks in column D (1 through 4) divided by number of checks in column C						

If reviewer identifies NO collaterals with whom the OP clinician should have collaborated, check here: ☐

Section 4: Concurrent indicators Please check if any of these events is found in the record. These items, when aggregated, provide an overall sense of the acuity and complexity of the youth's needs.			
Child welfare involvement	51a filed in last 12 mos (number of times)	number	
	Child in DCF placement anytime last 12 mos	Yes / no	
DMH involvement	Child referred for or has DMH case management	Yes / no	
	Child out of home in DMH placement anytime last 12 mos	Yes / no	
DYS involvement	Child committed to DYS anytime last 12 mos	Yes / no	
	DYS conditional grant of liberty revoked in last 12 mos (youth "pulled back in")	Yes / no	
BH crisis	Number of MCI encounters last 12 mos	Number	
BH acute	Number of CBAT or inpatient admissions last 12 mos (do not count stepdown or transfer as separate admission)	Number	
Law enforcement	Child arrested by police in last 12 mos	Yes / no	
Court	Child has CRA (previously CHINS) petition filed last 12 mos	Yes / no	
	Child has delinquency charge current in last 12 mos	Yes / no	
Medical	Hospital admission for accident / physical trauma last 12 mos	Yes / no	
	Hospital admission for other non-elective medical cause last 12 mos	Yes / no	
Family	Family member psychiatrically or medically hospitalized last 12 mos	Yes / no	
	Family member obtains restraining order during last 12 mos	Yes / no	
Homeless	Youth homeless in last 12 mos	Yes / no	
School	Youth expelled from school last 12 mos	Yes / no	
	Youth has out-of-school suspension last 12 mos (number of times)	Number	
Total number of indicators (sum of counts, a Yes is a 1):			

Summary comments	
Reviewer comments on quality of care in this case:	
Reviewer questions or comments on scoring issues:	
Total time spent in reading and scoring this chart (minutes):	

Amount of Records to Review: 25 (max) or 10% (whatever it the lesser number) of enrolled membership involved in outpatient per region (5 regions) per plan

Whose records to review: Medicaid members under 21 years old who received at least 8 units of OP in last year AND had no claims for ICC or IHT in last year.

Lookback period: Maximum of 1 year except for Assessment form, which may be older than one year.

Where the evidence will be found in the youth's treatment record: Assessment, Treatment Plan, Progress Notes, Releases, CANS, Letters, Email, Billing, and Other

Use Comments sections for reviewers to make notes & for training purposes; Not to be included in reports from this data

- **Column A:** A list of providers and supports that the OP provider could potentially collaborate with depending on the youth/family's need and agreement. The green sections are headers to help orient the reviewer and should not be completed. There is a N/A – No appropriate supports identified so that if that is the case it can be documented and not appear that the tool was not completed.
- **Column B:** This column indicates providers or supports with which the child / family is already involved in some way.
- **Column C:** For determining whether the youth and family need the outpatient provider to coordinate or collaborate, consider whether that support exists and whether it would be clinically appropriate considering the member's strengths and needs. Check the box only if the need is identified as appropriate by the reviewer. Supports checked in column C but not column B are those which the clinician should try to engage, with member consent. It is logically possible that a provider or support with whom the family is already engaged does not need any collaboration from the OP clinician (check on B but not C) but this would be unusual. Family declining permission does not mean no need for collaboration; this contingency can be indicated in column D4.
- **Column D:** If the answer to Column C on the row is yes, review the record to determine whether the OP Provider has made diligent effort to be in contact with that support. Use clinical judgment as to whether the level of effort was appropriate, could have used additional contacts / consults, or was missing needed contacts altogether. Choose as many as is appropriate.
    - Answer:
        - Yes – Appropriate level of contact is documented taking place, or diligent effort was made to do so
        - Partially – Some appropriate contacts and some missed opportunities for collaboration
        - No – Contacts are not present in the record according to member's/member's family need and no real effort was shown
        - Parent Declined - The youth or the youth's family chose to not allow the OP provider to contact that support.

- Diligent effort means repeated efforts to establish contact, and creativity as needed (e.g. escalate call to DCF supervisor; arrange calls at times convenient for the collateral; if one mode of communication does not work, one or two others are tried).

Appendix 2: Details on handling of missing data

5881: One record with two duplications (three entries in all) had, for most recent entry attempt, “yes” in the field for declining ICC or IHT in the last 12 months, and data for all three entries stopped at that point as if the question had been answered “yes”. Accordingly, these three records were excluded from further analysis.

8871: One record with two duplications agreed on all entered fields, so the most complete record was retained and the less complete records were excluded from further analysis.

7023: One record with one duplication agreed on all entered fields, so the most complete record was retained and the less complete record was excluded from further analysis.

3812: One record with one duplication agreed on all entered data except the field for declining ICC or IHT in the last 12 months, and both entries stopped at that point. Both were excluded from further analysis.

0655: One record with one duplication, the records differed on the field for declining ICC or IHT in the last 12 months, being marked “yes” on one case and missing in the other, and both entries stopped at this point. Both were excluded from further analysis.

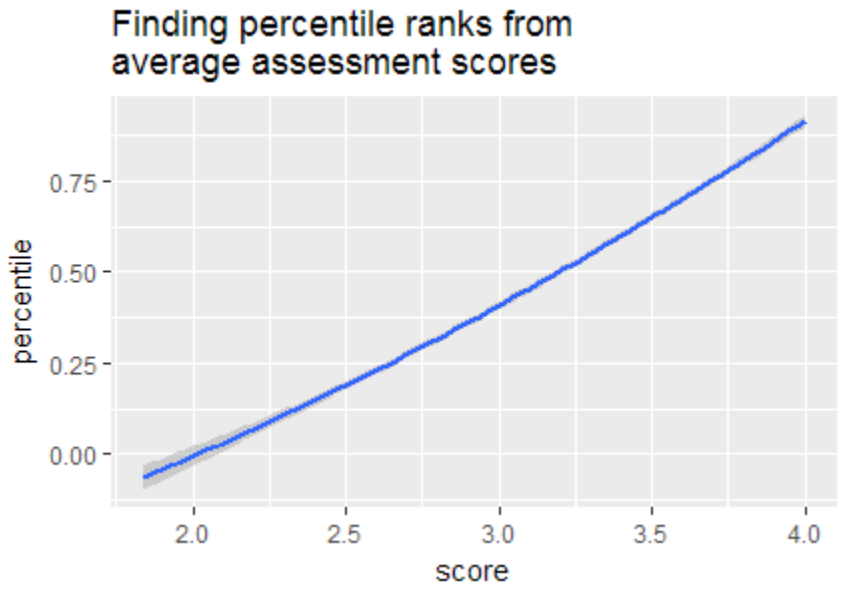
7721: One record with one duplication agreed on all entered data except the field for whether the member had ICC or IHT while receiving OP in the last 12 months. The “yes” entry stopped at that point. To retain as much data as possible the record with the “no” entry was retained (but the value was changed to “yes”) and the “yes” record was excluded from further analysis.

8102, and 1151: Two records with one duplication were similar in completeness but differed (slightly) in some data values entered. In both cases the more recently entered record was retained and the older record was excluded from further analysis.

Appendix 3: Item Intercorrelation for Assessment questions

	Presenting problem clear	Adequate data gathered	Strengths identified	Adequate Formulation	Appropriate Plan	Family involvement	Assessment is ongoing
Presenting problem clear	1	0.73	0.2	0.6	0.14	0.12	0
Adequate data gathered	0.73	1	0.54	0.74	0.43	0.34	0.28
Strengths identified	0.2	0.54	1	0.45	0.63	0.79	0.65
Adequate Formulation	0.6	0.74	0.45	1	0.46	0.33	0.4
Appropriate Plan	0.14	0.43	0.63	0.46	1	0.48	0.57
Family involvement	0.12	0.34	0.79	0.33	0.48	1	0.66
Assessment is ongoing	0	0.28	0.65	0.4	0.57	0.66	1

Appendix 4: percentile conversions for average Assessment scores



The curve above has been smoothed. Because of the ceiling on all items, percentiles above 85% are not meaningful. This does not affect the usefulness of mid-range values for tracking change.

average score	percentile
1.84	1%
2.00	2%
2.00	3%
2.00	4%
2.09	5%
2.14	6%
2.15	7%
2.25	8%
2.29	9%
2.29	10%
2.29	11%
2.38	12%
2.43	13%
2.44	14%
2.54	15%
2.57	16%
2.57	17%
2.57	18%
2.57	19%
2.63	20%
2.71	21%
2.71	22%
2.71	23%
2.71	24%
2.71	25%
2.71	26%
2.78	27%
2.86	28%
2.86	29%
2.86	30%
2.86	31%
2.86	32%
2.86	33%
2.86	34%
2.86	35%
2.86	36%
2.95	37%
3.00	38%

3.00	39%	3.29	59%
3.00	40%	3.29	60%
3.00	41%	3.29	61%
3.00	42%	3.29	62%
3.00	43%	3.34	63%
3.00	44%	3.43	64%
3.06	45%	3.43	65%
3.14	46%	3.43	66%
3.14	47%	3.46	67%
3.14	48%	3.57	68%
3.14	49%	3.57	69%
3.14	50%	3.63	70%
3.14	51%	3.71	71%
3.14	52%	3.71	72%
3.14	53%	3.71	73%
3.14	54%	3.71	74%
3.14	55%	3.71	75%
3.14	56%	3.71	76%
3.15	57%	3.78	77%
3.25	58%	3.86	78%

3.86	79%	4.00	99%
3.86	80%		
3.86	81%		
3.86	82%		
3.86	83%		
3.93	84%		
4.00	85%		
4.00	86%		
4.00	87%		
4.00	88%		
4.00	89%		
4.00	90%		
4.00	91%		
4.00	92%		
4.00	93%		
4.00	94%		
4.00	95%		
4.00	96%		
4.00	97%		
4.00	98%		

Appendix 5 - Adequacy of care Coordination by type of service or support

(see Review Tool, appendix 1, section 3, column A for full names of services and supports)

values	fam_friends_collab_suffic	school_collab_suffic	childcare_collab_suffic
1 - Yes	38	15	2
2 - Partially	10	10	1
3 - No	9	26	6
4 - Parent Declined	0	0	0

values	Community_Supports_collab_suffic	MD_RN_collab_suffic	psychopharm_collab_suffic
1 - Yes	1	16	16
2 - Partially	0	6	4
3 - No	1	12	6
4 - Parent Declined	0	1	0

values	FamTx_collab_suffic	Group_Tx_collab_suffic	Inpt_Partial_collab_suffic
1 - Yes	2	1	3
2 - Partially	0	0	0
3 - No	3	1	2

4 - Parent Declined	0	0	0

values	CBAT_Resi_collab_suffic	MCI_collab_suffic	TM_collab_suffic	IHBS_collab_suffic
1 - Yes	1	2	3	0
2 - Partially	0	0	2	0
3 - No	0	4	2	1
4 - Parent Declined	0	0	0	0

values	FP_collab_suffic	DCF_collab_suffic	DMH_collab_suffic	DYS_collab_suffic	DDS_collab_suffic
1 - Yes	0	7	0	0	0
2 - Partially	0	3	0	0	0
3 - No	0	1	1	0	0
4 - Parent Declined	0	0	0	0	0

values	BSAS_collab_suffic	JJ_PO_collab_suffic
1 - Yes	0	1
2 - Partially	0	3
3 - No	0	0
4 - Parent Declined	0	0