Massachusetts Practice Review (MPR)

Brief Summary Report: October 2015 Reviews

Introduction

In FY15, the Commonwealth pilot-tested a Massachusetts-specific qualitative case review protocol, the Massachusetts Practice Review (MPR), to evaluate the quality of care delivered to children/youth under 21 receiving MassHealth Children's Behavioral Health Initiative (CBHI) services. The MPR is designed to evaluate the quality of CBHI services at the practice level, and follows earlier implementation of the System of Care Practice Review (SOCPR) by the Commonwealth and the Community Service Review (CSR) by the *Rosie D.* Court Monitor for the same purpose. After a year of development and pilot testing of the MPR, the Commonwealth is proceeding with implementation of MPR case reviews in FY16, reviewing the care of approximately 120 youth enrolled in either In-Home Therapy (IHT) or Intensive Care Coordination (ICC) services.

As with the SOCPR and CSR, the MPR utilizes trained reviewers to obtain a comprehensive picture of a child/youth and family receiving CBHI services. Reviewers examine the clinical record and interview multiple stakeholders, including the IHT or ICC service provider, the caregiver, the child/youth (if over 12), and other formal providers working with the child/youth and family. By triangulating responses from all informants, reviewers are able to assess the extent to which practice is meeting established standards and best practices for the service under review (either IHT or ICC). Reviewers use the information gleaned from the record and interviews to rate 12 specific practice Areas within larger Domains which reflect CBHI values and principles. Rating is done on a scale from 1 to 5, with 1 being adverse practice and 5 being exemplary/best practice. Reviewers are also asked to rate two Areas concerning child/youth and family progress to determine the extent to which improvements have been realized in relation to specific skill development, functioning, well-being and quality of life. An overview of all 14 MPR Areas, along with Practice and Progress Indicator Rating Scales, can be found in **Appendix A**.

This brief report summarizes findings from the first round of FY16 MPR reviews conducted in October 2015. The care received by 38 children/youth enrolled in IHT as the hub service from 13 randomly sampled providers across the state was reviewed.

Provider Sampling/Case Selection

Using data from the May 2015 Massachusetts Behavioral Health Access (MABHA) report, 14 IHT providers from across the state were randomly selected to participate in the October 2015 reviews. At the time of sample selection, one provider had only 1 youth enrolled in IHT; thus, only 13 of the originally sampled provider sites were included.

The MPR sampling process stratifies providers by volume so that providers with more youth enrolled in services have more reviews conducted. **Table 1** below indicates the number of planned reviews per provider based on this process. Forty reviews in total were planned; however, two families withdrew consent on their interview days, resulting in 38 reviews being completed.

Table 1: October 2015 Sampling Based on Provider Volume

Volume Category	# Youth Enrolled in IHT	# Providers in Review Round	# of Youth Reviewed/ Provider
High Volume	200 or more youth	1	6
Medium	40-199 youth	5	4
Low	10-39 youth	7	2

Once providers were sampled, families were randomly selected at the 13 provider sites to be approached for consent to participate in the MPR. In order to obtain consent from the 38 participating families, 52 were asked to participate. Of the 14 families who declined to participate, most (62%) reported anxiety about having "strangers" in their home and feeling overwhelmed by the prospect of another task/responsibility added to their busy lives.

Results

Demographics

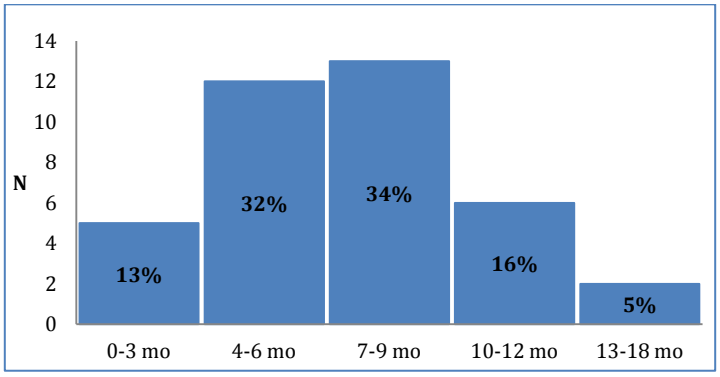
Basic demographic characteristics of the children/youth reviewed in October 2015 are summarized in **Table 2** below. More detail on select demographic variables is included in **Appendix B.**

Table 2: Basic Demographic Characteristics

Characteristic	N	%
Male	21	55%
White	11	29%
Age 5-9	16	42%
English as primary language	29	76%
Length of enrollment (≤ 12mos)	36	95%
> 1 BH Condition	22	58%

Thirty-six (95%) of those reviewed were enrolled in service less than 12 months, which is not unexpected as children/youth tend to have shorter stays in IHT compared with ICC. **Figure 1** on the next page illustrates the length of IHT enrollment for the children/youth reviewed this round.

Figure 1: Length of IHT Enrollment



Practice & Youth/Family Progress Domain Mean Scores

As shown in **Table 3**, MPR Practice Domain mean scores ranged from 2.71 to 3.65, with an overall mean score of 3.00.

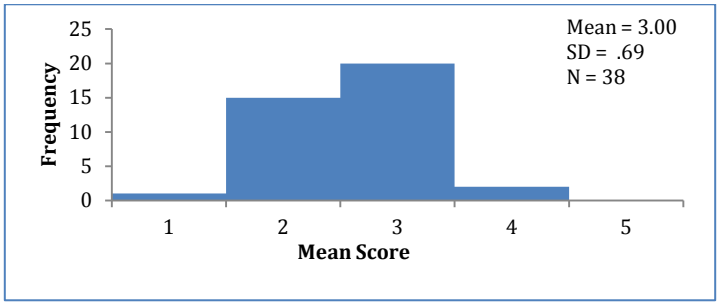
Table 3: MPR Practice Domain Overall & Mean Scores

Domain	Min	Max	Mean	Standard Deviation
Overall	**1.08**	**4.17**	**3.00**	**.69**
Domain1: Family Driven & Youth Guided	1.00	4.13	2.91	.79
Domain 2: Community-Based	1.50	5.00	3.65	.78
Domain 3: Culturally Competent	1.00	4.00	2.71	.71

Community-Based was the highest scoring Practice Domain with a mean score of 3.65. Two practice Areas within this Domain were among the three highest scoring Areas - Responsiveness (3.47) and Service Accessibility (3.82). The Family Driven & Youth Guided Domain had the next highest Practice Domain mean score of 2.91. While one of the three highest scoring Areas - Youth and Family Engagement (3.66) - was in this Domain, so was Transition (2.58), the lowest scoring Area. Culturally Competent had the lowest mean score of all Practice Domains (2.71), and the Cultural Sensitivity and Responsiveness Area within this Domain had the second lowest Area mean score (2.61).

Figure 2 illustrates the range of overall MPR Practice Domain mean scores for the youth/families reviewed.

Figure 2: Overall Practice Domain Mean Scores



Only 5% (n=2) of youth reviewed had overall case mean scores in the Good practice range. Just over half of the youth reviewed (53% or n=20) had mean scores in the Fair range, followed by 39% (n=15) in the Poor range. One youth (3%) had an overall mean score indicating adverse practice; adverse practice ratings were indicated for this youth across all 3 practice domains. Turnover of the original IHT clinician and inability of the new one to communicate effectively or form a therapeutic bond with the caregiver appeared to impact service delivery for this youth.

As shown in **Table 4**, Youth and Family Progress Domain mean scores ranged from 1.50 to 4.50, with an overall mean score of 3.12. **Figure 6** on page 4 illustrates the range of Youth & Family Progress Domain mean scores for those reviewed.

Table 4: Youth & Family Progress Domain Mean Scores

Domain	Min	Max	Mean	Standard Deviation
Domain 4: Youth/Family Progress	1.50	4.50	3.12	.88

Results by Domain/Area

The following sections summarize results across each MPR Domain and the Areas within them. Quantitative results and key themes from qualitative data collected are briefly summarized; more detail on qualitative themes and selected reviewers' comments are included in **Appendix C.**

Domain 1: Family Driven & Youth Guided

As **Figure 3** shows, only 8% (n=3) of the cases reviewed in this domain had mean scores indicating that practice was Good or consistently met established standards and best practices. Practice was rated as Fair or not consistently meeting established standards and best practices for 50% (n=19) of the cases, and as Poor or not meeting minimal standards for 34% (n=13).

Figure 3: Family Driven & Youth Guided Mean Scores

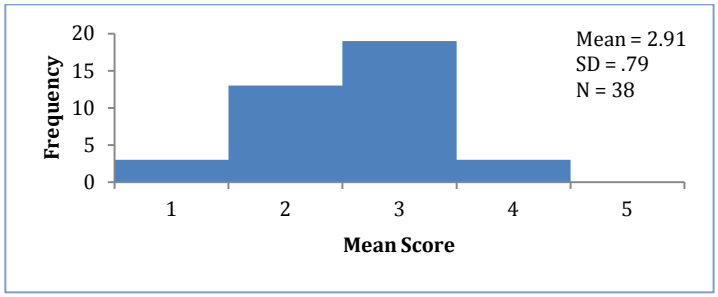


Table 5 summarizes the mean scores and frequencies for each of the 8 Areas in this Practice Domain.

Table 5: Domain 1 Area Mean Scores & Frequencies

Area	Mean	Frequencies (n) %*				
		Exemplary/ Best Practice 5	Good Practice 4	Fair Practice 3	Poor Practice 2	Adverse Practice 1
Assessment	2.87	-	(11) 29%	(14) 37%	(10) 26%	(3) 8%
Service Planning	2.95	(1) 3%	(14) 37%	(9) 24%	(10) 26%	(4) 10%
Service Delivery	3.18	(1) 3%	(14) 37%	(16) 42%	(5) 13%	(2) 5%
Youth & Family Engagement	3.66	(3) 8%	(22) 58%	(11) 29%	(1) 3%	(1) 3%
Team Formation	2.66	-	(9) 24%	(12) 32%	(12) 32%	(5) 13%
Team Participation	2.66	-	(9) 24%	(11) 29%	(14) 37%	(4) 10%
Care Coordination	2.76	-	(11) 29%	(10) 26%	(14) 37%	(3) 8%
Transition	2.58	-	(7) 18%	(14) 37%	(11) 29%	(6) 16%

*Due to rounding of percentages, some Area totals may equal >100%.

The Youth & Family Engagement practice Area most consistently met or exceeded established standards and best practices, with reviewers indicating 66% of the time that practice was in the Good to Exemplary range. Practice in the Area of Service Delivery was rated as Good to Exemplary 40% of the time. In general, service

delivery interventions focused on behavior management skills, teaching the youth and caregiver new coping skills and strategies to more effectively manage specific challenging and problematic behaviors.

While reviewers indicated nearly 30% of the time that practice in the Area of Assessment was Good, 37% of practice was rated Fair and 26% Poor. When compared with Assessment, slightly more practice was rated Good (37%) with regard to Service Planning, with Fair and Poor ratings 24% and 26% of the time, respectively. A thorough assessment forms the basis for understanding the strengths and needs of the youth/family and contributes to the formulation of a sound case conceptualization and treatment goals. Thus, when assessments were found to be lacking in depth and detail, so too it appeared were service planning documents.

With regard to Team Formation, reviewers indicated Good practice 24% of the time, with most ratings in the Fair (32%) and Poor (32%) ranges. Similarly, 24% of the ratings indicated Good practice in the Area of Team Participation, with the majority of practice indicated in the Fair (29%) and Poor (37%) ranges. Lack of communication and collaboration with and among other formal providers was the most consistent concern noted by reviewers related to Team Formation. With regard to Team Participation, while the IHT team cannot be held accountable for lack of involvement by other providers who may choose to be uninvolved, the MPR examines the level of effort the IHT provider puts forth attempting to arrange for and foster team participation.

As discussed in the IHT Supplemental Question section of this report, reviewers indicated only about one-third (29%) of the time that youth received the Care Coordination their situation required. Substandard practice in the prior two Areas appears related to the ability to meet established standards and best practices for Care Coordination as well.

Transition was the lowest scoring Area across all Domains, and had the highest number of adverse practice ratings overall (16% or n=6). Similar to the prior three Areas, Good practice in this Area was indicated less than a quarter (18%) of the time. Scores mostly fell in the Fair (37%) and Poor (29%) ranges. While 45% of the youth reviewed had been enrolled in the IHT service ≤ 6 months and may not have been at a stage to begin planning for transition, lack of transition planning upon referral to a new service or turnover of the IHT clinician was apparent in several cases.

Domain 2: Community-Based

Figure 4 shows Good practice in this domain that consistently met established standards and best practices 58% (n=22) of the time.

Figure 4: Community-Based Mean Scores

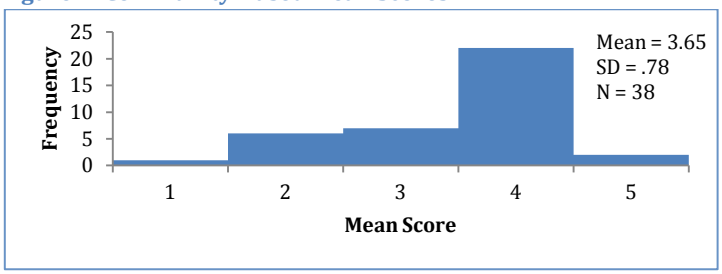


Table 6 summarizes the mean scores and frequencies for the two Areas in this practice domain. This Domain was a noted strength this MPR review round, with mean scores for both Areas within this domain among the three highest scoring of all 14 MPR Areas.

Table 6: Domain 2 Area Mean Scores & Frequencies

Domain/Area	Mean	Frequencies (n) %*				
Community-Based		Exemplary/ Best Practice 5	Good Practice 4	Fair Practice 3	Poor Practice 2	Adverse Practice 1
Responsiveness	3.47	(3) 8%	(21) 55%	(6) 16%	(7) 18%	(1) 3%
Service Accessibility	3.82	(5) 13%	(26) 68%	(3) 8%	(3) 8%	(1) 3%

*Due to rounding of percentages, some Area totals may equal >100%.

Nearly two-thirds (63% or n=24) of youth reviewed received scores indicating that the Responsiveness of services consistently met or exceeded established standards and best practices. Service Accessibility received the highest Area mean score (3.82), with Good to Exemplary practice noted 81% (n=31) of the time. The inherent nature of the IHT service is home-based service delivery with day/evening and weekend accessibility, and high ratings in this practice Area likely reflect both the need and appreciation among enrolled youth/families for this type of Service Accessibility.

Domain 3: Culturally Competent

As indicated in Figure 5 below, mean scores demonstrated Good practice related to the Culturally Competent Domain for 11% (n=4) of the youth/families reviewed. Fair practice was indicated 39% (n=15) of the time and Poor practice 45% (n=17) of the time.

Figure 5: Culturally Competent Mean Scores

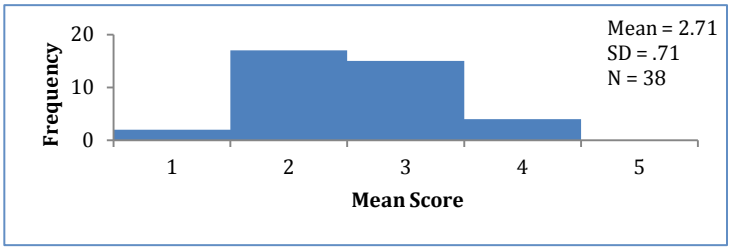


Table 7 summarizes this practice domain. As noted previously, the practice Area of Cultural Sensitivity and Responsiveness had the second lowest Area mean score of all 14 MPR Areas (2.61).

Table 7: Domain 3 Area Mean Scores & Frequencies

Domain/Area	Mean	Frequencies (n) %*				
Culturally Competent		Exemplary/ Best Practice 5	Good Practice 4	Fair Practice 3	Poor Practice 2	Adverse Practice 1
Cultural Awareness	2.82	-	(7) 18%	(18) 47%	(12) 32%	(1) 3%
Cultural Sensitivity & Responsiveness	2.61	-	(5) 13%	(15) 40%	(16) 42%	(2) 5%

*Due to rounding of percentages, some Area totals may equal >100%.

Noteworthy is that while some providers appeared to have an understanding of a youth/family's culture and could incorporate it into their work, a more narrow understanding and superficial exploration of youth/family culture was noted by a few reviewers. As with other interrelated practice areas, Fair or Poor performance in one area directly impacts others. Superficial exploration of a youth/family's culture can result in inconsistent

or inadequate practice with regard to Cultural Sensitivity and Responsiveness overall and throughout service delivery.

Domain 4: Youth/Family Progress

As Figure 6 illustrates, just over one-third (37% or n=14) of the youth/families reviewed had mean scores indicating Good progress was achieved since enrolling in the IHT service. Twenty-nine percent (n=11) demonstrated Fair progress, 26% (n=10) Little to No progress, and 8% (n=3) experienced Worsening or Declining Condition. In one of these instances, the IHT clinician and caregiver were not connecting well or in a strengths-based manner with the youth who apparently suffered from severe PTSD related to past trauma. In another, the youth had been improving, but poor safety planning and increased contact with a family member spurred outbursts that led to residential placement. The third youth showed progress during the summer, but symptoms worsened at the onset of the school year, and the inability of the clinician and parent to determine triggers to the youth's outbursts resulted in CBAT admission.

Figure 6: Youth & Family Progress Mean Scores

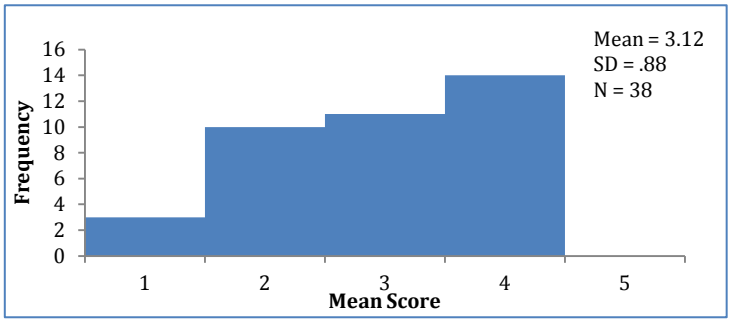


Table 8 summarizes the mean scores and frequencies for the youth and family progress Areas in this Domain.

Table 8: Domain 4 Area Mean Scores & Frequencies

Domain/Area	Mean	Frequencies (n) %*				
Youth/Family Progress		Exceptional Progress 5	Good Progress 4	Fair Progress 3	Little to No Progress 2	Worsening or Declining Condition 1
Youth Progress	3.05	-	(17) 45%	(9) 24%	(9) 24%	(3) 8%
Family Progress	3.18	(1) 3%	(15) 40%	(12) 32%	(10) 26%	-

*Due to rounding of percentages, some Area totals may equal >100%.

The majority of caregivers interviewed were able to identify an area of progress made by the youth. Frequently cited improvements in youth included more effective coping skills, especially in ability to manage anxiety and/or frustration; improved ability to express emotions; decrease in aggressive behavior; and getting along better with siblings. Likewise, caregivers most commonly noted Family Progress related to improved ability to manage specific and targeted behaviors, leading to improved relationships with their child and improved well-being and/or quality of life.

Youth and families experiencing multiple and more complex issues such as caregiver behavioral health issues, trauma, abuse, or substance abuse appeared to present a greater challenge for providers in a number of cases reviewed. In these instances, while families may have experienced progress related to managing specific target behaviors, lack of progress was often noted in regard to addressing and/or resolving these more complex issues.

IHT Supplemental Questions

To ascertain whether care coordination delivered as part of the IHT service is adequate to the needs and circumstances of enrolled youth/families, the MPR protocol includes eight supplemental questions regarding need for and appropriateness of the level of care coordination received, prior enrollment in Intensive Care Coordination (ICC) services, and the need for coordination with school, other service providers/systems, and state agencies. Table 9 summarizes the responses to these questions.

Table 9: IHT Supplemental Questions

Question	Results	
	Response	(n) %
1. Youth needs or receives multiple services from the same or multiple providers AND needs a CSA Wraparound care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof.	No	(20) 53%
2. Youth needs or receives services from state agencies, special education, or a combination thereof AND needs a CSA Wraparound care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof.	No	(26) 68%
3. Youth is receiving the amount and quality of care coordination his/her situation requires.		
Agree Very Much (n) %	**Agree (n) %**	**Neither (n) %**	**Disagree (n) %**	**Disagree Very Much (n) %**
(2) 5%	(10) 26%	(4) 11%	(14) 37%	(8) 21%
4 . Has the youth previously been enrolled in ICC?	No	(34) 89%
5 a. According to the CAREGIVER, has the IHT team ever discussed the option of ICC with the youth/family?	No	(18) 51%*
5 b. According to the IHT Clinician, has the team ever discussed the option of ICC with the youth/family?	No	(17) 47%*
6 a. Youth and family need the IHT provider to coordinate/ collaborate with school personnel.	Yes	(33) 87%
6 b. If yes, the IHT is in regular contact with school personnel involved with the youth and family.		
Agree Very Much (n) %	**Agree (n) %**	**Neither (n) %**	**Disagree (n) %**	**Disagree Very Much (n) %**
-	(14) 42%	(2) 6%	(10) 30%	(7) 21%
7 a. Youth and family need the IHT provider to coordinate/ collaborate with other service providers (e.g. TM, OP, psychiatry, etc.).	Yes	(27) 71%
7 b. If yes, the IHT is in regular contact with other providers (e.g. TM, OP, psychiatry, etc.) involved with the youth and family.		
Agree Very Much (n) %	**Agree (n) %**	**Neither (n) %**	**Disagree (n) %**	**Disagree Very Much (n) %**
(1) 4%	(8) 30%	(5) 19%	(9) 33%	(4) 15%
8 a. Youth and family need the IHT provider to coordinate/collaborate with state agencies (e.g. DCF, DYS, DDS, etc.)	No	(27) 71%
8 b. If yes, the IHT is in regular contact with state agencies (e.g. DCF, DYS, DDS, etc.) involved with the youth and family.		
Agree Very Much (n) %	**Agree (n) %**	**Neither (n) %**	**Disagree (n) %**	**Disagree Very Much (n) %**
(1) 9%	(3) 27%	(2) 18%	(2) 18%	(3) 27%

*"Not applicable" responses changed the n used for calculating these percentages.

In the majority of cases (69% or n=26) reviewers did not agree that youth were receiving the amount and quality of care coordination their situation required. While some of the cases reviewed might benefit from ICC, these results cannot be interpreted to mean that the majority of cases warranted ICC. As question 7a indicates, for 71% (n=27) of youth/families reviewed, reviewers felt there was a need for the IHT providers to coordinate and collaborate with other service providers. Also noteworthy was the need to coordinate specifically with school

personnel 87% of the time.

DISCUSSION

Overall, the results of this MPR review round suggest that providers are delivering IHT services with mixed consistency in adhering to established standards and best practices. The mean score for all youth/families reviewed and the distribution of cases along the practice and progress rating scales suggest Fair practice overall that does not consistently meet established standards.

Reviewers most frequently indicated Good practice related to the Community-Based Domain, noting that providers did particularly well delivering services that are Accessible and Responsive. Caregivers frequently commented on the positive benefits and support received by having this service provided in their home, at times most convenient for them and available days, evenings, and weekends. An added benefit is that this gives the IHT team the ability to observe youth and family dynamics, model for caregivers alternative strategies to manage behaviors, and provide immediate feedback to youth and caregivers as they learn new ways of dealing with situations. This appears to reinforce the learning and behavior change processes, as evidenced by scores received in the Youth & Family Progress Domain where improved ability to manage challenging behaviors and situations was frequently noted by reviewers. Provider efforts related to Youth and Family Engagement was another area of strength reflected in both the scoring and reviewer comments; practice was rated as Good to Exemplary in this Area for two-thirds of the youth/families reviewed.

While Good and/or Exemplary practice was noted in several Areas, scores and reviewers' comments also suggest several Areas needing practice improvement. Transition received the lowest mean score, and as previously noted, while a number of youth reviewed were enrolled in the service less than 6 months and may not have yet been at a transition planning stage, poor transitioning related to IHT clinician turnover and referrals to new services was apparent. Results also reflected inconsistent or inadequate practice in the Area of Cultural Sensitivity and Responsiveness, with many providers lacking apparent ability to effectively integrate cultural awareness into service planning and delivery.

Engaging and gaining active participation from other providers involved with youth/families was also identified as a practice Area needing improvement. Inconsistent practice in these areas inevitably contributed to weak Care Coordination. As indicated in IHT supplemental questions, youth did not appear to be receiving the amount and quality of care coordination his/her situation requires at least two-thirds of the time. IHT is a home-based, intensive therapy service with care coordination being one component of service provided by IHT clinicians. IHT clinicians may not perceive as clinical work those service activities essential for effective care coordination and may be less attentive or have insufficient time to dedicate to these tasks. When the case requires a more intensive level of care coordination, a referral to Intensive Care Coordination (ICC) services should be considered and acted upon. CBHI is working to more clearly define the IHT service and this should support providers in better understanding their role in coordinating care and in determining when a youth and family's needs require and would benefit from timely referral to ICC.

In addition, CBHI is actively working to address some of the other practice Areas identified as needing improvement during this review. Building on the IHT Practice Guidelines issued in 2015, CBHI, in partnership with the DMH Children's Behavioral Health Knowledge Center, is developing an IHT Practice Profile which will define and articulate principles and practices specific to IHT and support providers to more effectively implement services aligned with these standards. Practice Areas identified as needing improvement during this and prior review rounds also serve as potential topics for provider training.

Home-based services present a layer of complexity not experienced in clinic or facility-based services. While the youth is the identified client for the services, the family must also be actively engaged, and the home and surrounding environment must be factored into the assessment, service planning and service delivery processes. In addition to the vast array of clinical skills necessary to work effectively with youth with behavioral health issues, the range of skills and expertise required of IHT clinicians also includes care coordination, family systems, trauma-informed care, and evidence-based interventions. For some clinicians, especially those who are less experienced with limited exposure to circumstances vastly different from their own, being confronted with significantly complex families and circumstances may be beyond their current scope of practice or experience. The MPR does not currently collect data on clinicians' years of experience in the field. However, the data does indicate that nearly 50% of IHT clinicians have been in their current role and with their current agency less than one year.

A common theme raised by reviewers during the case review debrief process was the essential role supervision has in ensuring effective, comprehensive and quality service delivery. One critical function of supervision can be to provide the IHT clinician with an opportunity to step back with a more experienced clinician and review the larger picture of a family's life, and then adjust if necessary the focus, intensity or frequency of services. Future training efforts related to IHT practice will place special attention and focus on IHT supervisors so they can best support clinicians and staff to deliver the highest quality of service. CBHI may also consider future examination of specific agency practices related to supervision to reinforce its critical role in professional growth and development of staff.

Appendix A: MPR Domains/Areas and Indicator Rating Scales

MPR Domains/Areas

DOMAIN 1: Family-Driven & Youth-Guided

Area 1: Assessment

- Relevant data/information about the youth and family was diligently gathered through both initial and ongoing processes.
- The needs of the youth and family have been appropriately identified and prioritized across a full range of life domains.
- Actionable strengths of the youth and family have been identified and documented.
- The provider has explored natural supports with the family.
- The written assessment provides a clear understanding of the youth and family.

Area 2: Service Planning

- The provider actively engages and includes the youth and family in the service planning process.
- The service plan goals logically follow from the needs and strengths identified in the comprehensive assessment.
- Service plans and services are responsive to the emerging and changing needs of the youth and family.
- An effective risk management/safety plan is in place for the youth/family.

Area 3: Service Delivery

- The interventions provided to the youth and family match their needs and strengths.
- The provider incorporates the youth's and family's actionable strengths into the service delivery process.
- The intensity of the services/supports provided to the youth and family match their needs.
- Service providers assist the youth and family in understanding the provider agency and the service(s) in which they are participating.

Area 4: Youth & Family Engagement

- The provider actively engages the youth and family in the ongoing service delivery process.

Area 5: Team Formation

- The provider actively engages and includes formal providers in the service planning and delivery process (initial plan and updates).
- The provider actively engages and includes natural supports in the service planning and delivery process (initial plan and updates).

Area 6: Team Participation

- Providers, school personnel or other agencies involved with the youth participate in service planning.

Area 7: Care Coordination

- The provider (i.e. IHT clinician, ICC) successfully coordinates service planning and the delivery of services and supports.
- The youth is receiving the amount and quality of care coordination his/her situation requires.
- The provider facilitates ongoing, effective communication among all team members, including formal service providers, natural supports (if desired by the family), and family members including the youth.

Area 8: Transition

- Care transitions and life transitions (e.g. from youth to adult system, from one provider to another, from one service to another, from hospital to home, etc.) are anticipated, planned for, and well coordinated.

DOMAIN 2: Community-Based

Area 9: Responsiveness

- The provider responded to the referral (for its own service) in a timely and appropriate way.
- The provider made appropriate service referrals (for other services/supports) in a timely manner and engaged in follow-up efforts as necessary to ensure linkage with the identified services and supports.

Area 10: Service Accessibility

- Services are scheduled at convenient times for the youth and family.
- Services are provided in the location of the youth and family's preference.
- Service providers verbally communicate in the preferred language of the youth/family.
- Written documentation regarding services/planning is provided in the preferred language of the youth/family.

Indicator Rating Scales

Practice Indicators (Domains 1-3)

Exemplary/ Best Practice: 5	Consistently exceeds established standards and best practices
Good Practice: 4	Consistently meets established standards and best practices
Fair Practice: 3	Does not consistently meet established standards and best practices
Poor Practice: 2	Does not meet minimal established standards of practice
Adverse Practice: 1	Practice is either absent or wrong, and possibly harmful. Or practices being used may be inappropriate, contraindicated, or performed inappropriately or harmfully

Appendix A: MPR Domains/Areas and Indicator Rating Scales	
MPR Domains/Areas	**Indicator Rating Scales**
DOMAIN 3: Culturally Competent **Area 11: Cultural Awareness** • The service provider has explored and can describe the family's beliefs, culture, traditions, and identity. • Cultural differences and similarities between the provider and the youth/ family have been acknowledged and discussed, as they relate to the plan for working together. **Area 12: Cultural Sensitivity & Responsiveness** • The provider has acted on/incorporated knowledge of the family's culture into the work. • The provider has explored any youth or family history of migration, moves, or dislocation. If the youth or family has experienced stressful migration, moves, or dislocation, then those events inform the assessment of family's strengths and needs and the treatment/care plan. • The provider has explored any youth or family history of discrimination and victimization. If the youth or family has experienced discrimination or victimization, then the provider ensures that the treatment process is sensitive/responsive to the family's experience. • The provider has explored cultural differences within the family (e.g. intergenerational issues or due to couples having different backgrounds) and has incorporated this information into the understanding of the youth and family's strengths and needs and the care/treatment plan. • The provider helps the entire team understand and respect this family's culture.	
DOMAIN 4: Youth/Family Progress **Area 13: Youth Progress** • Since the youth's enrollment in the service being reviewed, he/she has developed improved coping or self-management skills. • Since the youth's enrollment in the service being reviewed, he/she has made progress in their social and/or emotional functioning at school. • Since the youth's enrollment in the service being reviewed, he/she has made progress in their social and/or emotional functioning in the community. • Since the youth's enrollment in the service being reviewed, he/she has made progress in their social and/or emotional functioning at home. • Since the youth's enrollment in the service being reviewed, there has been improvement in the youth's overall well-being and quality of life. **Area 14: Family Progress** • Since the family's enrollment in the service being reviewed, the parent/caregiver has made progress in their ability to cope with/manage their youth's behavior. • Since the family's enrollment in the service being reviewed, there has been improvement in the family's overall well-being and quality of life.	**Youth/Family Progress Indicators (Domain 4)** **Exceptional progress: 5** **Good progress: 4** **Fair Progress: 3** **Little to no progress: 2** **Worsening or declining condition: 1**

Appendix B: Select Demographic Information							
		(n)	%			(n)	%
Status of IHT Case at Time of Review	Open	37	97%	**Gender**	Male	21	55%
	Closed	1	3%		Female	17	45%
Age of Youth	0-4 years	3	8%	**Race/Ethnicity**	White	11	29%
	5-9 years	16	42%		Black	5	13%
	10-13 years	11	29%		Biracial/Mixed	6	16%
	14-17 years	6	16%		Latino/Hispanic	11	29%
	18-21 years	2	5%		Other	5	13%
>1 Behavioral Health Condition	Yes	22	58%	**Interventions (Current)**	Intensive Care Coordination (ICC)*	1	3%
	No	16	42%		In- Home Behavioral Services (IHBS)	2	5%
Behavioral Health Conditions	Mood Disorder	9	27%		Therapeutic Mentoring	10	26%
	Anxiety Disorder	8	21%		FS & T (Family Partner)	4	11%
	PTSD	9	24%		Therapeutic Training & Support	25	66%
	ADD/ADHD	14	37%		Mobile Crisis Intervention	5	13%
	Anger/Impulse Control	3	8%		Individual counseling	16	42%
	Substance Abuse/Dependence	1	3%		Family counseling	2	5%
	Learning Disorder	5	13%		Group counseling	2	5%
	Communication Disorder	1	3%		Psychiatrist	8	21%
	Autism/Autism Spectrum Disorder	4	11%		Substance Use Treatment	1	3%
	Disruptive Behavior Disorder	3	8%		Recreation activities	6	16%
	Intellectual Disability	1	3%		Inpatient/CBAT	2	5%
	Other	18	47%		Day tx/Partial Hosp.	1	3%
Service System Use (Current)	DMH	1	3%	**DCF Involved (Past Year)**	Yes	12	32%
	DCF	8	21%		No	26	68%
	Special Ed	20	53%				
	Probation	1	3%				
	Child Requiring Assistance (CRA)	3	8%				

*One youth who was enrolled in IHT during the random selection process was referred to and enrolled in ICC services 1 month prior to the scheduled MPR review.

Appendix C: Qualitative Comments by Reviewers by Domain/Area			
Domain/Area	**Mean**	**Qualitative Themes & Selected Reviewer Comments**	
		Practice Meeting or Exceeding Established Standards	**Practice Not Meeting Established Standards**
Family Driven & Youth Guided			
Assessment	2.87	Reviewer: "the team shows the threads from assessment to formulation to goals, interventions, progress and adaptation as new information is obtained and progress is made." Reviewer commented that assessment was very comprehensive; this was also verbalized by the family during the interview when the caregiver commented "they really know us."	While a number of the reviewers noted records had a current CANS, most were completed in a sparse or cursory manner. A few records also lacked safety plans as is required by the IHT service. "Assessment lacks depth and breadth, is vague and lacked exploration or inclusion of natural supports." "Strengths were not identified." "Comprehensive assessment did not include input from any of the other providers involved with the client/family."
Service Planning	2.95	"The team definitely integrated the youth and family's strengths into the service planning." "The most recent safety plan was a road map drawn with the youth and was wonderful." Commenting on the critical partnership between the IHT clinician and TT&S, one reviewer noted: "The TT&S demonstrated a real understanding of the family from initial assessment to ongoing treatment planning."	Reviewers frequently commented that the service plan itself was often found to be lacking in depth and detail. In a number of cases, reviewers also noted the service plan did not always contain detail in terms of target behavior or issue to be addressed and the interventions to be provided. Additionally, services provided by other providers were often not included on the service plan. Not involving biological family members who may or may not be currently living with the youth, but are involved in the youth's life, was also noted in a few cases. One reviewer noted that a case demonstrated that when the assessment and case formation are weak, this leads to poor service planning. The reviewed commented that in this case other providers and natural supports were unaware of what one another were working on. "There wasn't a lot of strengths-based language found and no evidence that the youth/family strengths were being incorporated into the service planning." "The treatment plan lacked use of actionable strengths and measurable outcomes."
Service Delivery	3.18	Individualized, strengths-based and creative interventions were noted in a number of cases. "Some of the coping skill strategies and engagement of the youth around art activities and animal themes were wonderful." "Creative interventions met the youth where he was at." "The team worked to create tools to help the mom. They realized mom did better with visuals and liked the schedules to help prompt her for things related to her children. They also did a lot of repetition of information as mom has a hard time retaining information." One theme noted in this area was the critical role of the Therapeutic Training and Support (TT&S) worker, who woks alongside the IHT clinician and provides therapeutic support to the family. A number of reviewers commented on the high quality of skill and service provided by the TT&S: "The TT&S actively engaged in working with the youth in the home and in the community, and her interventions identified are strengths based and easily measurable." "The TT&S worker was very articulate and engaged, he clearly and skillfully described how he has been working with the siblings in therapeutic play to improve their relationship." "The TT&S would provide psycho-education on age appropriate behaviors when she felt the parent's expectations were beyond the children's age level. She understood the parent's need to feel in control of her children and their care and would be sensitive to how she framed things for her."	More complex issues such as trauma, abuse, domestic violence, unmet parental or caregiver behavioral health needs may have been noted in the record yet not always addressed in the treatment planning and service delivery processes. Examples of service delivery noted by reviewers as inconsistent with established standards of practice include lack of attention to caregivers' apparent need and a lack of connection between the treatment plan and service delivery. "I got the sense that the team responded week to week to what was happening in the home, without a clear sense of the overarching goals and/or how to progress towards them." "Services lacked interventions that addressed the mother's priority need."
Youth & Family Engagement	3.66	A number of reviewers' comments included "engagement was great" or "engagement was a strength" in the case debrief summary notes. "The grandmother/caregiver mentioned communication from the IHT service as a strength." "Overall, the youth and family engagement is exceptional and	Substandard practice, when noted, reflected a similar theme as was noted in service delivery – not engaging family members or natural supports involved with the youth. In one case, the IHT team did not attempt to engage a family who struggled to consistently keep appointments although the youth remained enrolled in the service. The IHT clinician indicated thinking

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		can lead to further progress being made." "The clinician has very good engagement skills and the parent very much trusted him." "The clinician's approach with this family created a safe and welcoming environment that laid the foundation for clinical assessment and treatment planning."	that the family should be the one to contact the provider and demonstrate interest in receiving the service.
Team Formation	2.66	A reviewer of one case commented on the great communication by the IHT clinician with other team members and making appropriate referrals. One case involved multiple providers within the same organization and the reviewer noted strong and consistent internal communication amongst this team.	Lack of communication and collaboration with and among other formal providers was the most consistent concern noted by reviewers. Involvement of school personnel was noted as weak in several cases. Also noted was a lack of working with an outpatient therapist. In some cases lack of communication with medical professionals, including prescribing psychiatrists and referring primary care physicians, was noted. And as with service planning, lack of engaging or including involved family members or natural supports as part of the team was also noted.
Team Participation	2.66	Comments in this Area mirror those for Team Formation above.	
Care Coordination	2.76	No comments noted	A few reviewers noted little to no effort to coordinate with other providers involved with youth, such as special education, after school, outpatient, and/or physical health care providers/programs. "IHT clinician did not see it has her role as the HUB provider to coordinate services or initiate contact." Other concerns noted by reviewers include lack of knowledge about other providers' treatment goals or work with the youth, insufficient coordination with DCF, and in more than a few cases, lack of coordination or communication with school personnel.
Transition	2.58	No comments noted	Noteworthy in this area is the impact that staff/clinician turnover has on the service delivery. Lack of planning for transition was noted in a few cases involving the imminent departure of the IHT clinician. Referrals were at times made to a different service such as outpatient, yet no planning seemed to occur to promote seamless transition. The youth changing schools was also noted in a few cases as missed opportunities for transition planning.
Community-Based			
Responsiveness	3.47	Reviewer comments include: "The IHT team's responsiveness, and service accessibility was exceptional." "Responsive to emergent needs evident." "The IHT team did well in the community-based domain. This was evident in their responsiveness when they helped the family when a new situation/crisis occurred, and having their first appointment shortly after the referral." "The team is able to add new goals to the individual action plan to reflect what they are working with, and the needs of the family."	No comments noted
Service Accessibility	3.82	Positive comments reflecting the high quality of service accessibility included: "Service accessibility at a time and place that the family chose and in their preferred language was strong." "The team was very flexible with their time and schedule and were able to prioritize meetings with the family when needed. They were accessible for face to face visits and phone support." "This clinician was very responsive to the family when in need. He was flexible with scheduling sessions and available for support by phone. They were able to meet 2-3 times per week."	No comments noted
Culturally Competent			
Cultural Awareness	2.82	Where Good practice was noted in this area, reviewers made comments such as: "The IHT clinician excelled in their cultural competence, as they were aware of the family's culture, especially since it was so similar to their own."	Reviewer comments highlighting some of the deficits with regard to how culture was approached for the youth reviewed include: "There was a lot more areas for the IHT team to explore around culture. The only piece that was explored was ethnicity and religious practices."

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		One reviewer commented on the skill of a particular team member, the Therapeutic Mentor (TM) stating: "The TM involved seemed to have a deeper understanding of the family culture and incorporated it into the work she did."	"The IHT clinician seems to think culture is considered only when it presents as a barrier to services. For example, 'No issue or barrier' was documented throughout the areas of the CANS and Comprehensive Assessment asking about a family's culture and background."
Cultural Sensitivity & Responsiveness	2.61	"Noteworthy in this area is cultural sensitivity."	No comments noted
Youth/Family Progress			
Youth Progress	3.05	Frequently cited improvements in youth include more effective coping skills, especially in ability to manage anxiety and/or frustration; improved ability to express emotions; decrease in aggressive behavior; and getting along better with siblings. Caregiver comments: "[Youth] is much more able to express himself when angry instead of acting out feelings, and he is sleeping better." The caregiver went on to say, "we enjoy each other so much more with less episodes of aggression and so our home life is better." "My daughter is able to go to school now for months at a time and not get into a fight or kicked off the bus, and she also leaves here each morning caring about her hygiene and personal appearance. She is a much happier girl."	Reviewers indicated that while progress may have been noted by the caregiver and/or clinician, it was inconsistently documented in the record via updates to CANS scores or service plan documents.
Family Progress	3.18	As with Youth Progress, caregivers most commonly noted Family Progress related to improved ability to manage specific and targeted behaviors. Some caregivers mentioned that learning how to better manage and deal with problematic behaviors led to improved relationship with their child, and were also able to connect how these improvements contributed to improved well-being or quality of family life. One caregiver commented on how receiving psycho education on trauma and triggers allowed him to better understand and support his youth.	Families experiencing multiple and more complex issues, such as caregiver behavioral health issues, trauma, abuse, or substance abuse, appeared to present a greater challenge for some providers in a number of cases reviewed. In such cases, reviewers were able to agree with progress noted by caregivers in terms of specific target behaviors, but also identified when progress was lacking in addressing and/or resolving these more complex issues.