# System of Care Practice Review
# 2013-14 Statewide Report

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# Executive Summary

## Background

The System of Care Practice Review (SOCPR) was implemented as part of the Commonwealth's ongoing effort to evaluate the quality of care delivered to youth under 21 receiving MassHealth behavioral health services. This report presents a summary of the five regionally-based SOCPR reviews of the care delivered by Intensive Care Coordination (ICC) and In-Home Therapy (IHT) providers that took place between June 2013 and May 2014.

## Methodology

The System of Care Practice Review (SOCPR), developed by the University of South Florida (USF), uses a multiple case study methodology to learn how important System of Care (SOC) values and principles are operationalized at the practice level, where youth and families have direct contact with service providers. The care of 131 randomly selected youth who received services from ICC or IHT providers was reviewed using the SOCPR. Trained reviewers used the SOCPR protocol to review a youth's treatment record and to guide interviews with service providers, caregivers, and the youth. Reviewers then rated their impressions of the youth's care according to four domain areas that map closely to the core values of a SOC, as articulated by Stroul, Blau, and Friedman.[1]

### TABLE 1: SOCPR DOMAINS AND SUB-DOMAINS

| Domain | Sub-domains |
|---|---|
| Child-Centered & Family Focused | Individualized<br>Full-Participation<br>Care Coordination |
| Community-Based | Early Intervention<br>Access to Services<br>Minimal Restrictiveness<br>Integration and Coordination |
| Culturally Competent | Awareness<br>Sensitivity and Responsiveness<br>Agency Culture<br>Informal Supports |
| Impact | Improvement<br>Appropriateness |

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

[1] Stroul, B.A., Blau, G., & Friedman, R.M. (n.d). *Updating the System of Care Concept and Philosophy*. Washington, D.C.: National Technical Assistance Center for Children's Mental Health.

## Results

### Demographics

Youth between the ages of 5 and 9 constituted 31% (n = 41) of the sample, followed by youth between the ages of 14 and 17 at 29% (n = 38), and then youth between the ages of 10 and 13 at 25% (n = 33). In terms of race, youth who were White represented the largest percentage of the sample at 44% (n = 57), followed by those identified as Hispanic at 33% (n = 43). English was identified as the language spoken at home for 85% of the families (n = 112), followed by Spanish at 11% (n = 15). Out of the 131 youth reviewed, eighty-three (63%) had IHT serving as their "clinical hub," while another fifteen youth were enrolled in both IHT and ICC; thus almost 75% of the youth reviewed were participating in IHT in some way.

**TABLE 2: BASIC DEMOGRAPHICS OF YOUTH REVIEWED**

| | Total n (%) |
|---|---|
| Number of Reviews | 131 |
| IHT as Clinical Hub | 83 (63) |
| Male | 89 (68) |
| White | 57 (44) |
| Age 5-9 | 41 (31) |
| Length of Enrollment ≤ 12 mo | 102 (78) |
| DCF Involved | 42 (32) |
| Special Ed | 59 (45) |
| English Primary Language | 112 (85) |
| ≥ 1 Behavioral Health Diagnosis | 64 (67) |
| Prescribed psychiatric medication | 75 (58) |

### SOCPR Scores

SOCPR scores range from a low of 1 to a high of 7. Scores from 1 to 3 represent lower implementation of a System of Care (SOC) approach. A score of 4 suggests a neutral rating, indicating a lack of support for or against implementation. Scores in the 5 range represent good implementation of SOC principles, while those from 6 to 7 represent enhanced implementation of SOC principles. Across the five service regions, SOCPR mean domain scores ranged from 4.9 to 6.4. Overall, providers did best incorporating the Community-Based SOC principle into their work, followed by Culturally Competent, and Child-Centered and Family-Focused.. The Southeast Region demonstrated the highest overall case and practice domain mean scores.

### TABLE 3: SOCPR OVERALL & PRACTICE DOMAIN MEAN SCORES

| | Metro/Boston | Northeast | Central | Southeast | Western | Statewide |
|---|---|---|---|---|---|---|
| Overall | 5.5 | 5.9 | 5.5 | 6.0 | 5.8 | 5.8 |
| Domain 1: Child-Centered Family-Focused | 5.4 | 5.9 | 5.3 | 6.0 | 5.7 | 5.6 |
| Domain 2: Community-Based | 6.0. | 6.3 | 6.1 | 6.4 | 6.2 | 6.2 |
| Domain 3: Culturally Competent | 5.3 | 5.7 | 5.6 | 5.9 | 5.8 | 5.7 |

SOCPR domains 1-3 all assess how well practitioners' implemented various system of care principles in their work with youth and families. The *Impact* domain differs in that it is meant to assess whether services had a positive impact on the youth and family and whether these services appropriately met their identified needs. The statewide Impact domain mean score was 5.4 suggesting good (but not enhanced) impact. It is important to keep in mind that the vast majority of youth were still in active treatment at the time of the reviews. Accordingly, reviewers would expect to find clinicians and families continuing to work to resolve outstanding issues and meet treatment goals. Otherwise, there would be no continuing need for the services.

### TABLE 4: IMPACT DOMAIN MEAN SCORES

| | Metro/Boston | Northeast | Central | Southeast | Western | Statewide |
|---|---|---|---|---|---|---|
| Domain 4: Impact | 5.5 | 5.5 | 4.9 | 5.6 | 5.2 | 5.4 |

Overall findings from the SOCPR show that ICC and IHT providers are generally demonstrating a system of care approach to service planning and delivery. Areas of particular strength for providers appeared in the Community-Based Domain and included:

- Services were accessible to children and families and were offered at convenient times, in convenient locations, and in the primary language of the family.
- Services were provided in comfortable settings that were the least restrictive and most appropriate environment.

Findings indicated the greatest opportunities for growth for ICC and IHT providers in the following areas:

- Assessments in many cases were weak and appeared to lack a sound clinical conceptualization of the needs of the youth and family; in some instances this appeared to require greater clinical sophistication among staff conducting assessments and more oversight and review of assessment information by supervisory staff.

- Strengths of youth and families were not always considered when developing treatment planning goals and designing appropriate interventions.
- Services and supports that youth and families received were not always based on their individually identified needs and strengths.
- Service planning and delivery did not always include natural supports and services.
- Communication among and between all team members, including formal service providers, natural supports, family members, and the youth was frequently insufficient.
- The process for connecting youth and families with additional services and supports was not always smooth or seamless.

## Recommendations & Next Steps

This report, along with the information offered at the individual provider-specific debriefings that were convened by staff from MassHealth and EOHHS following each regional review, should be used to inform quality improvement efforts and guide discussions with providers about specific strategies they can undertake to build upon areas of strong performance. Likewise, the areas identified for growth should be the focus of provider-specific strategies to improve service delivery to youth and families through in-service trainings, greater attention and focus on these areas in individual and group staff supervision, and/or regular review of these areas as part of providers' quality assurance processes.

In addition to this general information about how to use the results from these reviews, TAC developed several additional recommendations for consideration by state policy makers. Most of these recommendations focus on the IHT provider system as the majority of reviews were of youth enrolled in IHT and findings revealed the need for more improvements among IHT providers. Furthermore, while considerable time, attention, and resources over the past few years have been dedicated to training and coaching for the Community Service Agencies (CSAs), the IHT provider system has not received the same level of attention. These recommendations are summarized below.

### *Create a Massachusetts-specific version of the SOCPR protocol.*

While stakeholders agree that the qualitative case review process is a key component of the state's quality management system, there was consensus among the review team that changes to the SOCPR protocol were needed. Suggested changes included:

- Editing the interview protocol to make the language more "family friendly;"
- Revising the impact domain to include information about progress in areas such as coping/self-management, social functioning, and well-being/quality of life;
- Eliminating redundant or confusing questions; and
- Including questions on key areas such as care transitions and safety planning.

Revisions to the protocol are currently in process. A pilot test of the new protocol, called the Massachusetts Practice Review (MPR), occurred in October 2014.

### *Clarify practice standards for IHT and invest in IHT workforce development.*

Clarifying the "how" of IHT and assisting IHT providers to deliver care in accordance with best practice standards through ongoing training and coaching is a necessary quality improvement activity. TAC understands that a set of IHT practice guidelines is under development and a plan exists for disseminating these guidelines in the winter of 2014. Moreover, a series of regional trainings for IHT providers is being planned for late winter and spring of 2015.

Additional steps to improve the skills and competencies of IHT staff also appear warranted. This might include training providers in use of evidence-informed interventions to address common psychiatric issues in youth such as anxiety, depression, trauma, or conduct problems. The state may want to consider, in particular, implementing modularized approaches that use the research base to inform and manage practice in a sustainable fashion.

Further with respect to workforce development, TAC recommends that the learning collaborative model currently used to engage the CSAs in a quality improvement process be extended to IHT providers in subsequent years. Topics for the IHT learning collaboratives could be derived from the areas for improvement identified during the qualitative case reviews. For example, given the finding that assessment was an area that providers need to enhance a specific learning collaborative on improving assessment practices could be convened. Integrate review data and training/coaching into a comprehensive quality improvement plan.

Given limited resources and the fact that it can take state policy makers and providers considerable time to address issues identified during these reviews, TAC recommends that reviews of care do not occur every year. Instead, TAC proposes that child/family reviews occur every other year at most so that resources can be dedicated to supporting providers in making the changes to their practice and operations.

### *Develop clear policies and procedures for clinical consultation and review of care.*

TAC recommends that all providers review their policies and procedures to assess the quality and appropriateness of care and establish procedures for clinicians and/or care planning teams to obtain internal or external "consultation." Furthermore, TAC suggests that the MCEs review these policies and procedures during their regularly established meetings with providers of IHT and ICC. As a first step, TAC recommends that providers should have standards or thresholds for identifying youth and families who are at "high risk" of psychiatric hospitalization, child welfare or juvenile justice involvement, domestic violence, homelessness, or school failure.

### *Promote greater inclusion and use of natural supports and "hub-dependent" services.*

While providers cannot be expected to solve the wide-ranging and often complex needs of the families they serve, they should be familiar with the services and supports available in the families' community and help connect families with the appropriate resources. Better use of established sources of information on community resources, including the Massachusetts 2-1-1 system and attendance at local SOC meetings, could help IHT staff persons use local resources more effectively to help the youth and families they serve. In addition, IHT providers should undertake more focused exploration of natural supports as well as services such as FS&T that could be drawn upon to support a youth and family is needed. IHT and ICC providers should be

challenged to come up with their own creative solutions about how to raise awareness among their staff regarding the resources in their communities.

### *Improve comprehensive transition planning.*

More deliberate attention to transition planning (e.g. from hospital to home, from child to adult system, from one level of care to the next) stood out as an area for improvement for all providers. Helping families think about and plan for transitioning from the beginning of treatment and identifying clear indicators of when everyone (e.g. the family, youth, natural supports, formal providers, etc.) will know it is time for services to end, should be a focus of provider training and coaching efforts. For all providers, developing clear policies and procedures with regard to making referrals for needed services, particularly those outside of their own agency, is another area to focus improvement efforts.

### *Improve strategies to engage families in ICC.*

The state should explore potential options for ensuring that youth who need ICC are identified and referred to CSAs. Strategies to consider include: evaluating how the MCEs could play a more prominent role in ensuring that youth are engaged in the appropriate level of care, and providing guidance to clinicians about the need to inform families of available services and to assess the need for other services on an ongoing basis.

## Background

Developed by the University of South Florida (USF), the SOCPR utilizes a multiple case study methodology to learn how important Systems of Care (SOC) values and principles are operationalized at the practice level, where youth and families have direct contact with service providers. Using the SOCPR protocol, trained reviewers conduct structured interviews with key informants including the parent/caregiver of a randomly selected youth, the youth (if 12 or older), service providers, and other helpers familiar with the care the youth and family are receiving. A review of a youth's record is also performed, which provides an additional source of information about the service planning and delivery process.

The SOCPR process is one component of the Commonwealth's quality monitoring infrastructure for services delivered to MassHealth enrolled youth with behavioral health challenges as part of the Children's Behavioral Health Initiative (CBHI). The values guiding the CBHI closely align with the domain areas assessed by the SOCPR (Table 4). This alignment served as one of the primary reasons why the SOCPR was selected by the Commonwealth to inform and guide current and future CBHI quality improvement efforts.

### TABLE 5: CBHI VALUES AND SOCPR DOMAINS

| CBHI Values | SOCPR Domains |
|---|---|
| Child-Centered and Family-Driven Strengths-Based | Child-Centered and Family-Focused |
| Culturally Responsive | Culturally Competent |
| Collaborative and Integrated | Community-Based |
| Continuously Improving | Impact |

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

In January 2013, the Commonwealth procured the Technical Assistance Collaborative, Inc. (TAC), a Boston-based nonprofit human services consulting firm, to assist in managing implementation and operation of the SOCPR process over the next several years. Between June 2013 and May 2014, TAC assisted the Commonwealth to conduct a series of five regionally-based reviews of the care delivered by Intensive Care Coordination (ICC) and In-Home Therapy (IHT) providers. Table 5 presents a summary of the review schedule.

**TABLE 6: REVIEW SCHEDULE BY STATE REGION**

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

ICC and IHT providers were selected for these reviews given their important role in the system delivering care coordination for youth with the most serious behavioral health challenges. Sometimes referred to as "clinical hubs," ICC and IHT providers are expected to do the following: perform a comprehensive assessment, develop a collaborative plan of care, facilitate referrals and linkages to needed services and supports, foster communication among the various providers and the youth and family, and effectively manage care transitions (e.g., hospital to home, child to adult system, one provider to another, etc.).

## Methodology

### Reviewer training

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

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

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

## Provider and youth selection

All ICC providers serving a region were reviewed with the exception of the Metro/Boston area. IHT providers were randomly selected for review using the Massachusetts Behavioral Health Access (MABHA) report. Table 6 details the number of ICC and IHT sites and unique providers reviewed in each region.

### TABLE 7: ICC AND IHT PROVIDERS AND SITES BY REGION

| | Metro/Boston | Northeast | Central | Southeast | Western |
|---|---|---|---|---|---|
| IHT Sites | 9 | 6 | 6 | 6 | 6 |
| Unique IHT Providers | 8 | 6 | 6 | 6 | 6 |
| ICC Sites | 0 | 6 | 6 | 6 | 7 |
| Unique ICC Providers | 0 | 4 | 4 | 6 | 6 |

Once providers were selected for participation, youth who were enrolled with those providers were randomly selected to participate. To be eligible for inclusion in the random selection, youth must have been enrolled in IHT or ICC for a minimum of three months. Also, so as to more clearly understand how IHT functioned as a "hub" of care coordination, only those youth enrolled in IHT without concurrent enrollment in ICC were eligible for the random selection from IHT providers.

More detailed information about the provider and youth selection processes is located in the regional reports.

## Consent process

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

## Scheduling process

Providers scheduled a minimum of three interviews (with a preference for four) with the following key informants: 1) the parent/caregiver; 2) the youth if 12 or older; 3) the IHT clinician or care coordinator; and 4) a second formal provider[2] who was familiar with the care provided to the youth (e.g., family partner, DCF worker, outpatient therapist, etc.). If the youth was under 12, the provider worked with the youth/family to select an alternate provider who was familiar with the care delivery and planning process to participate in an interview. A review of the youth's record at the provider agency preceded the interviews. It is important to note that for an SOCPR administration to be considered valid a minimum of three data points (the record review and two interviews) are necessary.

## SOCPR description

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

The reliability of the SOCPR has been evaluated, and high inter-rater reliability has been reported in its use.[3] The validity of the protocol is supported through triangulating information obtained from various informants and document reviews. The SOCPR was found to distinguish between a system of care site and a traditional services site. Moreover, Hernandez et al. found in their study that the SOCPR identified system of care sites as being more child-centered and family-focused, community-based, and culturally competent than services in a matched comparison site offering traditional mental health services.[4] System of care sites were more likely than traditional service systems to consider the social strengths of both youth and families and to include informal sources of support such as extended family and friends in the planning and delivery of services. In addition, Stephens, Holden, and Hernandez[5] found that the SOCPR ratings were associated with child-level outcome measures. In their comparison study, Stephens and colleagues discovered that youth who received services in systems that functioned in a manner consistent with system of care values and principles compared with traditional services had significant reductions in symptomatology and impairment one year after entry into services, whereas youth in organizations that did not use system of care values demonstrated less positive change.

[2] During the Metro/Boston reviews providers were asked to schedule a review with a natural support person.
[3] Hernandez, M., Gomez, A., Lipien, L., Greenbaum, P. E., Armstrong, K., & Gonzalez, P. (2001). Use of the system of care practice review in the national evaluation: Evaluating the fidelity of practice to system of care principles. *Journal of Emotional and Behavioral Disorders*, 9, 43-52
[4] Ibid.
[5] Stephens, R.L, Holden, E.W., & Hernandez, M. (2004). System-of-care practice review scores as predictors of behavioral symptomatology and functional impairment. *Journal of Child and Family Studies*, 13, 179-191.

## SOCPR method

The SOCPR uses a case study methodology informed by caregivers, youth, formal providers, and extant documents related to service planning and provision. The SOCPR relies on data gathered from interviews with multiple informants, as well as through a review of the youth's record. Document reviews precede interviews and provide the reviewer with important contextual information about the youth and family's treatment history and current treatment and planning processes. The unit of analysis is the family, with each family representing a test of the extent to which the system of care is implementing its services in accordance with system of care values and principles.

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

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

## SOCPR domains

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

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

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

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

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

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

## IHT supplemental questions

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

## Organization of the SOCPR

The SOCPR is organized into four major sections.

### *Section 1:*

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

### *Section 2:*

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

### *Section 3:*

Consists of the interview questions organized by the type of informant (primary caregiver, youth, formal service provider); the interviews are designed to gather information about each of the four identified domains (Child-Centered and Family-Focused, Community-Based, Culturally Competent, and Impact). Questions for each of the four domains are divided into sub-domains that define the domain in further detail. Questions in each of the sub-domains are designed to indicate the extent to which core system of care values guide practice. Data is gathered through a combination of closed-ended and more open-ended questions. The open-

ended questioning provides an opportunity for the reviewer to probe issues related to specific questions so that answers are as complete as possible. In addition, direct quotes from respondents are recorded whenever appropriate and possible.

### *Section 4:*

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

**TABLE 8: SUMMATIVE QUESTION SCALE**

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

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

## Data analysis

For this year-end report, mean scores were computed on a statewide basis for the overall SOCPR score, for each of the four SOCPR domains (Child-Centered and Family-Focused, Community-Based, Culturally Competent, and Impact), and for the sub-domains and areas within each domain. An item-by-item analysis of summative questions was not performed statewide, but is included in each regional summary report.

# Results

A summary of the results across the five regional reviews is included below. Demographic information that describes the characteristics of the sample is presented here, followed by the results in each of the four domain areas of interest (Child-Centered and Family-Focused, Community-Based, Cultural Competence, and Impact), and then for the sub-domains and areas within each domain.

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

## Demographics

Youth between the ages of 5-9 constituted 31% (n = 41) of the sample, followed by youth between the ages of 14-17 at 29% (n = 38), youth between the ages of 10-13 at 25% (n = 33), youth ages 0-4 at 9% (n = 12), and then youth ages 18-21 at 5% (n = 7). Sixty-eight percent (n = 89) of the youth were male. In terms of race, youth who were White represented 44% (n = 57) of the sample, followed by those youth who identified as Hispanic at 33% (n = 43). Eleven percent of the youth (n = 15) were Bi-Racial/Mixed Race, while ten youth (8%) were African-American and three youth (3%) were Asian/Pacific Islander.[6] English was identified as the language spoken at home for 85% of the families (n = 112). Over three-quarters of youth (n = 102 or 78%) had been enrolled in services for over 12 months. DCF involvement differed across regions, from a low of 17% in the Northeast region to a high of 50% in the Central region. Additionally, 45% of the youth reviewed (n = 59) received special education services. Sixty-four youth (67%) had more than one behavioral health diagnosis, with thirty-one (24%) having more than three diagnoses. More than half of the youth who were reviewed were prescribed psychiatric medication.

Out of the 131 youth reviewed, eighty-three (63%) had IHT serving as their “clinical hub,” while another fifteen youth were enrolled in both IHT and ICC, thus almost 75% of the youth reviewed were participating in IHT.

[6] One youth chose not to self-identify and race/ethnicity data was missing for two youth.

**TABLE 9: DEMOGRAPHICS OF YOUTH AND FAMILIES REVIEWED**

| | Metro/Boston n (%) | Northeast n (%) | Central n (%) | Southeast n (%) | Western n (%) | Total n (%) |
|---|---|---|---|---|---|---|
| Number of Reviews | 36 | 24 | 22 | 24 | 25 | 131 |
| IHT as Clinical Hub | 35* (97) | 12 (50) | 12 (55) | 12 (50) | 12 (48) | 83 (63) |
| Male | 23 (64) | 17 (71) | 17 (77) | 15 (63) | 17 (68) | 89 (68) |
| White | 7 (19) | 9 (38) | 13 (59) | 17 (71) | 11 (44) | 57 (44) |
| Age 5-9 | 6 (17) | 9 (38) | 7 (32) | 9 (38) | 10 (40) | 41 (31) |
| Length of Enrollment ≤ 12 mo | 27 (75) | 17 (71) | 19 (86) | 18 (75) | 21 (84) | 102 (78) |
| DCF Involved | 12 (33) | 4 (17) | 11 (50) | 6 (25) | 9 (36) | 42 (32) |
| Special Ed | 14 (39) | 10 (42) | 12 (55) | 12 (50) | 11 (44) | 59 (45) |
| English Primary Language | 28 (78) | 20 (83) | 20 (91) | 23 (96) | 21 (78) | 112 (85) |
| ≥ 1 Behavioral Health Diagnosis | ** | 15 (63) | 15 (68) | 15 (63) | 19 (76) | 64 (67) |
| Prescribed psychiatric medication | 17 (47) | 14 (61) | 13 (59) | 14 (58) | 17 (68) | 75 (58) |

**One youth in the Boston review was concurrently enrolled in ICC.*
***Information was only collected on the primary diagnosis for the Metro/Boston reviews. The demographic form was revised following this review.*

## SOCPR overall and domain mean scores

As mentioned previously, SOCPR scores range from a low of 1 to a high of 7. Scores in the 1 to 3 range represent lower implementation of a SOC approach. A score in the range 4 indicates a neutral rating or lack of support for or against implementation. Scores in the 5 range represent good implementation of SOC principles, while those from 6 to 7 represent enhanced implementation of SOC principles.

As shown in Table 10, SOCPR mean domain scores ranged from 4.9 to 6.4. Overall, providers did best incorporating the Community-Based SOC principle into their work, followed by Culturally Competent, Child-Centered and Family-Focused. The Southeast Region demonstrated the highest overall case and practice domain mean scores. While the Metro/Boston region demonstrated the lowest overall mean score, it is worth noting that this regional review focused entirely on providers of IHT, while other regional reviews included an equal number of ICC and IHT providers. This is significant because other regions' mean scores benefitted from the fact that ICC providers had a higher percentage of cases scoring in the enhanced implementation range in every domain area (see Figures 1-5).

### TABLE 10: SOCPR OVERALL & PRACTICE DOMAIN MEAN SCORES

| | Metro/Boston | Northeast | Central | Southeast | Western | Statewide |
|---|---|---|---|---|---|---|
| Overall | 5.5 | 5.9 | 5.5 | 6.0 | 5.8 | 5.8 |
| Domain 1: Child-Centered Family-Focused | 5.4 | 5.9 | 5.3 | 6.0 | 5.7 | 5.6 |
| Domain 2: Community-Based | 6.0 | 6.3 | 6.1 | 6.4 | 6.2 | 6.2 |
| Domain 3: Culturally Competent | 5.3 | 5.7 | 5.6 | 5.9 | 5.8 | 5.7 |

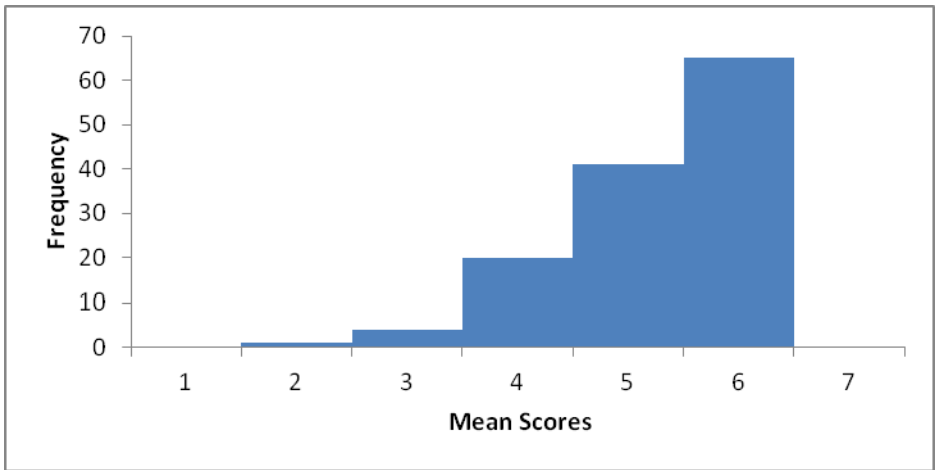
SOCPR domains 1-3 all assess how well practitioners' implemented various system of care principles in their work with youth and families. The *Impact* domain differs in that it is meant to assess whether services had a positive impact on the youth and family and whether these services appropriately met their identified needs. The statewide Impact domain mean score was 5.4 suggesting good (but not enhanced) impact. It is important to keep in mind that the vast majority of youth were still in active treatment at the time of the reviews. Accordingly, reviewers would expect to find clinicians and families continuing to work to resolve outstanding issues and meet treatment goals. Otherwise, there would be no continuing need for the services.

### TABLE 11: SOCPR IMPACT DOMAIN MEAN SCORES

| | Metro/Boston | Northeast | Central | Southeast | Western | Statewide |
|---|---|---|---|---|---|---|
| Domain 4: Impact | 5.5 | 5.5 | 4.9 | 5.6 | 5.2 | 5.4 |

As the histogram in Figure 1 illustrates, sixty-five (50%) of the 131 cases reviewed statewide had mean scores in the six range representing enhanced SOC implementation; this included 68% of all ICC cases reviewed versus 39% of all IHT cases reviewed. Forty-one cases (31%) had mean scores in the five range reflecting good SOC implementation; this included 21% of all ICC cases versus 37% of all IHT cases. Twenty cases (15%) had means in the four range, and five cases (4%) scored in the 2-3 range. Of the cases that fell below a five, twenty were IHT cases, while five were ICC cases, representing 24% of all IHT cases versus 11% of all ICC cases reviewed.

### FIGURE 1: OVERALL MEAN SCORES

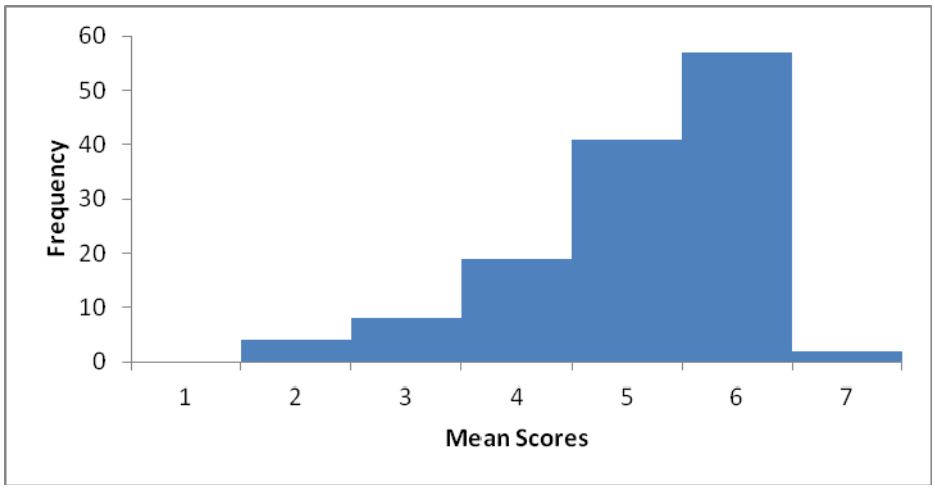



Mean = 5.75
SD = .92
N = 131

### *Child-Centered and Family-Focused*

As seen in Figure 2 below, in the Child-Centered Family-Focused domain, fifty-nine (46%) of the cases reviewed had mean scores that fell in the six to seven range, suggesting enhanced implementation of this SOC principle; this included 64% of all ICC cases reviewed versus 35% of all IHT cases reviewed. Another forty-one cases (31%) had means score in the five range, reflecting good adherence to this SOC principle; this included 26% of all ICC cases and 35% of all IHT cases. Nineteen of the cases (15%) scored in the four range and 12 cases (9%) scored in the 2-3 range. Of the cases that fell below a five, 26 were IHT cases, while five were ICC cases, representing 31% of all IHT cases versus 11% of all ICC cases.

### FIGURE 2: CHILD-CENTERED AND FAMILY-FOCUSED MEAN SCORES



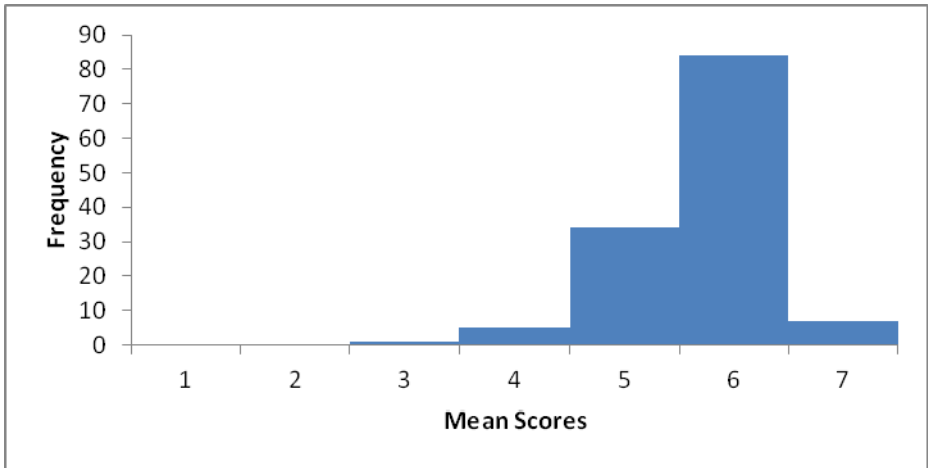

Mean = 5.61
SD = 1.14
N = 131

### *Community-Based*

Figure 3 illustrates the range of mean scores in the Community-Based domain for the youth/family reviewed. Ninety-one (69%) of the cases had mean scores in the six to seven range, reflecting enhanced implementation of this principle; this included 81% of all ICC cases reviewed versus 63% of all IHT cases reviewed. Another thirty-four cases (26%) had mean scores in the five range, reflecting good adherence to this SOC principle; this included 17% of

all ICC cases and 31% of all IHT cases. Five of the cases (4%) scored in the four range and one case (1%) scored in the three range. Of the cases that fell below a five, five were IHT cases, while one was an ICC case, representing 6% of all IHT cases versus 2% of all ICC cases.

**FIGURE 3: COMMUNITY-BASED MEAN SCORES**

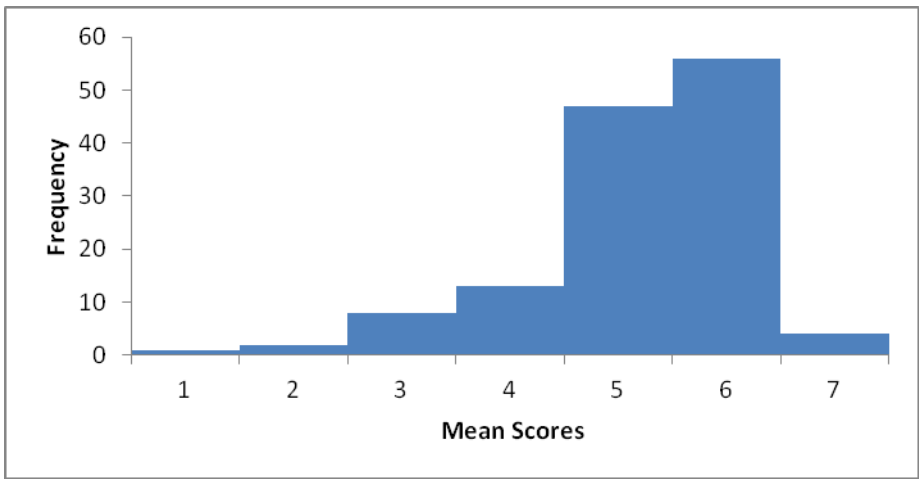



Mean = 6.21
SD = .68
N = 131

### *Culturally Competent*

As Figure 4 below shows, in the domain assessing how well providers delivered care that was culturally competent, sixty (46%) of the cases reviewed had a mean score that fell in the six to seven range, suggesting enhanced implementation of this SOC principle; this included 62% of all ICC cases reviewed versus 37% of all IHT cases reviewed. Another forty-seven cases (36%) had a mean score in the five range, reflecting good adherence to this SOC principle; this included 26% of all ICC cases and 42% of all IHT cases. Thirteen of the cases (10%) scored in the four range and 11 cases (9%) scored in the 1-3 range. Of the cases that fell below a five, 18 were IHT cases, while five were ICC cases, representing 21% of all IHT cases versus 13% of all ICC cases.

**FIGURE 4: CULTURALLY COMPETENT MEAN SCORES**

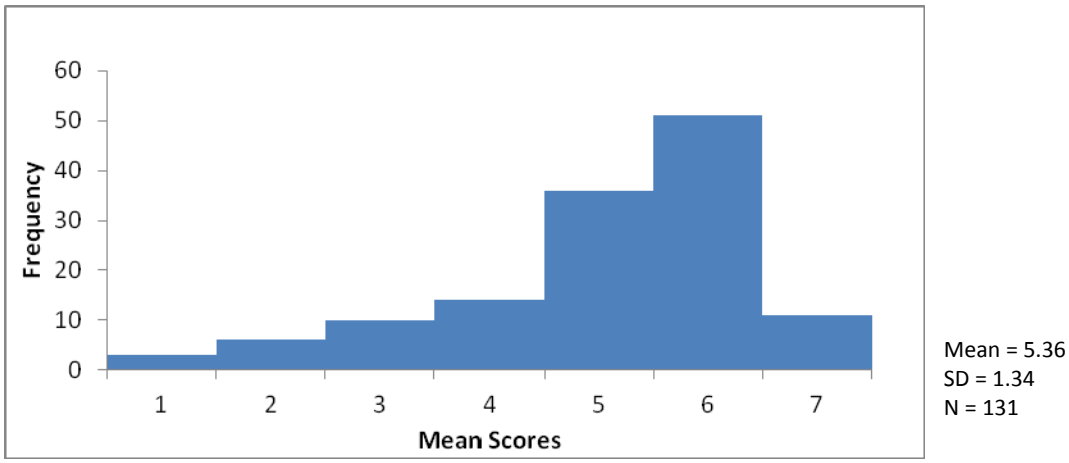



Mean = 5.65
SD = 1.03
N = 131

### *Impact*

As seen in Figure 5 below, in the Impact domain, sixty-two (47%) of the cases reviewed had mean scores that fell in the six to seven range, suggesting that the services and supports had enhanced impact; this included 51% of all ICC cases reviewed versus 45% of all IHT cases reviewed. Another thirty-six cases (27%) had mean scores in the five range, reflecting good impact; this included 25% of all ICC cases and 29% of all IHT cases. Fourteen of the cases (11%) scored in the four range and 19 cases (15%) scored in the 1-3 range, suggesting the need for enhancements in service delivery to more appropriately meet the needs of these youth and families and improve their situation. Of the cases that fell below a five, 22 were IHT cases, while 11 were ICC cases, representing 26% of all IHT cases and 23% of all ICC cases.

**FIGURE 5: IMPACT MEAN SCORES**




## SOCPR mean scores by sub-domain and area

Each regional summary report included an item-by-item analysis of the summative questions contained in each sub-domain and area that, when considered with qualitative reviewer comments, helped to demonstrate areas of particular strength among providers as well as areas that represent opportunities for growth. For this year-end report, mean scores for each of the sub-domains and areas within the four SOCPR domains are presented in Table 10 as an alternative way to summarize this information both by region and statewide. While standard interpretation of SOCPR scores considers means in the 5 range to represent good implementation of SOC principles, Massachusetts has applied a higher standard whereby some scores in the 5 range (i.e., 5.0 - 5.5) demonstrate the need for improvement in an area just as mean scores in the 1 - 4 range would suggest.

### TABLE 12: SOCPR MEAN SCORES BY SUB-DOMAIN & AREA

| SOCPR Domain, Sub-Domain & Area | Metro/Boston | Northeast | Central | Southeast | Western | Statewide |
|---|---|---|---|---|---|---|
| **Domain 1: Child-Centered & Family-Focused** | **5.4** | **5.9** | **5.3** | **6.0** | **5.7** | **5.6** |
| Sub-domain 1a: Individualized | 5.2 | 5.8 | 5.2 | 5.8 | 5.6 | 5.5 |
| Assessment/Inventory | 5.4 | 5.9 | 5.2 | 5.9 | 5.8 | 5.6 |
| Service Planning | 4.9 | 5.8 | 5.1 | 5.5 | 5.6 | 5.3 |
| Types of Services/Supports | 5.1 | 5.6 | 5.1 | 5.8 | 5.7 | 5.4 |
| Intensity of Services/Supports | 5.5 | 5.7 | 5.5 | 6.0 | 5.6 | 5.6 |
| Sub-domain 1b: Full Participation | 5.6 | 6.1 | 5.5 | 6.3 | 5.9 | 5.9 |
| Sub-domain 1c: Care Coordination | 5.3 | 5.9 | 5.3 | 5.9 | 5.6 | 5.6 |
| **Domain 2: Community-Based** | **6.0** | **6.3** | **6.1** | **6.4** | **6.2** | **6.2** |
| Sub-domain 2a: Early Intervention | 5.4 | 6.0 | 5.3 | 5.9 | 5.8 | 5.6 |
| Sub-domain 2b: Access to Services | 6.7 | 6.7 | 6.1 | 6.8 | 6.7 | 6.7 |
| Convenient Times | 6.7 | 6.8 | 6.8 | 6.7 | 6.8 | 6.8 |
| Convenient Locations | 6.8 | 67.0 | 7.0 | 6.8 | 7.0 | 7.0 |
| Appropriate Language | 6.6 | 6.5 | 6.8 | 6.9 | 6.5 | 6.6 |
| Sub-domain 2c: Minimal Restrictiveness | 6.6 | 6.9 | 6.8 | 6.9 | 6.7 | 6.8 |
| Sub-domain 2d: Integration & Coordination | 5.1 | 5.6 | 4.9 | 5.4 | 5.0 | 5.2 |
| **Domain 3: Culturally Competent** | **5.3** | **5.7** | **5.6** | **5.9** | **5.8** | **5.7** |
| Sub-domain 3a: Awareness | 5.6 | 5.7 | 5.6 | 5.9 | 6.0 | 5.7 |
| Awareness of Child/Family's Culture | 5.5 | 5.9 | 5.8 | 6.0 | 6.1 | 5.8 |
| Awareness of Provider's Culture | 5.5 | 5.6 | 5.5 | 5.8 | 5.8 | 5.7 |
| Awareness of Cultural Dynamics | 5.6 | 5.3 | 5.4 | 5.8 | 5.9 | 5.6 |
| Sub-domain 3b: Sensitivity & Responsiveness | 5.6 | 5.8 | 5.7 | 5.9 | 5.7 | 5.7 |
| Sub-domain 3c: Agency Culture | 5.4 | 5.8 | 5.9 | 6.5 | 6.2 | 5.9 |
| Sub-domain 3d: Informal Supports | 4.5 | 5.0 | 4.4 | 4.9 | 4.3 | 4.6 |
| **Domain 4: Impact** | **5.5** | **5.5** | **4.9** | **5.6** | **5.2** | **5.4** |
| Sub-domain 4a: Improvement | 5. 7 | 5.5 | 4.8 | 5.6 | 5.3 | 5.4 |
| Sub-domain 4b: Appropriateness | 5.4 | 5.5 | 5.1 | 5.6 | 5.1 | 5.3 |

### *Community-Based*

As noted previously, the Community-Based domain had the highest overall mean score statewide, with each region scoring the highest in this domain. All regions performed exceptionally well in the Access to Services sub-domain, by providing services at convenient times and locations, and in the preferred language of the family. Furthermore, providers across the state ensured that services were delivered in settings that were comfortable for the family and were provided in the least restrictive and most appropriate environment.

Mean scores in the Early Intervention sub-domain reflected some challenges for providers in the Metro/Boston and Central regions, suggesting the need for improvement with respect to how quickly providers clarify the youth and family's needs and respond by offering the appropriate combination of services and supports. Scores in the Integration and Coordination sub-domain suggest the need for improvement across all regions with the possible exception of the Northeast.

### *Culturally Competent*

Culturally Competent was the second highest scoring domain statewide. The Metro/Boston region had an overall mean score slightly below the others, with particular challenges reflected in the agency culture and informal supports sub-domains. The Metro/Boston region was not alone in needing improvement with respect to including informal or natural supports in the service planning and delivery processes; all regions had mean scores in this sub-domain falling at five or below. Providers in the Northeast and Central regions could also improve their practice with respect to enhancing their awareness of the dynamics inherent when working with families whose cultural values, beliefs, and lifestyle may be different from or similar to their own.

Strengths among the Western region providers in this domain are noted in the area of awareness of the child/family's culture and in the Agency Culture sub-domain. Southeast region providers also performed well in the Agency Culture sub-domain by assisting youth and families in understanding the agencies they represent and helping families understanding the expectations of the service in which they were participating.

### *Child-Centered and Family-Focused*

In the Child-Centered and Family-Focused domain, both the Metro/Boston and Central regions had mean scores that suggested a need for some improvement in this domain, with specific challenges in the areas of assessment, service planning, and ensuring that the types of services and supports provided to the youth/family reflect their needs and strengths. The Central region also could improve with respect to ensuring that the intensity of services/supports provided to the youth/family reflects their needs and strengths. The Metro/Boston and Central regions also had the lowest mean scores in the Care Coordination sub-domain.

In the Full Participation sub-domain which includes questions assessing how well the youth and family, along with service providers and informal helpers, participate in developing, implementing, and evaluating the service plan, the Northeast and Southeast regions were particularly strong, with mean scores in the 6 range.

### *Impact*

As stated earlier it is important to clarify that the impact domain does not measure adherence to SOC values and principles, but rather whether services had a positive impact on the youth and family and whether these services appropriately met their identified needs.[7] The statewide mean score in the Improvement sub-domain reflects the fact that the situation of the youth and families served had not improved. It is important to consider, however, that the vast majority of youth who participated in these reviews remained in active treatment; therefore, it would be expected that unresolved issues for many youth remain and that treatment goals may have not yet been realized.

## IHT supplemental questions results

In addition to the standard set of questions contained in the SOCPR protocol, nine additional questions were added to the Massachusetts version of the SOCPR. The additional questions were created to assess if the 83 youth[8] with IHT serving as their "clinical hub" are receiving all medically necessary remedial services, including appropriate care coordination. Therefore, these questions were not completed for the 48 youth who had ICC serving as their clinical hub.

Question 1 inquired about the need for or receipt of multiple services and the need for coordination of those services. Reviewers indicated that 57% of the youth (n = 47) did not need a care planning team to coordinate services from the same or multiple providers.

Question 2 asked about receiving services from state agencies or special education and the need for coordination of those services. Reviewers indicated that 69% of youth (n = 57) did not need a care planning team to coordinate services from state agencies or special education.

### TABLE 13: NEED FOR COORDINATION

| | Response | n (%) |
|---|---|---|
| Q1. The youth needs or receives multiple services from the same or multiple providers. AND The youth needs are care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof. | No | 47 (57) |
| Q2. The youth needs or receives services from, state agencies, special education, or a combination thereof. AND The youth needs a care planning team to coordinate services from multiple providers or state agencies, special education, or a combination thereof. | No | 57 (69) |

Question 3 asked if the level of care coordination, in this case IHT, was appropriate. Sixty-one percent (n = 50) agreed moderately or very much that the youth was receiving the appropriate level of care coordination.

[7] Due to concerns related to reviewers understanding of this construct, there is a plan to revise this domain for future reviews.
[8] One youth in the Metro/Boston region was concurrently enrolled in ICC and therefore was not included in the IHT supplemental analysis.

### TABLE 14: APPROPRIATE LEVEL OF CARE COORDINATION

| | Disagree very much n (%) | Disagree moderately n (%) | Disagree slightly n (%) | Neither agree nor disagree n (%) | Agree slightly n (%) | Agree moderately n (%) | Agree very much n (%) |
|---|---|---|---|---|---|---|---|
| Q3. The youth/family is receiving the level of care coordination his/her situation requires. | 7 (8) | 8 (10) | 5 (6) | 0 | 13 (15) | 28 (34) | 22 (27) |

Eleven (13%) of youth had been previously enrolled in ICC.

### TABLE 15: PRIOR ICC ENROLLMENT

| | Response | n (%) |
|---|---|---|
| Q4. Has the youth previously been enrolled in ICC? | No | 72 (87) |

Question 5 inquired whether or not the IHT team ever discussed the option of ICC with the youth/family. Results indicated that for 54% of the youth with IHT, the clinician did not discuss the option of IHT. In those instances where the clinician did not discuss IHT with the family, the majority of clinicians indicated that they did not believe the family needed ICC. In a few instances, IHT clinicians did not discuss ICC with the family because the family had been previously enrolled in ICC, while some mentioned that they were planning to discuss ICC once the family had been enrolled in IHT longer. A few reviewers failed to provide a specific reason why ICC was never discussed with the family.

### TABLE 16: DISCUSSION OF ICC WITH YOUTH/FAMILY

| | Response | n (%) |
|---|---|---|
| Q5. Has the IHT team ever discussed the option of ICC with the youth/family? | No | 45 (54) |

Question 6 asked if the youth needed assistance from their provider in working with the schools. For about sixty-nine (69%) of the youth, reviewers agreed moderately or very much that the youth/family needed assistance in working with the school system.

### TABLE 17: NEED FOR COORDINATION WITH SCHOOL

| | Disagree very much n (%) | Disagree moderately n (%) | Disagree slightly n (%) | Neither agree nor disagree n (%) | Agree slightly n (%) | Agree moderately n (%) | Agree very much n (%) |
|---|---|---|---|---|---|---|---|
| Q6. The youth needs providers to coordinate/ collaborate with school personnel. | 8 (10) | 3 (4) | 2 (2) | 4 (5) | 9 (11) | 27 (33) | 30 (36) |

Question 7 asked reviewers to indicate if the IHT team was in contact with all the service systems involved with the youth and family. Over half (54%) agreed moderately or very much that the IHT team was connecting with the other service systems.

### TABLE 18: CONTACT WITH PROVIDERS AND SERVICE SYSTEMS

| | Disagree very much n (%) | Disagree moderately n (%) | Disagree slightly n (%) | Neither agree nor disagree n (%) | Agree slightly n (%) | Agree moderately n (%) | Agree very much n (%) |
|---|---|---|---|---|---|---|---|
| Q7. The IHT is in regular contact with other providers, state agencies and school personnel involved with the youth and family. | 4 (5) | 14 (17) | 4 (5) | 0 | 16 (19) | 24 (29) | 21 (25) |

For question 8, reviewers were asked to indicate if the multiple service systems involved with the youth participate in care planning. Over one-third (37%) of reviewers agreed moderately or very much that other providers or state agency personnel involved with the youth participate in care planning.

### TABLE 19: PARTICIPATION IN PLANNING

| | Disagree very much n (%) | Disagree moderately n (%) | Disagree slightly n (%) | Neither agree nor disagree n (%) | Agree slightly n (%) | Agree moderately n (%) | Agree very much n (%) |
|---|---|---|---|---|---|---|---|
| Q8. Providers, school personnel or other state agencies involved with the youth participate in care planning. | 16 (19) | 10 (12) | 9 (11) | 0 | 17 (21) | 20 (24) | 11 (13) |

Question 9 asked for information about the other hub dependent services that youth were receiving at the time of the review. Twenty-three youth (28%) were participating in Therapeutic

Mentoring, five youth (6%) had a family partner, and three youth (4%) were participating in IHBS.

**TABLE 20: OTHER HUB DEPENDENT SERVICES**

| Q9. Indicate the other "hub dependent" services supported by IHT | Response | n (%) |
|---|---|---|
| Q9i. Therapeutic Mentoring | Yes | 23 (28) |
| Q9ii. Family Support and Training | Yes | 5 (6) |
| Q9iii. In-Home Behavioral Services | Yes | 3 (4) |

# Discussion

## Strengths of the service system

Overall, the findings from this year's reviews indicate that ICC and IHT providers are generally demonstrating a system of care approach to service planning and delivery, performing best at including the Community-Based SOC value in service planning and provision. Areas of particular strength for ICC and IHT providers across the state included service accessibility and minimal restrictiveness, as discussed below.

### *Service accessibility*

*Services were accessible to children and families and were offered at convenient times, in convenient locations, and in the primary language of the family.* Providers were clearly respectful of the preferences of youth and families with regard to their choice of service location, appointment times, and language. This finding is positive as it suggests that the system is moving toward a more family and youth-driven approach to service delivery. Not long ago, most families of youth with behavioral health challenges could only obtain appointments at provider sites and at times convenient for the provider rather than the family. Evening or weekend appointments were rare. Conducting the assessment, treatment planning, and interventions in the youth and family's home, school, and/or community allows for customization of services to the youth and their unique familial and environmental contexts.

### *Minimal restrictiveness*

Reviewers found that *services were provided in comfortable environments that were the least restrictive and most appropriate*. Several reviewers and families commented that the services helped youth avoid the hospital or placement in more restrictive settings. Statements reflective of this included:

- "Mother once thought this child might need residential so supporting him in the community has been a big success."
- "In many ways the fact that this complex and difficult youngster remains at home is remarkable."

- "Services are provided in the family's home – the least restrictive and most appropriate environment. The child has not required hospitalization in almost a year."

The persistence and diligence of both providers and families to support these youth with serious behavioral health challenges to remain in their homes and local communities is a clear strength of the Massachusetts children's behavioral health delivery system.

## Opportunities for improvement

Although ratings for the majority of youth reviewed fell in the enhanced (n = 65) or good (n = 41) range, findings indicated the greatest opportunities for improvement in the following areas:

### *Service planning*

*Strengths of the youth and family were not always considered when developing treatment planning goals and designing appropriate interventions.* Difficulty incorporating strengths into goals was likely a result of the fact that some providers failed to identify strengths during the assessment process. In some cases, strengths were identified but they were vague or were not actionable strengths (e.g., mom is engaged in services, the family cares about each other, etc.) that could be drawn upon to support designing appropriate treatment interventions. Once a need and a goal is clarified, exploring what strengths, resources, and capacities the family has available that can be drawn upon to help them meet their goal is an important part of the service planning and delivery process.

### *Alignment of services and supports with identified needs*

*Services and supports a youth and family received were not always based on their individually identified needs and strengths.* For providers in the Metro/Boston and Central regions in particular, the lack of fit between the needs of the youth and family and the services and supports they were receiving may have resulted from an assessment that failed to adequately identify or prioritize the needs and strengths of the youth and family.

In some cases, particularly for youth with IHT in the Western region, it was not clear that all available services and supports were fully considered as options during the assessment and planning phases of treatment. It was notable that none of the 12 youth with IHT serving as their clinical hub in this region were participating in Therapeutic Mentoring, Family Support and Training, or In-Home Behavioral Services.

For other youth, reviewers noted that families had an overwhelming number of formal support services in place, yet it was not always clear as to the specific task or goal some of these providers were charged with. More services without a rational plan or a clear connection to an identified need for the family only appeared to lead to more chaos and confusion for some families.

### *Identification and inclusion of natural supports and services*

*Service planning and delivery did not always include natural supports and services.* While both ICC and IHT providers experienced challenges in identifying and incorporating informal supports into the service planning and delivery process, IHT providers experienced particular difficulty.

Performance specifications for IHT state that providers are supposed to identify community resources and develop natural supports, yet discussion in the debriefings suggested that both IHT providers and families were often unaware of supports and services from which a family might benefit. This finding could also be a factor contributing to the issue highlighted above; providers may have failed to adequately consider how natural and community-based supports could be employed to meet the youths and family needs, resulting in poor congruence between needs and the types of services and supports put in place to support the family.

### *Care integration and coordination*

*Ongoing two-way communication among and between all team members, including formal service providers, natural supports, and family members including the youth was frequently insufficient.* Reviewers in every region noted that communication with school personnel was especially difficult. While the majority of reviewers (61%) indicated that youth who had IHT serving as their "clinical hub" were receiving the appropriate level of care coordination, more than a third did not. In several cases, IHT clinicians indicated they had not considered convening a formal meeting among the various service providers, school, and/or state agency staff working with a family; some remarked that formal team meetings were not a required component of the service and therefore were not occurring, while others reported feeling as if they did not have the "authority" to convene these types of meetings or were not empowered to do so. While formal team meetings are not the only mechanism for establishing regular communication, they can be a useful strategy for ensuring that everyone is "on the same page." Reviewers also mentioned that in some cases it did not appear that providers persevered in their efforts to engage or outreach to important partners to establish a more collaborative working relationship on behalf of the youth and family.

*The process for connecting youth and families with additional services and supports was not always smooth or seamless.* Delays in making referrals for services, such as outpatient therapy and therapeutic mentoring, that could have been of benefit to the youth were observed. Locating and gaining access to housing services and supports was noted by reviewers as a challenge in more than one region. Staff turn-over, insurance complications (e.g., youth/family losing insurance for a period of time), wait times for certain services (e.g., outpatient therapy, IHT, and IHBS), and lack of consideration or ignorance of available services and supports (e.g. Family Support and Training for youth in IHT) were cited as factors contributing to the difficulties in connecting families to additional services and supports. Furthermore, a lack of focused attention and effort with respect to transition planning was noted in a number of cases. This led to care transitions that appeared abrupt and without a solid plan in place to help the family maintain the gains they made in IHT or ICC.

## Recommendations

As a result of this year's reviews, TAC developed several recommendations for consideration by state policy makers, providers, and other stakeholders. These recommendations are summarized below.

### *Create a Massachusetts-specific version of the SOCPR protocol.*

This year was the first time Massachusetts used the SOCPR protocol to evaluate adherence to system of care values and principles. Throughout the year, reviewers, providers, and family members offered valuable feedback regarding its utility. All stakeholders involved in the SOCPR process agreed that qualitative case reviews offer important information about how CBHI services are working "on the ground" for youth and families; information that state policy makers, system planners, and providers can use to make informed decisions about how to allocate workforce training and development resources and to guide changes to existing policies and procedures (e.g.,. treatment referral and "intake" procedures, staff selection and hiring, supervision practices, etc.). In this way, the reviews can be seen as the "study" part of an overall approach to quality management.

While stakeholders agree that the qualitative case review process is a key component of the state's quality management system, there was consensus among the review team that changes to the SOCPR protocol were needed. Suggested changes included:

- Editing the interview protocol to make the language more "family friendly;"
- Revising the impact domain to include information about progress in areas such as coping/self-management, social functioning, and well-being/quality of life;
- Eliminating redundant or confusing questions; and
- Including questions on key areas such as care transitions and safety planning.

Revisions to the protocol are currently in process. A pilot test of the new protocol, called the Massachusetts Practice Review (MPR), occurred in October 2014.

### *Clarify practice standards for IHT and invest in IHT workforce development.*

Wraparound is a well-defined care coordination model with evidence supporting its effectiveness. This clarity regarding how to "do the work" of care coordination, along with the implementation support offered by the state in the form of training and coaching in the Wraparound model and ongoing performance assessment using the Wraparound Fidelity Index (WFI), has been key to its success in supporting youth and families with serious behavioral health challenges. While results of these reviews identified areas where ICC performance could be improved, more practice challenges and areas for improvement were identified for the IHT providers reviewed this year, particularly in key practice areas such as care coordination, identification and utilization of strengths, and quality and thoroughness of assessments.

Clarifying the "how" of IHT and assisting IHT providers to deliver care in accordance with best practice standards through ongoing training and coaching is an important quality improvement activity. These reviews highlighted the need for clearer expectations for IHT providers with respect to fostering communication among the various service providers and their role in

coordinating care. While performance specifications for IHT exist and may offer useful information regarding expected activities, timeframes for completion of expected activities, the staffing model, and practitioner qualifications, they do not offer guidance on how to approach the work of IHT. TAC understands that a set of IHT practice guidelines is under development and a plan exists for disseminating these guidelines in the Winter of 2014. In addition, a series of regional trainings for IHT providers are being planned for the later Winter and Spring of 2015. These two activities should promote the competency of this workforce and will hopefully lead to improvements in quality of care and outcomes for youth and families participating in IHT.

In addition to the development and dissemination of the practice guidelines and the associated trainings for IHT providers, TAC recommends that the MCEs discuss with each provider detailing how they will incorporate the information from the guidelines into their IHT program operations, including how the provider will implement changes to key functions such as referral and program intake, staff training and supervision, treatment planning, care coordination, documentation, and transition/discharge planning.

Another intervention for helping providers make improvements to their program operations and practice is a learning collaborative. The learning collaborative model, which was developed by the Institute for Healthcare Improvement, is a learning system focused on a topic area that is "ripe" for improvement. Groups of providers work on making changes in a specific area with the support of a subject matter expert(s). It would be wrong to consider these learning collaboratives simply as training, as they require that providers engage in focused quality improvement activity following the "plan-do-study-act" cycle. By employing this type of model, providers would be actively working to make improvements in an area highlighted during the child/family or program level fidelity reviews (see quality improvement discussion below).

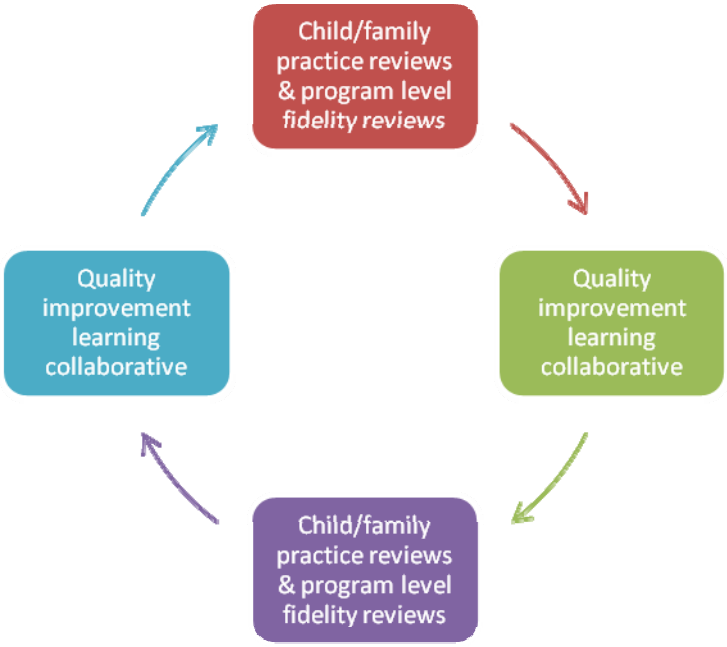
This model for improvement is currently being used by the CSAs to help foster changes in three areas: 1) training and supervision, 2) team collaboration, and 3) supporting families and staff through transition. These three learning collaboratives which began in September 2014 and will conclude with a statewide best practices conference in May 2015 where CSAs will share the results of their improvement projects. TAC recommends that these learning collaboratives be extended to IHT providers in subsequent years. Topics for the IHT learning collaboratives could be derived from the areas for improvement identified during the qualitative case reviews. For example, given the finding that assessment was an area that providers need to enhance a specific learning collaborative on improving assessment practices could be convened.

***Integrate review data and training/coaching into a comprehensive quality improvement plan.***

Over the past year the state has undertaken two important activities intended to improve the quality of care for youth served by IHT and ICC. The qualitative case reviews represent one key activity. The other has been the peer coaching for CSAs on care coordination and family support. Given limited resources and the fact that it can take state policy makers and providers considerable time to address issues identified during the reviews, TAC recommends that reviews of care do not occur every year. Instead, TAC proposes that child/family reviews occur every other year at most so that resources can be dedicated to supporting providers in making

the changes to their practice and operations (see Figure 6). More information about a recommended model for supporting providers in making these changes is discussed below.

**FIGURE 6: PROPOSED QUALITY IMPROVEMENT REVIEW CYCLE**




***Develop clear policies and procedures for clinical consultation and review of care.***

Reviewers commented during debriefing sessions that there appeared to be a need for provider organizations to develop strategies to obtain expert consultation or clinical review when complex or challenging youth or family situations are present. Reviewers expressed worry that ICC and IHT staff members are not "escalating" issues of concern either up to supervisors or other clinical leaders at their organization. This issue brought forth concerns about supervisory practices and oversight at some provider organizations.

TAC recommends that all providers review their policies and procedures for assessing the quality and appropriateness of care and establish procedures for clinicians and/or care planning teams to obtain internal or external "consultation." Furthermore, TAC suggests that the MCEs review these policies and procedures during their regularly established meetings with providers of IHT and ICC. As a first step, providers should have clear standards or thresholds for identifying youth and families who are at "high risk" of psychiatric hospitalization, child welfare or juvenile justice involvement, domestic violence, homelessness, or school failure. The CANS might be used to "flag" high-risk youth and families for review by a clinical review team. In addition, clinicians and care coordinators should have a mechanism to proactively request a review of care for internal or external review. Providers could even establish partnerships or agreements with other providers to perform independent reviews of care and/or provide consultation to clinicians or care coordinators on those youth/families with difficult or complex needs.

While some providers have established clinical review procedures beyond one-to-one supervision, such as holding regular multi-disciplinary team reviews of care or convening regular "high risk" clinical review meetings, it was not clear that clinicians, supervisors, or care coordinators made use of these types of structures or were even familiar with how to access these venues.

It seems that the child and family team meeting structure used in Wraparound would be a perfect venue to bring in an outside consultant to help those teams that are feeling "stuck" to help evaluate why the current plan for the youth and family is not working and offer recommendations to the team for consideration. Furthermore, TAC recommends providers consider how to employ a diverse array of supervision strategies that rely on direct observation of practice in the field, review of documentation, and collection of performance feedback through use of formal assessment tools and interviews with youth and families.

### *Promote greater inclusion and use of natural supports and "hub-dependent" services*

While providers cannot be expected to solve the wide-ranging and often complex needs of the families they serve, they should be familiar with the services and supports available in the family's community and help connect families with the appropriate resources. Better use of established sources of information on community resources, including the Massachusetts 2-1-1 system and attendance at local SOC meetings, could help IHT staff persons make more effective use of local resources to help the youth and families they serve. IHT and ICC providers should be challenged to come up with their own creative solutions for how to raise awareness of their staff regarding the resources in their communities.

In addition, more focused exploration by IHT providers of natural supports as well as services such as FS&T that could be drawn upon to support a youth and family is needed. Greater inclusion of family partners and natural and community-based supports in the service planning and delivery process may help providers create more effective transition plans that are sustainable over time.

### *Improve comprehensive transition planning.*

More deliberate attention to transition planning (e.g., from hospital to home, from child to adult system, from one level of care to the next) stood out as an area for improvement for all providers. Helping families think about and plan for transitioning from the beginning of treatment and identifying clear indicators of when everyone (e.g., the family, youth, natural supports, formal providers, etc.) will know it is time for services to end, should be a focus of provider training and coaching efforts. For all providers, developing clear policies and procedures with regard to making referrals for needed services, particularly those outside of their own agency, is another area to focus improvement efforts.

### *Improve strategies to engage families in ICC.*

Results of the IHT Supplemental Section indicated that 43% of youth with IHT serving as their clinical hub need or currently receive services from the same or multiple providers and needs a

care planning team to coordinate these services[9]. Similarly, reviewers indicated that 31% of youth with IHT as a hub need or currently receives services from a state agency(s), special education, or a combination thereof. Furthermore, in more than half (54%) of the youth reviewed, reviewers reported that the option of ICC was not discussed with the family. Reviewers also indicated that more than a third of families were not getting the level of care coordination their situation warranted. These results suggest that many more families can and should be referred for ICC. The reasons why more families are not being referred for ICC are likely complex and cannot be distilled into one clear factor. Some reasons could include poor understanding of the services offered by a CSA on the part of referral sources, more IHT access points (there are many more IHT providers across the state than CSAs), a lack of clear, unambiguous criteria for who should be referred to a CSA versus IHT, and providers who are reluctant to make referrals outside of their own organizations. The state should explore potential options for ensuring that youth who need ICC are identified and referred to CSAs. Strategies to consider include e.

## Conclusion

Overall, the results of these SOCPR reviews suggested that providers are delivering care in a way that adheres to important SOC and CBHI values. Mean scores for 65 cases (50%) fell into the six range representing enhanced SOC implementation with another forty-one cases (31%) scoring in the five range, reflecting good adherence to SOC values and principles.

Providers across the state are particularly strong when it comes to ensuring that youth and families can make best use of services by ensuring that services are provided at convenient times, locations, and in the primary language of the family. Providers ensured that services were provided in comfortable settings and were offered in the least restrictive environment.

While practice appeared good overall, opportunities for improvement stood out related to identification and inclusion of natural supports in the service planning and delivery process, incorporating strengths into goals, connecting youth and families with needed services and supports, and supervisory and clinical oversight of care.

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

[9] Whether reviewers believed the youth needed an ICC care planning team or simply a team convened by the IHT provider is unclear.