

Exhibit 6



FISCAL YEAR 2017
MASSACHUSETTS PRACTICE REVIEW (MPR)
PRACTICE SUMMARY REPORT

MassHealth
CHILDREN'S BEHAVIORAL HEALTH INITIATIVE (CBHI)



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Introduction

For the past four years, the Commonwealth has been evaluating the quality of care delivered to youth under the age of 21 who receive MassHealth Children’s Behavioral Health Initiative (CBHI) services. Initially, this was done using the System of Care Practice Review (SOCPR).¹ More recently, beginning in Fiscal Year (FY) 2016, these quality service reviews have been conducted using the Massachusetts Practice Review (MPR).²

The MPR is a qualitative case review tool that is implemented by trained reviewers who examine the clinical record and interview multiple stakeholders, including the CBHI service provider, the caregiver, the youth (if over 12), and other formal providers who work with the youth and family. MPR reviews are specifically focused on In-Home Therapy (IHT) and Intensive Care Coordination (ICC) services because of the critical role these services play as the “hub” of care coordination for the youth and families served. Quantitative ratings combined with qualitative observations allow for examination of trends in IHT and ICC service delivery practice and youth and family progress since their enrollment in these services, and ultimately provides an understanding of the current state of practice – by service, by agency/provider, and for the system overall.

The themes that have consistently emerged from these quality service reviews have reinforced the critical importance of CBHI services for the youth and families served. They have also assisted the Commonwealth and MassHealth to identify the service delivery challenges experienced by providers and the impact this has on consistently achieving the high standards of care established for CBHI services. This has in turn led to the development and implementation of numerous initiatives offering targeted support to providers to strengthen the overall quality of services.

This report summarizes key findings from 121 MPR reviews conducted during FY 2017, and the implications of these findings for providers and the system overall. Service quality improvement initiatives the Commonwealth is undertaking to support practice improvement among providers are described, along with recommendations for ongoing and future practice improvement efforts.

¹ <http://logicmodel.fmhi.usf.edu/resources/PDF/SOCPR-Protocol.pdf>

² Additional information on the MPR protocol and methodology can be found in **Appendix A**.

Key Findings & Implications for Providers

In FY 2017, 61 MPR reviews were conducted with youth/families enrolled in In-Home Therapy (IHT) and 60 with youth/families enrolled in Intensive Care Coordination (ICC) services. Based on the data summarized in **Appendices B and C** and the key themes that emerged from MPR reviewers' qualitative observations, the findings point to areas of strength, areas that have shown improvement, and opportunities for additional growth. This year, practice patterns across IHT and ICC were relatively similar, much more so than in previous years. **Figure 1** below summarizes eight of the MPR's 12 practice areas identified as representing either a system strength, improvement, or opportunity for additional improvement, as demonstrated by the statewide scores.

Figure 1: Summary of FY 17 MPR Findings

Findings	MPR Area			
	Service Accessibility	Youth and Family Engagement	Responsiveness	Cultural Awareness
Practice Strengths				
Practice Improvements (IHT)	Team Formation		Team Participation	
Opportunities for Additional Improvement	Assessment		Transition	

Practice Strengths

As mentioned above, the practice strengths of IHT and ICC were quite similar. As such, the discussion below reflects practice for both levels of care unless otherwise noted. An area was considered a strength if the overall score was 3.5 or above (See **Appendix B** for area ratings). Service Accessibility stood out with the highest score, closely followed by Youth and Family Engagement; Responsiveness and Cultural Awareness were equally strong.

Service Accessibility

Findings in the area of Service Accessibility continue to reveal that the work is inherently structured to accommodate the needs and preferences of families. Logistical arrangements such as meeting times and locations are highly flexible and responsive to the changing needs of the youth and family. This flexibility has also been extended to other providers by holding meetings in locations such as schools and outpatient clinics to allow for greater participation. Additionally, access to bilingual and bicultural staff offers families the full range of accessibility. Year after year, this continues to shine as an area of strength for IHT and ICC practice, and underscores CBHI's commitment to community-based services.

Reviewer Observation: "In addition to the expected flexibility and respect for family preferences, this IHT has gone to meet with the family on Saturdays in response to urgent need, has initiated the therapy sessions at the residential program, and met with the family almost every day over the summer when the whole family was struggling."

Youth and Family Engagement

Initiating pathways of connection and building rapport with youth and families requires an arsenal of varied skills applied in an individualized and thoughtful manner. Since inception of the MPR, IHT and ICC providers have shown widespread and sustained success in this area. This indicates that providers both value and have the tools to build a relational foundation with youth and caregivers – a critical component for any intervention. Additionally, both youth and caregivers alike have noted the usefulness of psychoeducation provided by staff to enhance their own understanding of mental health needs and supports.

Reviewer Observation: “The ICC and FP (family partner) were incredibly thoughtful in their strategy to build rapport with this family. Their initial assessment outlined the caregiver's concerns with previous providers and other systems. They also considered the family's immigration status and were sensitive to those concerns. The ICC sought out ways to solicit participation from the youth and noted that he enjoyed contributing to the family vision and talking about one another's strengths.”

Responsiveness

This area demonstrates consistent and persistent work in the area of referrals to other supports and services. Strong practice reflects an individualized and thoughtful approach to initiating work with formal supports and community connections. While not evident statewide, there were demonstrations of an efficient referral response time for the service itself (IHT/ICC). In those instances, there was a quick turnaround time on the referral and very low wait times for services to begin.

Reviewer Observation: “At the start of service, the clinician immediately began to work with the family on requesting special education services. The clinician also made referrals to Therapeutic Mentor and Family Partner (FP) (ICC services were offered but the family declined) to connect the youth and his family to a variety of community resources. The family was also connected to a PCP, and the youth to a psychiatrist with the assistance of the IHT clinician and FP. A referral to outpatient therapy for the youth was also made in preparation for transition out of IHT.”

Cultural Awareness

This area was not only a practice strength in FY17, it also has shown steady improvement between FY16 and FY17. The notion of culture is broad and complex, requiring the use of skilled assessment and engagement techniques, as well as a highly developed sense of self within a provider. Findings for IHT practice in particular demonstrated a cultural exploration process that has broadened in terms of depth and scope. Overall, there was greater appreciation among providers regarding the importance of culture as it relates to its relevance to and impact on the entire service delivery. These are good indicators that quality in this area will continue to develop which will likely serve to bolster other components of the practice.

Reviewer Observation: “The IHT was able to describe not just [their specific religious faith] but how their faith informs their life choices. The IHT has given thought to how her own life experiences of spirituality and family conflict help her to understand this family, and they have openly discussed their shared culture and their differences. IHT is also aware of the importance of exploring the culture around adoption, which they are slowly beginning to do, as the family regains balance.”

Areas Demonstrating Practice Improvement

IHT practice demonstrated notable improvements in the areas of Team Formation and Team Participation from FY16 to FY17. While the scores do not yet meet the benchmark to be considered a strength overall, it is important to remark on the progress to date.

Team Formation and Team Participation

IHT providers have made significant gains related to the creation and sustainability of a team. This requires identification and outreach of possible team members, followed by ongoing contact and engagement to

..... facilitate a cohesive approach to care. Within a developmental lens, it makes sense that the initial strides for team-based work have primarily occurred with parties internal to the IHT provider agencies (such as Therapeutic Mentoring, Outpatient, etc.) This provides a strong foundation from which to reach out and expand the team to include external parties involved with the youth/family, such as state agencies, schools, prescribers, and natural supports.

Reviewer Observation: "The IHT clinician solicited information from DCF and the school in the initial assessment and service planning phase. When the Family Partner (FP) joined the team, she [IHT] incorporated the FP plan into the service plan. The IHT clinician attended the initial meeting with the psychiatrist to include him in the service delivery."

.....

Opportunities for Additional Practice Improvement

While IHT and ICC providers continue to show relatively strong practice in the areas described in the two previous sections, the FY17 MPR reviews also identified areas where practice challenges continue to persist. Both Assessment and Transition had scores of 3.0, which reflects a level of quality that does not consistently meet established standards and best practices. The following describes particular opportunities for quality improvement across both IHT and ICC services in these two areas.

Assessment

While some pockets of good work were evident, overall, assessments are lacking both in both process and product. Assessment is understood to be an interactive and ongoing process to gather information from the youth/family and other key stakeholders. This process produces a rich, comprehensive and living document that is a resource for the youth/family and providers alike. Most importantly, this provides a formulation and blueprint to inform the course of care – from start to finish. Given that, inadequate assessments set in motion a treatment that is ill informed and hampered despite other strong efforts. Components that were particularly lacking with regard to assessments include limited historical data, insufficient depth, no clinical formulation, and a lack of diagnostic clarity. Additionally, practitioners viewed the experience as static and time limited and did not demonstrate sufficient persistence with regard to obtaining documents from other providers and information from families.

.....

Reviewer Observation: "There was no overarching formulation about why this youth was in distress or why he had been stating that he wants to die. The result was a lack of agreement on needs; many were mentioned, but there was no clear focus on where to start and how to proceed."

.....

Transition

A variety of changes, both anticipated and unexpected, invariably occur throughout the course of care. This includes examples such as staff departures, school changes, in/out of acute levels of care, completion of services and much more. These junctures require prospective discussion, contingency planning, and coordination among families and providers alike. Staffing instability and high rates of provider turnover plague provider systems and have a real impact for youth and families. When staff shifts occur abruptly and unexpectedly, families may not be afforded the time needed to appropriately process the change. This disconnection can then interfere with their ability to build rapport with the next staff person, thus impacting the remaining course of care. For IHT in particular, there was significant confusion around the length of services and a dearth of long-term planning for termination.

Reviewer Observation: "The family was totally unaware as to when services might end. Although the ICC crafted a thoughtful vision that appeared to be in the family's own voice, there was no connection made between the vision and graduation. When asked about when services might end, caregiver stated, "your [reviewer's] guess is as good as mine".

Quality Improvement Initiatives for Providers

The Commonwealth has undertaken several initiatives aimed at improving the quality of CBHI services, based in part on findings from previous quality reviews. These include targeted training and coaching activities for IHT and ICC providers, many of which are aligned with the MPR areas that have been identified as needing improvement. The initiatives that address both strengths and challenges as reflected in the MPR results are described below.

IHT Practice Profile³

This comprehensive manual offers a rich, deep-dive into the key areas of In-Home Therapy (IHT) and was disseminated to all IHT providers in March 2017. MassHealth and DMH convened the **IHT Practice Profile Work Group** with nine IHT provider sites in the spring of 2017 as an effective means of testing and revising three implementation strategies:

- Monthly Supervision Guided by Staff Self-Assessment
- Field Observation
- Peer Learning through Behavioral Rehearsal

The nine core competencies within the Profile are well-aligned with many of the areas in the MPR. As noted previously, there was significant improvements for IHT providers in the two areas of Team Formation and Team Participation. These correspond directly with three of the Practice Profile core competencies including Collaborative Intervention Planning, Care Coordination and Collaboration, and Engaging Natural Supports and Community Resources. Moving forward, the Profile may be a useful resource to improve two additional competencies, Assessment and Clinical Understanding, and Preparing to Exit – both identified from the MPR as practice areas that present opportunities for improvement.

³ The full IHT Practice Profile can be found here: <http://www.cbhknowledge.center/ihtpp/>

Trauma Training

As MPR data collected by reviewers indicates, trauma is a prevalent experience for youth enrolled in IHT and ICC services – a critical component to identify, understand, and consider throughout the assessment and service delivery process. To ensure vulnerable youth receive appropriate trauma-informed care, MassHealth, in collaboration with the Children’s Behavioral Health Knowledge Center at the Department of Mental Health (DMH), convened a training and consultation initiative. Thirty IHT and ICC providers received training in the **GROW model**, an adaptation of the Attachment, Self-Regulation, and Competency (ARC) Framework developed by the Justice Resource Institute (JRI). Often, where the MPR revealed pockets of strength in the area of assessment, these providers had a strong foundation and consistent approach to trauma-informed care; as such this type of training may help strengthen providers’ practice in this area.

Supervision Supports

Supervision is a vital component of the behavioral health service delivery system. To that end, MassHealth collaborated with the Children’s Behavioral Health Knowledge Center at the DMH to deliver two training programs. Six IHT providers took part in a **Reflective Supervision Learning Community**, which offered a trauma-informed approach to care through its model of collaboration. Four additional providers had the opportunity to partner with the **Yale Program on Supervision** which provided a multi-level training approach that included individualized, onsite supervision consultation, and organizational change support on agency standards, policies, and procedures. In addition, frontline supervisors and mid-level managers were trained on Yale’s supervision model, which includes administration, education, and support. MPR data collected on staff delivering CBHI services and reviewers’ qualitative observations point to staff turnover as a critical issue that often negatively impacts many aspects of the service. Effective supervisory support can be a lynchpin when staff turnover occurs. At that critical juncture, the supervisor has an opportunity to ensure that providers and families have a thoughtful, appropriate plan in place to transition between provider staff. As supervision is bolstered, so too may be the area of Transition for youth and families.

Wraparound Coaching

Training and coaching continues to be provided to the CSAs to support fidelity to the Wraparound model and to sustain a high-quality service delivery model overall. In the past year and moving forward, the ICC and Family Partner coaches will offer **Family Partner Leadership Forums, Regional CSA Meetings, and Individualized Coaching**. Coaches will facilitate Family Voice Forums at each CSA throughout the coming year to gather input from caregiver and young adults regarding their experiences with the behavioral health system.

Assessment & Clinical Understanding Initiative

MassHealth, along with the UMASS CANS Training Program, has set out to improve the quality of assessment and clinical understanding for ICC, IHT, and Outpatient services. The objectives of the initiative are to define best practices, to disseminate web-based training resources, to provide tools for assessing practice at the case and program levels, and to provide performance feedback and technical assistance to meet quality goals. Training development will occur in fall and winter with full implementation planned for June 2018. When finished, this will be a valuable training and coaching tool to improve the assessment process across the three hub services.

Recommendations & Next Steps

Below are recommendations for the Commonwealth to consider that would support practice improvements overall with specific attention to the areas of Assessment and Transition.

IHT Practice Profile Implementation

Once the IHT Practice Profile (PP) workgroup concludes in September 2017, MassHealth, DMH, and key consultants will incorporate feedback from the workgroup into the tools and guidance for each implementation strategy. The plan for widespread training and application of the PP across all IHT providers has the potential to significantly improve the quality of work overall including the inadequacies previously discussed. While the PP offers a rich, comprehensive description of the developmental arc for areas such as Assessment and Clinical Understanding, providers need clear, efficient ways to implement and track progress. Additional supports and technical assistance would help to ensure that all providers have embraced the PP as a methodology in terms of service provision, staff training, and quality indicators.

Workforce Development

In order to achieve consistent quality standards with IHT practice, it is critical to maintain a strong workforce. Given that a significant number of IHT practitioners are coming directly from graduate programs, MassHealth will pilot an **IHT Intern Fellowship Program** beginning October 2017. This will be an opportunity to offer additional training and supports to second year MSW students currently in an IHT field placement. Ultimately, a more prepared workforce may lead to increased retention, satisfaction, proficiency and, ultimately, improve the quality of services delivered to youth and families. The **CBHI Licensure Reimbursement Program** is a scholarship offered to IHT and ICC staff in pursuit of independent licensure. Accepted staff are eligible to receive up to \$1,500 to cover licensing prep/study courses, license test fees, and the license cost. While there are various intents and methods, both of these programs seek to reduce IHT/ICC staff attrition.

Wider Dissemination of Training Tools

The Commonwealth has demonstrated a commitment to continuous quality improvement with a wide range of training mechanisms. However, there were many IHT and ICC providers that did not participate in the programming. Even for those providers that did participate, as staff turnover continues to persist, new information can be lost before it has had a chance to become embedded into the fabric of a program. It would be helpful if these trainings could be packaged in a way to be more accessible to a wider audience and over an extended period of time. This could include online resources such as toolkits, training videos, and other resources that would support the sustainability and impact of these valuable opportunities.

Transition Toolkit

As staff turnover continues to persist, it impacts provider agencies and families alike. While staff departure may not subside, there are steps that can be taken to mitigate the impact. Findings in the MPR have noted widespread variance across agencies as to the expectations and procedures for response when staff resign. Some agency protocols include a strong written plan with supervisory oversight while others offer very little notice to families and other team members are left uninformed. The ICC and FP coaching team could develop a transition toolkit that would provide a template for the various staff departure scenarios. This would outline steps and a timeline for notification and a process to ensure strong communication during a challenging time. This could then be modified to include other levels of care. Consistency across staff and agencies during these tenuous times can bring some assurance to youth/families and other providers.

Appendix A: MPR Protocol Description & Methodology

Protocol Description

The MPR is a qualitative case review tool that is used to guide evaluation of the clinical record and interviews with multiple stakeholders, including the In-Home Therapy (IHT) or Intensive Care Coordination (ICC) service provider, the caregiver, the child/youth (if over 12), and other formal providers working with the child/youth and family. Trained reviewers use the MPR protocol to elicit specific information on 12 Areas of service delivery practice and 2 Areas that examine youth and family progress since their enrollment in IHT or ICC services.

By triangulating responses from the record review and other informants, MPR reviewers obtain a comprehensive picture of services delivered at the practice level, and then are asked to rate each of the 14 Areas by assigning a numerical score that reflects the extent to which practice is meeting established standards and best practice for the service. Qualitative information, such as quotes or specific examples, is also recorded by reviewers to support the numerical ratings, and because of its explanatory and illustrative value.

Practice Domains/Areas

Table 1 summarizes the 12 specific Areas that are scored across the 3 MPR Practice Domains, along with the prompts or considerations that are included in the protocol for each area to guide reviewers in scoring.

Table 1: MPR Practice Domains/Areas & Reviewer Scoring Prompts

Practice Domain/Area:	Domain 1: Family-Driven & Youth-Guided
Area 1: Assessment	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> The provider actively engages the youth and family in the ongoing service delivery process.
Area 5: Team Formation	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Providers, school personnel or other agencies involved with the youth participate in service planning.

Practice Domain/Area: Domain 1: Family-Driven & Youth-Guided	
Area 7: Care Coordination	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 Ability	<ul style="list-style-type: none"> 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.
Domain 3: Culturally Competent	
Area 11: Cultural Awareness	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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.

Practice Indicator Rating Scale

Scoring of the 12 MPR practice Areas within Domains 1-3 is done using a 5-point rating scale tied to practice indicators as shown in Table 2.

Table 2: MPR Practice Rating Scale & Indicators (Domains 1-3)

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

Progress Domain/Areas

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. **Table 3** summarizes the two Areas that are scored within the Progress Domain, along with the accompanying reviewer prompts or considerations for scoring contained in the MPR protocol.

Table 3: MPR Progress Domain/Areas & Reviewer Scoring Prompts

Progress Domain	Domain 4: Youth & Family Progress
Area 13: Youth Progress	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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.

Progress Indicator Rating Scale

Scoring of the 2 MPR progress Areas (Domain 4) is done using a 5-point rating scale tied to progress indicators as shown in **Table 4**.

Table 4: MPR Progress Rating Scale & Indicators (Domain 4)

Worsening or Declining Condition	Little to No Progress	Fair Progress	Good Progress	Exceptional Progress
1	2	3	4	5

Demographic & IHT Supplemental Questions

In addition to collecting information to rate the 14 MPR Areas, reviewers also collect basic demographic information for the youth/family being reviewed, along with other basic service-related information. Eight IHT Supplemental questions assess whether youth with IHT serving as their clinical hub are receiving the quality and level of care coordination they require (See **Appendix B** for IHT Supplemental Questions).

MPR Methodology

Review Team

The Commonwealth's contractor for the MPR review process, the Technical Assistance Collaborative, Inc. (TAC), has recruited and maintains a core team of qualified MPR reviewers with strong clinical understanding, and appreciation for System of Care (SOC) principles and the design of MassHealth's CBHI service system, as well as sound interviewing skills. Training for reviewers consists of didactic presentation, role playing, and experiential scoring. Reviewers have the opportunity to shadow one another for ongoing learning and development.

FY 17 Provider Sampling & Selection

The Commonwealth is committed to conducting at least 120 MPR reviews of CBHI services annually. This year's sampling strategy ensured the state could evaluate ICC practice delivered at all 32 CSAs by assigning each CSA two reviews (n=64 ICC reviews total). To ensure an adequate number of IHT reviews, all of the state's IHT providers are sorted by their total capacity and location prior to being randomly sampled. Providers are stratified in this way to ensure that high volume providers have more reviews completed than low volume providers, and that reviews aren't concentrated in one area of the state. Twenty-one IHT provider sites were sampled this year.

Youth Sampling, Consent & Interview Process

Once providers are sampled, enrolled youth are randomly selected to participate. 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 are eligible for the random selection from IHT providers. Providers are trained on the MPR process, their responsibilities pertaining to obtaining informed consent, and MPR scheduling procedures. IHT clinicians or care coordinators approach the randomly selected youth (if 18 or older) or the parent/caregiver to obtain consent to participate. Providers also explain the MPR process to youth between the ages of 12-17 whose parents agree for them to be interviewed and obtain their written assent to participate.

Table 5: Families Approached, Decline Rate & Completed Reviews

FY16 Reviews	ICC	IHT	Total
Reviews Planned	64	63	127
Families Approached	137	112	249
Families Declining	70	47	117
Incomplete Reviews			
<i>Incomplete family interviews</i>	3	0	3
<i>Less than required # of interviewees</i>	0	1	1
Canceled Reviews	4	3	7
Reviews Completed	60	61	121

Once the family/youth consents, providers schedule interviews with the following key informants: 1) the parent/caregiver; 2) the youth, if 12 or older; 3) the IHT clinician or care coordinator; and 4) up to 3 additional formal providers familiar with the care provided to the youth (e.g. family partner, DCF worker, outpatient therapist, etc.). A review of the youth's record at the provider agency precedes the interviews. An MPR review is considered valid only if a minimum of four data points (the record review and three interviews) are completed.

Review Debriefings & Data Management/Analysis

Monthly meetings are facilitated during MPR review months, during which reviewers join MassHealth, TAC, MCE representatives, the *Rosie D.* Court Monitor, and other system partners to debrief on their findings for each youth/family reviewed. Relevant historical, demographic, diagnostic, and service history of the youth/family are presented, followed by in-depth discussion regarding practice strengths/challenges, and client satisfaction with services and progress. Reviews are scored in advance, enabling a review of scoring accuracy based on the information presented.

MPR data are entered by reviewers into a HIPAA-compliant Survey Monkey database, and extracted and analyzed by TAC separately for each review round, and for each Fiscal Year overall. That data is used to produce provider-level reports which provide a rating for each area as well as qualitative comments offering feedback on components of the work that was strong as well as those areas needing improvement. These reports are produced twice each review cycle in order to share the data in a timely fashion with providers.

Appendix B: Quantitative Results

Select Demographic Characteristics

Table 6: Demographics of Youth/Families Reviewed

		(n)	%			(n)	%	
Status of Case at Time of Review	Open	(105)	87%	Gender	Male	(74)	61%	
	Closed	(16)	13%		Female	(45)	37%	
					Other	(2)	2%	
Age of Youth	0-4 years	(3)	2%	Race/Ethnicity	White	(61)	50%	
	5-9 years	(48)	40%		Latino/Hispanic	(25)	21%	
	10-13 years	(37)	31%		Biracial/Mixed	(15)	12%	
	14-17 years	(30)	25%		Black	(10)	8%	
	18-21 years	(3)	2%		Other	(7)	6%	
>1 Behavioral Health Condition	Yes	(83)	69%		Asian	(2)	2%	
	No	(38)	31%		Chooses not to self-identify	(1)	1%	
Behavioral Health Conditions	Trauma/Stressor-related disorder	(58)	48%		Interventions (Current)	Individual Counseling	(71)	59%
	ADD/ADHD	(56)	46%			In-Home Therapy (IHT)	(67)	55%
	Mood Disorder	(40)	33%			FS&T (Family Partner)	(58)	48%
	Anxiety Disorder	(33)	27%	Intensive Care Coordination (ICC)		(57)	47%	
	Disruptive Behavior Disorder	(22)	18%	Psychopharmacology		(56)	46%	
	Autism/Autism Spectrum Disorder	(15)	12%	Therapeutic Mentoring		(56)	46%	
	Anger/Impulse Control	(10)	8%	Therapeutic Training & Support		(34)	28%	
	Communication Disorder	(7)	6%	Recreation activities		(16)	13%	
	Learning Disorder	(7)	6%	Other		(13)	11%	
	Other	(6)	5%	In- Home Behavioral Services (IHBS)		(10)	8%	
	Intellectual Disability	(4)	3%	Family counseling		(2)	2%	
	Thought disorder	(3)	2%	Mobile Crisis Intervention		(1)	1%	
	Substance Use Disorder	(1)	1%	Substance Use Treatment		(1)	1%	
	Service System Use (Current)	Special Education	(77)	64%		DCF Involved (Past Year)*	No	(59)
DCF		(49)	40%	Yes	(13)		18%	
Child Requiring Assistance (CRA)		(7)	6%	*Excludes those with current DCF involvement				
Probation		(6)	5%					
DDS		(4)	3%					
DMH		(4)	3%					
Other		(1)	1%					

Practice Domain Results

MPR scores range from 1 to 5, with 1 representing Adverse practice, 2 being Poor practice, 3 being Fair practice, 4 being Good practice, and 5 representing Exemplary/Best practice.

Table 7 summarizes MPR Practice Domain mean scores, which ranged from 3.2 to 3.7 with an overall mean score of 3.3.

Table 7: MPR Practice Mean Scores – Overall & by Domain

Domain	Min	Max	Mean	Standard Deviation
Practice Overall	1.8	4.8	3.3	.68
-ICC	2.1	4.8	3.3	.67
-IHT	1.8	4.5	3.3	.70
Domain1: Family Driven & Youth Guided	1.4	4.8	3.2	.77
-ICC	1.9	4.8	3.2	.75
-IHT	1.4	4.6	3.2	.80
Domain 2: Community-Based	2.0	5.0	3.7	.58
-ICC	2.0	5.0	3.7	.61
-IHT	2.5	5.0	3.8	.54
Domain 3: Culturally Competent	1.5	5.0	3.3	.87
-ICC	1.5	5.0	3.2	.87
-IHT	1.5	5.0	3.4	.88

Table 8 summarizes the mean scores and frequencies for each of the 8 areas within Domain 1. Overall, youth experienced practice that was Good or better in 43% of instances across the domain.

Table 8: Family Driven & Youth Guided - Area Mean Scores & Frequencies

Area	Mean	Frequencies (n) %*					Percent Good or above **
		Adverse Practice 1	Poor Practice 2	Fair Practice 3	Good Practice 4	Exemplary/ Best Practice 5	
Assessment	3.0	(9) 7%	(31) 26%	(41) 34%	(34) 28%	(6) 5%	33%
-ICC	3.0	(2) 3%	(17) 28%	(23) 38%	(15) 25%	(3) 5%	30%
-IHT	3.0	(7) 11%	(14) 23%	(18) 30%	(19) 31%	(3) 5%	36%
Service Planning	3.1	(7) 6%	(22) 18%	(52) 43%	(32) 26%	(8) 7%	33%
-ICC	3.2	(1) 2%	(12) 20%	(29) 48%	(13) 22%	(5) 8%	30%
-IHT	3.1	(6) 10%	(10) 16%	(23) 38%	(19) 31%	(3) 5%	36%
Service Delivery	3.4	(1) 1%	(17) 14%	(44) 36%	(47) 39%	(12) 10%	49%
-ICC	3.5	-	(5) 8%	(28) 47%	(21) 35%	(6) 10%	45%
-IHT	3.4	(1) 2%	(12) 20%	(16) 26%	(26) 43%	(6) 10%	53%

Area	Mean	Frequencies (n) %*					Percent Good or above **
		Adverse Practice 1	Poor Practice 2	Fair Practice 3	Good Practice 4	Exemplary/ Best Practice 5	
Youth & Family Engagement	3.7	(1) 1%	(10) 8%	(31) 26%	(58) 48%	(21) 17%	65%
-ICC	3.7	(1) 2%	(4) 7%	(19) 32%	(25) 42%	(11) 18%	60%
-IHT	3.8	-	(6) 10%	(12) 20%	(33) 54%	(10) 16%	70%
Team Formation	3.1	(4) 3%	(27) 22%	(47) 39%	(38) 31%	(5) 4%	36%
-ICC	3.0	(2) 3%	(17) 28%	(20) 33%	(19) 32%	(2) 3%	35%
-IHT	3.2	(2) 3%	(10) 16%	(27) 44%	(19) 31%	(3) 5%	36%
Team Participation	3.1	(4) 3%	(30) 25%	(38) 31%	(45) 37%	(4) 3%	40%
-ICC	3.1	(2) 3%	(17) 28%	(14) 23%	(25) 42%	(2) 3%	45%
-IHT	3.1	(2) 3%	(13) 21%	(24) 39%	(20) 33%	(2) 3%	36%
Care Coordination	3.2	(8) 7%	(22) 18%	(35) 29%	(46) 38%	(10) 8%	46%
-ICC	3.3	(2) 3%	(12) 20%	(16) 27%	(25) 42%	(5) 8%	50%
-IHT	3.2	(6) 10%	(10) 16%	(19) 31%	(21) 34%	(5) 8%	42%
Transition	3.0	(9) 7%	(35) 29%	(30) 25%	(37) 31%	(10) 8%	39%
-ICC	3.1	(4) 7%	(17) 28%	(16) 27%	(18) 30%	(5) 8%	38%
-IHT	3.0	(5) 8%	(18) 30%	(14) 23%	(19) 31%	(5) 8%	39%

*Due to rounding of percentages, some area totals may not equal 100%.

** Accurately rounded percentages.

Table 9 summarizes the mean scores and frequencies for the two areas in the Community-Based practice domain. Across Domain 2, youth experienced practice that was Good or better in 70% of instances.

Table 9: Community-Based - Area Mean Scores & Frequencies

Area	Mean	Frequencies (n) %*					Percent Good or above **
		Adverse Practice 1	Poor Practice 2	Fair Practice 3	Good Practice 4	Exemplary/ Best Practice 5	
Responsiveness	3.5	-	(13) 11%	(44) 36%	(56) 46%	(8) 7%	53%
-ICC	3.5	-	(7) 12%	(22) 37%	(27) 45%	(4) 7%	52%
-IHT	3.5	-	(6) 10%	(22) 36%	(29) 48%	(4) 7%	55%
Service Accessibility	4.0	-	(1) 1%	(15) 12%	(89) 74%	(16) 13%	87%
-ICC	4.0	-	(1) 2%	(7) 12%	(43) 72%	(9) 15%	87%
-IHT	4.0	-	-	(8) 13%	(46) 75%	(7) 11%	86%

*Due to rounding of percentages, some area totals may not equal 100%.

** Accurately rounded percentages.

Table 10 summarizes mean score and frequencies for the areas within the Culturally Competent Domain. Practice for Domain 3 was Good or better in 43% of instances.

Table 10: Culturally Competent - Area Mean Scores & Frequencies

Area	Mean	Frequencies (n) %*					Percent Good or above **
		Adverse Practice 1	Poor Practice 2	Fair Practice 3	Good Practice 4	Exemplary/ Best Practice 5	
Cultural Awareness	3.5	(3) 2%	(13) 11%	(43) 36%	(49) 40%	(13) 11%	51%
-ICC	3.3	(2) 3%	(8) 13%	(23) 38%	(22) 37%	(5) 8%	45%
-IHT	3.6	(1) 2%	(5) 8%	(20) 33%	(27) 44%	(8) 13%	57%
Cultural Sensitivity & Responsiveness	3.1	-	(41) 34%	(38) 31%	(31) 26%	(11) 9%	35%
-ICC	3.0	-	(22) 37%	(20) 33%	(14) 23%	(4) 7%	30%
-IHT	3.2	-	(19) 31%	(18) 30%	(17) 28%	(7) 11%	39%

*Due to rounding of percentages, some area totals may not equal 100%.

** Accurately rounded percentages.

Youth & Family Progress Domain Results

Table 11 shows that overall mean scores for the Youth and Family Progress Domain ranged from 1.5 to 4.5, with an overall mean score of 3.1.

Table 11: Youth & Family Progress Domain Mean Scores

Domain	Min	Max	Mean	Standard Deviation
Domain 4: Youth/Family Progress	1.5	4.5	3.1	.75
-ICC	1.5	4.0	3.0	.71
-IHT	1.5	4.5	3.1	.80

Table 12 summarizes the mean scores and frequencies for the youth and family progress in this Domain. Overall, youth and family progress were rated similarly for IHT and ICC as 56% had Good or better progress.

Table 12: Youth & Family Progress - Area Mean Scores & Frequencies

Domain/Area	Mean	Frequencies (n) %*					Percent Good or above **
		Worsening or Declining Condition 1	Little to No Progress 2	Fair Progress 3	Good Progress 4	Exceptional Progress 5	
Youth Progress	3.1	(4) 3%	(11) 9%	(39) 32%	(48) 40%	(19) 16%	55%
-ICC	3.0	-	(1) 2%	(14) 23%	(28) 47%	(17) 28%	75%
-IHT	3.1	(4) 7%	(10) 16%	(25) 41%	(20) 33%	(2) 3%	36%
Family Progress	3.0	(1) 1%	(17) 14%	(35) 29%	(52) 43%	(16) 13%	56%
-ICC	2.9	-	(3) 5%	(14) 23%	(28) 47%	(15) 25%	72%
-IHT	3.2	(1) 2%	(14) 23%	(21) 34%	(24) 39%	(1) 2%	41%

*Due to rounding of percentages, some Area totals may not equal 100%.

** Accurately rounded percentages.

IHT Supplemental Question Results

Table 13 summarizes responses to the eight supplemental questions added to the MPR protocol to ascertain whether care coordination delivered as part of the IHT service was adequate to the needs and circumstances of the youth/families reviewed.

Table 13: IHT Supplemental Question Results

Question		Results		
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 (49) 80%		
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 (50) 82%		
3. Youth is receiving the amount and quality of care coordination his/her situation requires.				
Disagree Very Much (n) % (6) 10%	Disagree (n) % (12) 20%	Neither (n) % (11) 18%	Agree (n) % (25) 41%	Agree Very Much (n) % (7) 11%
4. Has the youth previously been enrolled in ICC?		No (45) 74%		
5 a.) According to the CAREGIVER, has the IHT team ever discussed the option of ICC with the youth/family?*		No (29) 48%		
5 b.) According to the IHT Clinician, has the team ever discussed the option of ICC with the youth/family?*		Yes (31) 51%		
6 a.) Youth and family need the IHT provider to coordinate/ collaborate with school personnel.		Yes (51) 84%		
6 b.) If yes, the IHT is in regular contact with school personnel involved with the youth and family.*				
Disagree Very Much (n) % (7) 14%	Disagree (n) % (12) 24%	Neither (n) % (6) 12%	Agree (n) % (18) 35%	Agree Very Much (n) % (8) 16%
7 a.) Youth and family need the IHT provider to coordinate/ collaborate with other service providers (e.g. TM, OP, psychiatry, etc.)		Yes (48) 79%		
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.*				
Disagree Very Much (n) % (5) 10%	Disagree (n) % (8) 17%	Neither (n) % (7) 15%	Agree (n) % (19) 40%	Agree Very Much (n) % (9) 19%
8 a.) Youth and family need the IHT provider to coordinate/collaborate with state agencies (e.g. DCF, DYS, DDS, etc.)		No (34) 56%		
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.*				
Disagree Very Much (n) % (1) 4%	Disagree (n) % (3) 11%	Neither (n) % (8) 30%	Agree (n) % (11) 41%	Agree Very Much (n) % (4) 15%

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

Appendix C: Qualitative Results

This Appendix presents the qualitative data compiled from MPR reviewer comments that serve to demonstrate the spectrum of service quality from Exemplary/Good to Poor/Adverse practice. The comments provide a rich look into the experiences of families and providers and their perception of the service provision. They also highlight examples of provider ingenuity, as well as the challenges that persist.

Area	Strong Practice	Practice Needing Improvement
Assessment	<p>ICC The ICC collected scads of reports to inform the process both initially and ongoing such as previous school's FBA, IHBS FBA, IEP, hospital discharge, speech and language assessment, previous ICC/FP files, and info from primary care doctor. CA also explores the relationship and efficacy of past providers/placements. While the needs of this youth were plenty, the ICC appropriately honed in on the most critical calling for safety and stability through the development of a strong, skilled team.</p> <p>IHT The IHT gathered information for the assessment from both parents, the youth, her siblings, the ICC prior to discharge and the outpatient therapist. Needs, strengths, culture and community functioning were well documented in the comprehensive assessment and the CANS. Developmental and psychiatric history was also well documented. The interpretive summary contained insight on how parental conflict was negatively impacting the youth. The clinician used a self-administered questionnaire with the parents to elicit their parenting strengths and challenges.</p>	<p>ICC The assessment narrative was minimal, and important areas of youth's life were not explored. For example, youth's birth father was not mentioned in the assessment, although youth often spends weekends with him. The older brother who allegedly abused youth was mentioned with no exploration of the past abuse or the effect of his return to the home. While the current ICC was not responsible for the original assessment, updates consisted of brief notes on the CANS about progress and did not add any substantial understanding of the youth or family.</p> <p>IHT Several assessments and updates exist, but are skimpy and generally rely on checklists and reference to CANS. There is virtually no family history explored (despite evidence of parental mental health and substance use concerns, homelessness, and a different father of one child). The assessments include no discussion of Special Education services or copy of IEP, no exploration of previous difficulties in youth's early childhood education setting, no clarity about DCF involvement, and almost no documentation of other services. The CANS updates are so general as to be unhelpful.</p>
	Service Planning	<p>ICC Safety plan was reviewed at every CPT meeting and updated often and ICC would then send to MCI. The ICC generated a list of strengths for every member of the family in all domains such as spiritual, educational, etc. Needs were prioritized and assessed on a rating scale and corresponded with what was reflected in the CA and SNCD as well as the CANS.</p> <p>IHT The clinician worked closely with the family to plan for services for the youth. It was clear that the assessment information was used by the clinician in formulating her thinking and working with this family to develop appropriate goals. The treatment planning was focused on trauma informed care and the clinician used the ARC model. The family was engaged in developing the vision and goals and felt like their voice was part of the service planning process throughout the entire time they have been involved.</p>

Area	Strong Practice	Practice Needing Improvement
Service Delivery	<p>ICC The ICC did exceptionally fine work with this Youth, especially evident in her work with the school. She made contact literally on the first day to ensure that he was enrolled, immediately requested an IEP meeting to follow up on the special education concerns, and brought the team to the IEP meeting in November. At that point, youth had been removed from his family's care and his future location was unknown, so ICC worked with the school to keep a 504 plan for transportation so that his school placement would be stable despite all the other moves. Also, she also worked persistently on access to a prescriber so that medications could be securely continued.</p> <p>IHT The clinician and TT&S have done an excellent job in providing the services to the family. Using trauma informed treatment (ARC) has matched the needs of the youth and the family. The service delivery has provided this family with a "tool box" of different strategies to use with the youth. The intensity of the work has matched the needs of the family. They started out with more intensity and have just recently moved to an every other week level of intensity which matches the current progress of the family. The family has been included in all decisions about treatment.</p>	<p>ICC All team members interviewed felt that the youth is missing grief counseling services, except the ICC who only thought a psychiatric evaluation was missing. The services delivered seemed to lack individualization and there was no evidence of incorporating family's strengths to the delivery process. A great opportunity to individualize work with this family was missed with the youth. He was described by many as difficult to engage for all providers, but there were no creative attempts to change that.</p> <p>IHT The interventions provided to the youth seemed to leave many of her needs unaddressed and none of the youth's strengths were incorporated into the service delivery process. The intensity of the service delivery has not matched the needs. The IHT clinician says she would like to have sessions two times per week, but that is usually not possible. There was also a large gap in the IHT clinician's service delivery to the youth and family that was unexplained. The TT&S continued meeting with the youth and family during that time.</p>
Youth & Family Engagement	<p>ICC The ICC and FP were incredibly thoughtful in their strategy to build rapport with this family. Their initial assessment outlined the caregiver's concerns with previous providers and other systems. They also considered the family's immigration status and were sensitive to those concerns. The ICC sought out ways to solicit participation from the youth and noted that he enjoyed contributing to the family vision and talking about one another's strengths.</p> <p>IHT As noted previously, caregiver described this IHT and TM team as the first that she could trust in ten years of service. The IHT has approached the family in a collaborative spirit with the level of hands-on support that caregiver has needed. He has supported caregiver in attending all meetings that concern the youth, including DCF, school, psychiatry appointments, and regular meetings at the CBAT program where sister spent a month.</p>	<p>ICC The team has never met with the youth and just recently started to try to get him to join CPTs. However, no effort has been put into making his voice heard, preparing him for meetings, and helping him further engage in this process.</p> <p>IHT Mother has been very cooperative with services, and youth has gradually warmed up. However, engagement would be significantly improved if there were some creative effort to engage father in at least one meeting. Mother also reports having concerns about progress, which she says that she has not expressed directly to IHT. This suggests that engagement is not secure enough for open dialog about the service, and IHT team does not regularly and openly ask for feedback.</p>
Team Formation	<p>ICC The ICC was incredibly thoughtful in the development and ongoing participation of all team members. For example, the caregiver's partner traveled significantly for employment reasons and the OP therapist was often unable to attend due to a limited schedule. The ICC consistently brought their celebrations and concerns to the care planning process and utilized the absent partner form.</p> <p>IHT While there have been fewer full team meetings than the IHT clinician would prefer, he has done an outstanding job of collaborating with a wide range of professional and natural supports. He participates in person in every relevant meeting, including clinical meetings at the sister's CBAT, recognizing the</p>	<p>ICC In over a year of service, meetings have consisted only of the ICC and mother, or suspension hearings with school personnel, mother, and ICC, which did not address the Care Plan or any other coordination of care with participants. The ICC was not in touch with the new school until school personnel called her. Despite reports of good rapport between youth and former school, there was no one from that school approached as a team member. Neither the probation officer nor the CRA attorney have been considered as team members, when this situation cries out for consistent, coordinated effort. Youth also has excellent supports in his sports league teams, but the ICC was not even able to identify what or where the teams were. The result of adverse team formation is a fragmented, inconsistent, unsustainable approach to youth's serious academic and</p>

Area	Strong Practice	Practice Needing Improvement
	<p>impact on the family of her treatment and return home. He keeps all parties informed of important developments, and he engages others in working as a team. This is especially notable with the TM who plays an important role in practicing skills with youth and keeping in touch with caregiver and school every week. The team includes extended family who help with respite as well as supportive community resources such as the community police liaison and sports team coaches.</p>	<p>behavioral issues.</p> <p>IHT The IHT Clinician actively engaged her TT&S in the service delivery as they were a team throughout the case. The IHBS Therapist was also engaged in the last month since she started. However, the IHT never had any contact with the IHBS Monitor, the prescriber, the OPT, the PCP, the youth's school or the after-school program. During the time the ICC was involved, there was no engagement with that person either despite their outreach to the IHT by letter. Natural supports that were sometimes present as alternate caregivers were not engaged either.</p>
<p>Team Participation</p>	<p>ICC All team members have demonstrated a strong commitment to helping this family through their consistency with meeting with the family and attending all meetings. Members attend every CPT meeting and report progress to ICC weekly by phone. Conference calls between providers are scheduled in between CPTs to increase communication and ensure roles are clear amongst all team members. Psychiatrist communicates regularly with the grandmother, as well as IHT clinician, who reports back to the team. School communication and collaboration with the family and ICC is consistent. Team members have participated in several school meetings. Care Plan meetings and school meetings have been combined. All team members attended a discharge meeting when the youth was leaving CBAT.</p> <p>IHT A testament to the good work with this family by both IHT and DCF is the commitment of the DCF worker to hold a team meeting at DCF every other month to help coordinate all services for the 3 children. Similarly, the school personnel have adapted their approach to youth to use behavior management strategies suggested by the IHT clinician that are consistent with successful approaches at home, and youth's school progress has been notably higher since this coordination. The clinician has been collaborating with the school to bring all team members together for regular meetings. There has been 3 meetings with the school, youth's mother, the clinician, Family Partner, and DCF. One of the youth's psychiatrist conferenced in to brainstorm with the team, including the school nurse, around the youth's medications.</p>	<p>ICC Individuals invited to the CPT were not consistent contributors and there was no evidence of effort to boost participation. Mother's boyfriend attended once only. The OP therapist often had scheduling conflicts. Youth attended only in the summer when not in school. The DCF worker did not reply to the email invitation, and the ICC took no further steps to engage him, despite saying that their organization has a good relationship with the local DCF office.</p> <p>IHT The IHT clinician includes the TT&S and the TM on the team. She collaborated with the youth's old outpatient therapist a couple of times. However, she never included the prescriber or the youth's school in service delivery or planning. Some of the family's natural supports were included in service delivery if they happened to be around, but it was never done in a planned or purposeful way.</p>
<p>Care Coordination</p>	<p>ICC There is very good coordination among the providers. Mother was able to describe everyone's unique role. The ICC has been very active in helping mother navigate various systems (DTA, DDS, the schools). The Family Partner and TM both noted that the ICC is a good communicator, and that they always feel they know what is happening with the youth and family. The current prescribing psychiatrist is the consulting psychiatrist to this CSA, which has made consultation and collaboration easier.</p> <p>IHT The clinician for this family is doing an excellent job with this team. There are many providers involved with this family, including the IHT Team, DCF Adoption Worker, DCF Social</p>	<p>ICC Care coordination is substandard. ICC has left communication with the school almost entirely to mother, despite evidence of significant conflict between mother and school personnel about the way the school has handled some of her son's behavior. Lack of effort with DCF is also especially concerning, given that mother did not admit to reviewers that DCF is involved, and their investigation began with a police raid on the home.</p> <p>IHT This youth is not receiving the amount of care coordination her situation requires. There is only coordination with her TT&S and the TM from within the same agency. Other than that, her team does not work together and is not planning the youth's</p>

Area	Strong Practice	Practice Needing Improvement
	<p>Worker, Attorney for the youth, Attorney for the mother, GAL, family members and PCP. Monthly meetings are held and are attended by the team. The clinician also keeps everyone informed by email and phone. She is always available to provide information to the team and has done a great job of keeping everyone informed and coordinating the care for this youth and family. She recognizes that she has a good relationship with the family and that the family trust her to coordinate these services, especially given the complexities. She uses her clinical expertise to help everyone understand the issues.</p>	<p>treatment and interventions together. When asked about communication with the youth's OPT, she admitted that she has not kept the OPT in the loop, but thinks the caregiver updates her. She said she did not feel that more coordination was necessary since they were on the same page. She felt that way because they had similar treatment goals regarding communication, coping, and social skills. When asked about the youth's prescriber, the IHT clinician said it used to be the PCP until the youth stopped taking her medications. However, she had never attempted contact with the PCP other than sending him a release when the case opened.</p>
Transition	<p>ICC ICC and Family Partner were actively involved in assisting the family transition to their new apartment and connect to their new community at the end of September. They provided support by making calls to the housing authority and assisting the mother in gathering all needed documentation. They provided guidance around the transfer of the IEP to the new school. Additionally, they have been working towards preparing the family to transition out of Wraparound/ICC services. The youth's mother is well aware of the transition and feels she has acquired the skills to coordinate her son's care.</p> <p>IHT Every time a staff changed, IHT had a face to face meeting to hand off from one provider to another. He led very strong communication during the two CBAT and STARR placements, learning from each (for example, the CBAT report of trauma to youth in connection to his father's arrest). This teamwork supported smooth transitions home. He supported an excellent transition with youth to discontinue medications, with frequent reporting to the prescriber by the youth and careful, monitored withdrawal. (This was especially notable since previous non-compliance with medication had been an issue.) In terms of transitioning out of services, IHT has gradually slowed down to exit, with more focus on the family taking over (caregiver is the school contact, youth is taking charge of his treatment decisions).</p>	<p>ICC Transitions are not being anticipated and planned for appropriately. This is the family's third time receiving ICC services and there have been no conversations about what needs to happen differently this time to ensure the family is able to continue their success. Yet, in the caregiver interview, she stated that she thinks a factor in the family not being successful after ICC services close is that all their other services end up closing at the same time. She said she hoped that does not happen again. Another major transition coming is that the ICC will be leaving his position in about two weeks, and the family does not seem to be aware of it.</p> <p>IHT This family is now working with their third IHT clinician. The first one had her last session with the family without them knowing it would be their last session. The next one was assigned several weeks later, but never documented any notes, having an unknown amount of contact with the family. He was let go from the agency abruptly, and the third clinician was assigned. The first two clinicians left so quickly and without notice that it did not allow for proper transition planning. A major transition coming up for this youth is that he will be starting kindergarten in the fall. The IHT clinician does not seem aware of the significance of this considering his emotional and behavioral struggles at this time in pre-K and at home. Regarding the family's transition out of IHT, they have not discussed this at all, except to say the case will close when they meet all their goals. The IHT clinician also said that they will speak with the family about closing one month before they do it.</p>
Responsiveness	<p>ICC The ICC was responsive to the referral source's request of meeting together initially, so the intake was done at the school with the youth and caregiver upon discharge of partial. When it came to making referrals for a new therapist and psychiatrist, the ICC hand-picked providers as much as possible, in hopes of getting the most appropriate match. The ICC recently made a referral for a new TM for the youth, personalized it to include details about this youth's needs in a TM, and her program director attached a letter to the referral similarly requesting an appropriate match.</p> <p>IHT The IHT services started almost immediately after referral. At the start of service, the clinician immediately began to work with the</p>	<p>ICC The family was on a waitlist for over three months for an ICC, though the agency provided the family with a FP during that time. The family's original referral for DDS fell through the cracks when the team realized the previous FP had not submitted it and found it in her office. The ICC then completed the process herself. IHT made several referrals for this youth and it is unclear if these were decided as a team. Both the IHT therapist and the ICC made referrals for neuro-psychological evaluations, but it was unclear if they were aware of it.</p> <p>IHT The IHT team's confusion regarding the IHBS referral was concerning and no one is following up on it (the TT&S said the</p>

Area	Strong Practice	Practice Needing Improvement
	<p>family on requesting special education services. The clinician also made referrals to Therapeutic Mentor and Family Partner (ICC services were offered but the family declined) to connect the youth and his family to a variety of community resources. The family was also connected to a PCP, and the youth to a psychiatrist with the assistance of the IHT clinician and FP. The clinician is also working with the FP agency to assign a new FP since the initial FP left the agency abruptly. A referral to outpatient therapy for the youth was also made in preparation for transition out of IHT.</p>	<p>clinician completed it, but the clinician said it was the TT&S). The clinician also reported that they do not follow-up on referrals, and wait for the family to say they were contacted by the IHBS program when they check on the waitlist. There is also some confusion around the TT&S helping the family apply for DMH. This task was not in the clinician's notes or on the service plan, and when the youth was accepted for DMH, the family declined it because they did not want their current IHT team replaced with another in-home team through DMH.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Service Accessibility</p>	<p>ICC Communication was a significant focus for the first year of work. The ICC and team members were creative and persistent to ensure that the mother understood the information. They used visual gestures to introduce materials and consistent repetition. Initially the TM agency wouldn't provide an ASL interpreter, so the ICC advocated with agency leadership and notified the MCDHH. The school had difficulty obtaining interpreters and the ICC advocated in a strong but supportive manner. At times, the grandmother would attempt to translate but the ICC encouraged her not to do so in order that she be able to fully participate in the meeting. Also, when the TM was using the youth to interpret the ICC helped the entire team (including the youth) understand why this was not appropriate.</p> <p>IHT In addition to the expected flexibility and respect for family preferences, this IHT has gone to meet with the family on Saturdays in response to urgent need, has initiated the therapy sessions at the residential program, and met with the family almost every day over the summer when the whole family was struggling.</p>	<p>ICC Services were always provided at the office due to the results of a safety assessment completed at the beginning of the case. However, there had not been any contact with perpetrator since 2011. FP has gone to house once but the ICC had not spoken to her supervisor about changing the decision "because it is working out fine." Caregiver's transportation struggles have led to cancelled appointments.</p> <p>IHT The IHT clinician and TT&S speak Spanish to the family, which is their preferred language. However, all written documentation is provided to the family in English. The provider says they verbally translate the documents when they review it with the family, but hadn't considered translating them into Spanish.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Cultural Awareness</p>	<p>ICC This ICC took the time to understand mother's attitudes and values about school and compulsory education and correctly hypothesized that the values from her own childhood were, in part, contributing to the difficulties with the youth attending school. ICC also noted the differences between his experience and values being from urban Mexico City and this mother being from more rural Puerto Rico, and was able to talk with mother about this, which further helped their engagement.</p> <p>IHT The clinician has an excellent understanding of this family's culture. She understands the trauma that the youth has experienced, including being removed from his mother three times. She also understands the generational trauma experienced by caregivers. She has a good understanding of the positive relationship the youth had with his father, the traumatic grief the youth is experiencing as well as the grief that is experienced by the uncle at the loss of his brother. She understands that this is all new to these caregivers in raising a youth that has all of these experiences.</p>	<p>ICC The ICC expressed that the culture for this family was not incorporated into the work because "most of it is the same for most clients."</p> <p>IHT The IHT seems to have a general awareness of the family's connections to Latino culture but without any detail. The generalized idea of father's role as breadwinner and mother's role as caregiver was never explored, although it has provided a facile explanation for not in any way working with father even though children expressed strong need for more interaction with their father. There is essentially no understanding of adoption culture, or of the cultural aspects of having a blended family of 2 adopted and 2 birth children.</p>

Area	Strong Practice	Practice Needing Improvement
Cultural Sensitivity & Responsiveness	<p>ICC The ICC and Family Partner demonstrated a clear understanding and respect for the family. They were very aware of the trauma that youth and father were exposed to and how that impacted the current family functioning. They also had an appreciation of how the father was experiencing grief over the realization of his son's mental health challenges and also struggling with his own. Team members were all aware of the families past and current challenges. Interventions were geared towards maximizing family cohesion and positive experiences.</p> <p>IHT The IHT clinician did a wonderful job early on of exploring and respecting mother's religious beliefs and cultural heritage which allowed this mother to overcome her distrust and form a therapeutic working relationship. Additionally, the clinician incorporated this information into her coaching style with mother to support her through crisis.</p>	<p>ICC The family had a long history of disruptions through frequent moves and loss of family members, including the death of the maternal grandmother, loss of biological father due to domestic violence, and estrangement of the extended family members due to these losses. The ICC had very little knowledge of the family's history and the impact on current relationships and overall functioning.</p> <p>IHT Further exploration of the practice of grandparents raising children (noted by mother) might have prompted IHT to be more intentional about understanding the paternal grandmother's role in the family and potential inclusion in the intervention. There was also no record of any discussions of culture with any of the treatment team or school personnel.</p>